Kentucky HIV/AIDS
Planning and Advisory Council

August 31, 2007

Mr. Robert Sherman
Legislative Research Commission
Room 300, Capitol Building
700 Capitol Avenue
Frankfort, KY 40601

Dear Mr. Sherman:

Pursuant to KRS 214.640, the HIV/AIDS Advisory Council submits to the General Assembly its Year-End Report, dated August 31, 2007. Thank you for your attention to this information.

Sincerely,

Robert E. Stone, Chairman
Kentucky HIV/AIDS Planning and
Advisory Council

Attachment

cc: Robert Jenkins, Committee Staff Administrator
Interim Joint Committee on Health and Welfare

KENTUCKY
HIV/AIDS PLANNING AND ADVISORY COUNCIL

YEAR-END REPORT
SEPTEMBER 2007

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR PUBLIC HEALTH

TABLE OF CONTENTS

Executive Summary

The 2007 Year-End Report of the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) summarizes KHPAC's actions throughout the last year and offers recommendations to the Cabinet for Health and Family Services (the Cabinet) and the Kentucky General Assembly to ensure better health for HIV positive Kentuckians. Despite successful past efforts, critical issues remain that require immediate and ongoing attention.

KHPAC IS RECOMMENDING LEGISLATIVE ACTION IN THE FOLLOWING AREAS:

Funding of HIV Surveillance Activities
KHPAC supports the Kentucky Department for Public Health's HIV/AIDS Branch request for a $100,000 allocation of state funds to be directed to statewide core surveillance activities. Currently, these activities are receiving no state funding, and federal funding has remained flat at $130,000 for a decade. The lack of adequate funding of these activities has eroded the program resulting in a continuous struggle to provide comprehensive HIV/AIDS surveillance. Since federal funding of HIV/AIDS prevention and care services hinges on state surveillance data, KHPAC recognizes that increased funding to HIV/AIDS surveillance is imperative to assuring appropriate levels of federal funding for HIV prevention and care services.

HIV Testing of Inmates
HIV testing of inmates is an issue that was brought to the forefront of the 2007 Kentucky Legislative session in Senate Bill 201. While KHPAC concurs with the need for inmate testing for HIV upon release, there are other critical issues that need to be considered when implementing an HIV testing protocol within a correctional setting. KHPAC supports the development and implementation of a comprehensive HIV testing process for inmates that not only tests prior to release, but upon admission and as warranted by an inmates "known" engagement in risky behaviors. KHPAC believes that representation from the KY Department of Corrections and the KY Department for Public Health is critical for developing such legislation.

Support of HIV and Hepatitis C Initiatives for Correctional Facilities
KHPAC supports the Kentucky Department for Public Health's HIV/AIDS Branch request for $3.5 million to support HIV and Hepatitis C initiatives for Kentucky correctional facilities. There is a tremendous need to address the growing public health concern that individuals who are HIV positive and pass through our correctional settings present to our correctional facilities and communities. The HIV/AIDS Branch's request sites three immediate needs within Kentucky's correctional settings: a collaborative comprehensive educational program for inmates and correctional staff; an HIV and Hepatitis testing program; and an HIV discharge planning program, and KHPAC concurs fully with these identified needs.

Guardianship of Minor Children
Currently, Kentucky has no legislative provision for standby guardianship of minor children, or for parents to designate a guardian for their minor child without surrendering their parental rights. Recognizing this need in the population of persons infected with, and affected by, HIV/AIDS, KHPAC recommends that Kentucky adopt standby guardianship legislation, as endorsed by Congress with the passage of the Adoption and Safe Families Act of 1997. Standby

guardianship would provide Kentucky parents with a legal option to plan for the care of their minor child, without surrendering their parental rights. Such legislation would benefit all children in Kentucky, in the event of parental incapacity due to illness or injury.

Media Campaign
KHPAC recommends that the State implement a policy to assure the implementation of a statewide media campaign that is designed to decrease HIV infections by encouraging HIV testing in the general population.

Kentucky AIDS Drug Assistance Program
KHPAC recommends that the State increase its contribution to KADAP by $6 million. Although there is no longer a waiting list for Kentucky's AIDS Drug Assistance Program (KADAP), the recommended $6 million increase would provide KADAP with the increased capacity to serve HIV positive individuals who are also diagnosed with Hepatitis. As Appendix A demonstrates, Kentucky has approximately 300 individuals who are co-infected with Hepatitis C, and the annual cost for treatment of these individuals is estimated to be $576 thousand per month. An additional $6 million would allow KADAP to assist with Hepatitis C treatment medications, which are currently not available on the KADAP formulary and are cost prohibitive for most uninsured Kentuckians.

Condom Accessibility
KHPAC recommends that legislation be passed allowing inmates within Kentucky correctional facilities to purchase, possess and use condoms as a part of a comprehensive prevention and education program with a goal of reducing the spread of HIV and other sexually transmitted diseases. Two sample bills are contained within the 2007 Year-End Report to assist the Kentucky Legislature in developing such legislation, and KHPAC welcomes an invitation by the Legislature to assist in developing such legislation. KHPAC also recommends that the Department of Corrections be consulted during the development of this legislation.

Promote Harm Reduction
KHPAC recommends implementation of a statewide Harm Reduction Program, targeting individuals engaging in high-risk behavior, in order to prevent/reduce the transmission of HIV, Hepatitis and other blood borne diseases. KHPAC further recommends that current legislation be revised/repealed to permit implementation of a fully effective harm reduction program. Considering limited funding, strategies employing harm reduction have been proven to be both highly successful, and cost effective, when compared with more stringent interventions used in the past. These recommendations are based on the fact that the use of a new, sterile syringe for every injection is a critical component to preventing the spread of HIV, Hepatitis and other blood borne diseases.

HIV/AIDS Continuing Medical Education Requirements
KHPAC recommends implementing a two-tier, profession specific approach to continuing HIV medical education for healthcare providers. This continuing HIV education will be required every two years, thereby providing timely and relevant HIV information in a complex and ever-changing field.
KHPAC IS RECOMMENDING REGULATORY ACTION IN THE FOLLOWING AREAS:

Disease Surveillance
KHPAC recommends that the Cabinet revise 902 KAR 2:020 Section 7 (1) so that the regulation is more inclusive, regarding which healthcare providers and facilities are required to report diagnosed cases of HIV and AIDS. Currently 902 KAR 2:020 Section 7 (1) reads, "Physicians and Medical Laboratories shall report…" KHPAC contends that 902 KAR 2:202 Section 7 should be revised to more clearly state who is required to report new HIV and AIDS cases to the State.

Re-Entry Programs from Correctional Settings to the Community
The Cabinet of Health and Family Services and the Department of Corrections assess current re-entry plans and create mechanisms which foster greater levels of cooperation between HIV care and services providers and state correctional centers when an inmate is exiting a correctional facility and returning to his/her community .

KHPAC HAS IDENTIFIED THE FOLLOWING ADDITIONAL "HOT TOPICS":

Increase Access to HIV Information
KRS 214.620 Subsection 4 ensures that Kentuckians will have access to information related to HIV infection when receiving services through certain identified facilities. KHPAC is concerned that several types of treatment facilities are not currently covered under KRS 214.620 and that critical information related to HIV testing is not mandated under the statute as written. However in July of this year we learned that such a requirement may already exist so KHPAC is in the process of reviewing this new information and determining if this concern has previously been addressed through legislation or regulatory action. Therefore KHPAC reiterates its concerns here in the 2007 report, but cautions on any action until a better understanding of any gaps is determined.

School-Based Youth Educational Programs
Recently, studies and peer reviews have questioned the effectiveness of abstinence only programs in schools. Teen pregnancy and sexually transmitted disease in our youth are a concern that KHPAC began to explore more thoroughly this year, and as a result of this exploration, KHPAC concludes that there are available actions that can be taken to benefit Kentucky's young people. But at the same time KHPAC is keenly aware that each school and school district has a unique set of circumstances that need to be considered when developing effective educational tools to address HIV education as required by the Kentucky Department of Education's Program of Studies, revised 2006. In the coming years, KHPAC envisions a partnership with the Department of Education and school-based decision making councils to develop educational programs that are appropriate to specific communities' needs.

Condom Accessibility in School Settings
Is making condoms available in school settings an appropriate activity? If you just consider two conclusions to this question, you probably answered yes or no, but the issue is one that is much more complicated. KHPAC believes that there are Kentucky schools where making condoms available to students should be practiced, but determining which schools is not a simple matter. In a continued effort to assure the health of our young people KHPAC has identified condom accessibility in school settings as a "hot" topic, which requires our attention and action in the coming years.

Section I

LEGISLATIVE ACTION

A. Funding of HIV Surveillance Activities

Kentucky HIV/AIDS Planning and Advisory Council Recommendation:

The State provide, at least, $100,000 to be directed to statewide core HIV/AIDS surveillance activities.

KHPAC supports the Kentucky Department for Public Health, HIV/AIDS Branch request for a $100,000 allocation of state funds to be directed to statewide core surveillance activities. Currently, these activities are receiving no state funding, and federal funding has remained flat at $130,000 for a decade.[1] The lack of adequate funding of these activities has eroded the program resulting in a continuous struggle to provide comprehensive HIV/AIDS surveillance. Since federal funding of HIV/AIDS prevention and care services hinges on state surveillance data, KHPAC recognizes that increased funding to HIV/AIDS surveillance is imperative to assuring appropriate levels of federal funding for HIV prevention and care services.

The appropriations request from the HIV/AIDS Branch identifies several ways in which this funding will broaden the capacity of HIV/AIDS Surveillance services:

1. The data collection process will be broadened to increase case finding opportunities and educate providers on reporting requirements;
2. Extensive patient chart reviews will be conducted;
3. A medical provider reporting certification training program will be implemented; and
4. A more aggressive interstate reporting program will be implemented.[2]

Kentucky delayed the implementation of HIV reporting until July 2004, and while KHPAC concurs with this decision, there is now an urgent need to assure timely reporting of new HIV and AIDS diagnoses while in tandem identifying pre-existing HIV positive diagnoses. The requested allocation of state funds would foster achieving this goal.

To close on this recommendation it should be noted that federal funding for prevention and care services is contingent upon the number of Kentuckians diagnosed with HIV or AIDS. Subsequently, HIV/AIDS surveillance is crucial to assuring adequate prevention and care services. Currently, there are only three HIV/AIDS staff responsible for covering Kentucky's 120 counties. Is this adequate? KHPAC agrees that it is not, and we recommend that the Department for Public Health, HIV/AIDS Branch's request for $100,000 in state funding be allocated in the FY2008 Appropriations legislation.

[1] Appendix 1.
[2] Appendix 1

B. HIV Testing of Inmates

Kentucky HIV/AIDS Planning and Advisory Council Recommendation:

The State establish a process for conducting HIV testing of an inmate upon entry, during incarceration and before his/her release from any unit or center of the department. HIV testing should include counseling regarding treatment options if an inmate tests positive for human immunodeficiency virus (HIV).

HIV testing of inmates is an issue that was brought to the forefront of the 2007 Kentucky Legislative session in Senate Bill 201.[3] While KHPAC concurs with the need for inmate testing for HIV upon release, there are other critical issues that need to be considered when implementing an HIV testing protocol within a correctional setting. KHPAC supports the development and implementation of a comprehensive HIV testing process for inmates that not only tests prior to release, but upon admission and as warranted by an inmates "known" engagement in risky behaviors. KHPAC believes that representation from the KY Department of Corrections and the KY Department for Public Health is critical for developing such legislation.

"HIV rates are fourteen times higher in this [correctional] population than the general U.S. population."[4] Consequently, HIV testing of inmates upon release is a practical step for reducing the spread of HIV disease. However HIV testing of inmates is often a "fueled" topic. In some cases HIV testing of inmates is synonymous with the right for some one else to know. KHPAC contends and research supports that HIV testing within correctional settings should be designed to educate individuals on effective ways to reduce the spread of HIV, and if an individual tests HIV positive, to help that person understand an HIV diagnosis, access treatment and medications, and reduce the risk of exposure to others. HIV testing should not be a method for informing others of someone's HIV status.

KHPAC implores the Kentucky Legislature to afford inmates the same privacy protections that are afforded any Kentuckian who is tested for HIV and/or whose HIV test is positive. In addition, KHPAC believes such legislation should contain an "informed" opt-out provision. An opt-out provision means that an inmate may refuse a test for HIV, and his/her refusal will not be considered a violation of prison rules or result in disciplinary action.[5]

In other states and jurisdiction where inmates are tested for HIV there is usually an agreement between the correctional facility and a Community-Based or governmental public health provider to conduct the testing and counseling. In fact, there is already a Kentucky example of such an arrangement in Davies County.[6] The tests that are conducted within correctional facilities thus become a part of that agencies annual testing plan, and the costs are incurred by the agency conducting the testing as part of their annual provision of services. KHPAC believes that a collaborative effort between the Department of Corrections and the Department for Public

[3] Appendix 2.
[4] Appendix 3.
[5] Appendix 4.
[6] Appendix 5, page B3.

Health would allow for HIV testing to be implemented within correctional facilities without the allocation of additional state funds.

In summary, KHPAC requests that the Legislature call upon the Department of Corrections and Department for Public Health to develop an HIV testing program for inmates. This testing program should be part of a broader educational program that promotes behavior changes that reduce the spread of HIV, and foster participation in treatment and adherence to prescribed treatments while incarcerated and upon release.

C. Support of HIV and Hepatitis C Initiatives for Correctional Facilities

Kentucky HIV/AIDS Planning and Advisory Council Recommendation:

The State provide $3.5 million to support HIV and Hepatitis C initiatives within correctional facilities.

KHPAC supports the Kentucky Department for Public Health, HIV/AIDS Branch request for $3.5 million to support HIV and Hepatitis C initiatives for Kentucky correctional facilities. As was indicated in earlier parts of the Year-End Report and in the HIV/AIDS Branch's appropriations request, there is a tremendous need to address the growing public health concern that individuals who are HIV positive and pass through our correctional settings present to our correctional facilities and communities. The HIV/AIDS Branch's request sites three immediate needs within Kentucky correctional settings:

1. A collaborative comprehensive educational program for inmates and correctional staff;
2. An HIV and Hepatitis testing program; and
3. An HIV discharge planning program,[7]

and KHPAC concurs fully with these identified needs.

During this past year, KHPAC has developed a keen awareness of HIV/AIDS issues as they relate to correctional settings, and our 2007 Year-End Report is reflective of that. Four of fifteen issues identified within this report are specifically related to HIV and correctional facilities. As much of the research accompanying this report indicates, the relationship between HIV and individuals who pass through correctional facilities is of growing concern. This is not a new development. The law enforcement profession itself has long stressed the need for correctional facilities to become more proactive in their approach to preventing, identifying and treating HIV within their facilities.[8] However there continues to be a lot of fear and discrimination surrounding the response to HIV within correctional facilities.

KHPAC applauds and supports the HIV/AIDS Branch for their courage in seeking $3.5 million to promote a collaborative comprehensive educational program, provide an HIV and Hepatitis testing program within correctional facilities, and develop and implement a discharge planning program for individuals who are HIV positive. KHPAC also recommends that implementation of these programs be a collaborative effort between the Department of Corrections and Department for Public Health. KHPAC now calls upon the Kentucky Legislature and Governor to bring this request to fruition and thus, answer a call that has gone unheralded for far too long.

[7] Appendix 1.
[8] Appendix 6.

D. Guardianship of Minor Children

HIV/AIDS Planning and Advisory Council Recommendation:

Amend Kentucky's guardianship laws to create standby guardianship for minor children.

KHPAC recommends that the Legislature amend Kentucky's guardianship legislation to create a new section for standby guardianship of minor children.[9] Furthermore, KHPAC requests that the Cabinet support KHPAC's recommendation for standby guardianship, and make a commitment to encourage the creation of standby guardianship legislation in its communications, and interactions during the 2008 legislative session.

Currently, Kentucky has no legislative provision for standby guardianship of minor children, or for parents to designate a guardian for their minor child without surrendering parental rights. Recognizing this need in the population of persons infected with, and affected by, HIV/AIDS, KHPAC recommends that Kentucky adopt standby guardianship legislation, as endorsed by Congress with the passage of the Adoption and Safe Families Act of 1997. As of July 2006, twenty-two States and the District of Columbia had passed a version of standby guardianship legislation that incorporates the spirit of the Adoption and Safe Families Act of 1997. Standby guardianship would provide Kentucky parents with a legal option to plan for the care of their minor child, without surrendering their parental rights. Such legislation would benefit all children in Kentucky, in the event of parental incapacity due to illness or injury.

Any parent could become seriously ill at any time, and be unable to meet the responsibilities of caring for their child. Examples of such situations include: major trauma, chemotherapy, radiation, or diagnosis with a serious illness such as cancer or HIV/AIDS. Some previously terminal illnesses have become chronic or even curable illnesses due to advances in medical science. Standby guardianship allows a parent to grant temporary custody of their child to a person of their choosing, during the parent's intermittent or temporary incapacity related to his/her/their illness or injury. Standby guardianship provides a means for legislation to keep pace with advances in medical care and treatment by addressing one of the many societal issues associated with these advances.

In enacting the Adoption and Safe Families Act of 1997, Congress endorsed standby guardianships and urged states to adopt standby guardianship legislation or similar legislation for cases where a child's future care is at risk and adoption is not feasible. In addition to the previously noted states with such legislation, several other states have standby guardianship legislation pending. These states have all recognized that standby guardianship laws allow a parent with a progressive or chronic illness to designate a caregiver for a child in the event of the parent's incapacity. This designation can occur during the parent's life and may be triggered by

[9] Kentucky currently does have a guardianship provision that allows for a petitioner to name a person to act on the petitioner's behalf in the event of the petitioner's incapacity. This provision allows the petitioner to designate this "standby" guardian in advance, subject to court approval. The standby guardian becomes legally authorized to act for the petitioner upon a "triggering event", i.e. the petitioner's incapacitating illness. However, this only allows the stand-by guardian to act for the petitioner; it does not authorize the guardian to act as the legal custodian or guardian for the petitioner's minor children. See KRS 387.330.

the parent's incapacity. The standby guardian has authority to make legal, medical and other decisions for the child. Such legislation allows for an orderly transfer of legal authority from parent to standby guardian and back to parent with minimal need for court approval or oversight.

During the 2006 legislative session, H.B. 221, relating to the standby guardianship of minors, was passed 94-0 by the House of Representatives, and received in the Senate Judiciary committee for consideration. The session ended before the Senate was able to consider the bill. However, the bill had wide support in both chambers, as well as the support of educational professionals across the state. The legislator who sponsored H.B. 221 agreed to sponsor similar legislation during the 2007 legislative session, as well as seek bipartisan sponsorship of the legislation in both chambers of the legislature.

E. Statewide Media Campaign

Kentucky HIV/AIDS Planning and Advisory Council Recommendation:

The State establish a media campaign designed to decrease HIV infections by encouraging HIV testing in the general population.

In compliance with CDC guidance, HIV prevention efforts in the state of Kentucky have focused almost exclusively on high-risk groups. To date, little effort has been made to reach the general population of Kentucky.

A statewide media campaign using billboards as well as printed publication, radio, and television advertisements would be a powerful way to address this gap. Such a strategy would reach a majority of Kentuckians, including individuals knowingly practicing high-risk behaviors, as well as individuals who may not consider themselves to be at risk. Anecdotal evidence from localized media campaigns in Lexington, Paducah, and Northern Kentucky strongly suggests that there will be a direct increase in those seeking testing and prevention counseling as a result of such a statewide campaign.[10] This is consistent with the CDC's own *Morbidity and Mortality Weekly Report*, "National HIV Testing Day at CDC-Funded HIV Counseling, Testing, and Referral Sites—United States, 1994–1998" (June 23, 2000), which reported that media campaigns have had a direct and positive effect on counseling and testing nationally.

Key components of a statewide counseling and prevention media campaign would be:

- The involvement of an action/advocacy entity such as the Kentucky HIV/AIDS Advocacy and Action Group to actually facilitate the implementation of the campaign throughout the state.
- One key message translated as appropriate to reach primary populations that speak languages other than English (examples include "HIV is alive and well. Are you?" "Are you (HIV positive)? How do you know?" "Got HIV?").
- A coordinated effort to secure donated advertisement space/time as well as grant and matching funding (examples include local access cable channels, working with local media outlets to obtain donated time/space, and applying for grants from sources such as the Tony Cox Grant Foundation).
- Visible signs providing the contact information of the nearest facility that offers HIV testing and counseling to be displayed in facilities offering health care and social services.
- A standardized means of tracking the numbers of people statewide who respond to the campaign, by indicating that the media campaign was a factor in their decision to seek counseling and testing.
- A commitment from the Kentucky Legislature for funding of such a campaign upon presentation of evidence that the pilot phase of the program has generated a measurable increase in counseling and testing statewide.

[10] Appendix 7

KHPAC recommends that the State take the following actions in policy rather than legislation to assure implementation of the media campaign:

1. The Legislature passes a resolution supporting the campaign.

2. The Governor signs a proclamation adopting the campaign.

3. The Secretary for the Cabinet directs the Commissioner for Public Health to establish a committee consisting of representatives from the HIV/AIDS and STD Branches, State and Local Health Departments, the Kentucky HIV/AIDS Advocacy and Action Group, Community Based Organizations and other volunteers to discuss means of funding a statewide media campaign in the shortest possible time.

4. Provide the concept of this campaign to state and local medical communities and strongly encourage their support in making this a Statewide-Community effort.

F. Kentucky AIDS Drug Assistance Program Funding (KADAP)

HIV/AIDS Planning and Advisory Council Recommendation:

Increase the State's financial contribution to KADAP.

KHPAC recommends that the State increase its contribution to KADAP by $6 million. Although there is no longer a waiting list for Kentucky's AIDS Drug Assistance Program (KADAP), the recommended $6 million increase would provide KADAP with the increased capacity to serve HIV positive individuals who are also diagnosed with Hepatitis. As Appendix A demonstrates, Kentucky has approximately 300 individuals who are co-infected with Hepatitis C, and the cost for treatment of these individuals is estimated to be $576 thousand per month.[11] An additional $6 million would allow KADAP to assist with Hepatitis C treatment medications, which are currently not available on the KADAP formulary and are cost prohibitive for most uninsured Kentuckians.

KHPAC is aware that Kentucky has experienced some financial struggles in recent years, and despite this, legislative action has been taken to increase the State's annual contribution to KADAP. In fact, in 2006 the House Budget Review Committee recommended a $750,000 increase to KADAP. Although this was not approved, KHPAC appreciates the $70,000 funding increase authorized through H.B.1 of the 2006 Legislature. No additional State funding was allocated to KADAP by the 2007 Legislature. The grave situation that exists for individuals co-infected with HIV and Hepatitis C warrants the allocation of additional state funds.

The implementation of Medicare Prescription Drug Plans has been instrumental in eliminating the KADAP waiting list however Hepatitis C treatment of co-infected individuals is now paramount and requires state funding to assure appropriate medical care of some 300 Kentuckians co-infected with HIV and Hepatitis. As Appendix A indicates the average monthly cost for Hepatitis C treatment is approximately $1,920.[12] A patient being treated for Hepatitis C usually would receive 4 Peg Intron ($869.64), 1 Pegasys Kit ($824.59) and 2 Intron A ($225.86) per month.

The medications that KADAP currently makes available to eligible Kentuckians are necessary to keep individuals in the work force, keep them from becoming more ill, and to help prevent other healthcare costs. However, the absence of Hepatitis C treatment medications on the KADAP Formulary promotes the possibility that a person with HIV might require inpatient medical, treatment. Additional state funding of KADAP would go a long way to reducing the likelihood of such inpatient care. Subsequent cost reductions would result through decreased hospitalizations, and decreased urgent and emergency care needs. HIV positive individuals, who remain healthy, are more able to work, pay taxes, and participate in the daily economy of our State. Consequently, KHPAC recommends increasing the State's financial funding of KADAP to $6.25 million (the current $250,000, plus $6 million) thus preventing future more costly health

[11] Appendix 8
[12] Appendix 8

care expenditures and providing access to Hepatitis C medications to all KADAP eligible Kentuckians.

G. Condom Accessibility in Correctional Settings

Kentucky HIV/AIDS Planning and Advisory Council Recommendation:

The State permit a committed person to obtain, possess, and use condoms. In doing so the Department of Corrections shall develop a plan to make condoms available to a committed person according to established public health practices in a manner that protects the health, safety and privacy of the committed persons and correctional facility staff.

Because of the disproportionately high prevalence of HIV infection among individuals who are or who have been incarcerated, KHPAC urges the Legislative and Executive branches to pass legislation allowing for condoms to be distributed and possessed within correctional facilities. According to Public Health and Corrections, "HIV rates are fourteen times higher in this [correctional] population than the general U.S. population."[13]

Perhaps the strongest statement for a call to action comes from the American Journal of Public Health, "Correctional inmates engage in drug-related and sexual behaviors, and the transmission of HIV, hepatitis, and sexually transmitted diseases occurs in correctional facilities…Whether infection was acquired within or outside correctional facilities, the prevalence of HIV and other infectious diseases is much higher among inmates than among those in the general community, and the burden of disease among inmates and releasees is disproportionately heavy. A comprehensive response is needed…."[14]

In other states and jurisdictions where condoms are distributed to inmates such distribution is usually conducted by a community-based or governmental public health provider. Condoms are distributed by workers from these agencies as part of their annual comprehensive disease prevention strategy. KHPAC asserts that if the Department of Corrections and Department for Public Health work with statewide correctional facilities and disease prevention programs similar methods for providing condoms to prisoners can be developed and thus, eliminate the need for additional public funding.

Making condoms available to inmates is one strategy for reducing disease transmission within correctional settings. KHPAC is aware that many opponents of condom distribution programs site the fear of "legitimizing" illegal and/or prohibited behaviors such as sex among prisoners (consensual or otherwise), and drug use. These are fears that should be taken seriously, but KHPAC's evaluation of the research on the topic suggest otherwise. Dr. Elizabeth Kantor's research reports, "Condoms have been available in most European prisons for more than ten years. Studies have found few incidents of improper condom use and a high level of reported safer sex.[15] In addition, the National Sheriffs' Association's study on AIDS within the correctional system has long been a proponent of condom distribution within correctional

[13] Appendix 3.
[14] Appendix 9.
[15] Appendix 10.

settings even providing a sample condom distribution procedure.[16] In fact several state and urban jail systems including Vermont, Mississippi, New York City, Philadelphia, Los Angeles, San Francisco, and the District of Columbia allow condom distribution within their correctional facilities.[17]

KHPAC recommends that inmates within Kentucky correctional facilities be allowed to obtain, possess and use condoms as a part of a comprehensive prevention and education program with a goal of reducing the spread of HIV and other sexually transmitted diseases. Two sample bills are contained within the 2007 Year-End Report to assist the Kentucky Legislature in developing such legislation, and KHPAC welcomes an invitation by the Legislature to assist in developing such legislation.[18] [19] KHPAC also recommends that the Department of Corrections and Department for Public Health maintain an ongoing dialogue during this process.

[16] Appendix 6.
[17] Appendix 10, page 9.
[18] Appendix 11.
[19] Appendix 12.

H. Promote Harm Reduction

HIV/AIDS Planning and Advisory Council Recommendation:

Promote Harm Reduction

KHPAC recommends implementation of a statewide Harm Reduction Program, targeting individuals engaging in high-risk behavior, in order to prevent/reduce the transmission of HIV, Hepatitis and other blood borne diseases. KHPAC further recommends that current legislation be revised and/or repealed to permit implementation of a fully effective harm reduction program. Considering limited funding, strategies employing harm reduction have been proven to be both highly successful, and cost effective, when compared with more stringent interventions used in the past. These recommendations are based on the fact that the use of a new, sterile syringe for every injection is a critical component to preventing the spread of HIV, Hepatitis and other blood borne diseases.[20]

Harm Reduction is the adoption of policies and programs designed to reduce the adverse medical, public health, social and economic consequences of risky behaviors to the individuals engaging in the behavior, as well as, their families and the community, without requiring the cessation of the behavior. The societal benefit of harm reduction programs is the protection of the health and welfare of both the individual, and the community, until such time as the individual engaging in the risky behavior is ready and able to enter rehabilitation. Harm reduction is not the same as legalization, nor does adoption of harm reduction express support for legalization of the specific behavior. The success of harm reduction techniques applied to other public health concerns is well documented and generally accepted by the public.

With the exception of providing lifesaving medication for people living with HIV, harm reduction principles provide the most effective means to target limited funding to the individuals most at risk. KHPAC is not suggesting that a harm reduction program be implemented among the general population in Kentucky, but rather targeted to the population within the community engaging in high-risk behavior. Harm reduction strategies would:

- Test and educate individuals who are truly at risk for HIV infection.
- Provide HIV positive citizens, and those most at risk, with complete and culturally appropriate education for living a healthy lifestyle and preventing the spread of HIV.
- Decriminalize possession and distribution of sterile injection equipment, and provide for safe disposal of syringes, while simultaneously providing education on healthy lifestyles and access to addiction treatment.

The magnitude of the HIV infection among injection drug users (IDUs) is strongly indicative that treatment, prevention and criminal penalties have been ineffective in reducing the adverse effects of injection drug use. Harm reduction strategies such as needle exchange programs, which provide sterile syringes, decriminalize the possession/sale of injection equipment and promote

[20] Robert Wood Johnson Foundation – Grants Results Report: A U.S. Needle Exchange Program Dramatically Reduces HIV Transmission, March 2002

safe disposal of syringes, have been proven to effectively reduce HIV infection in injecting drug users (IDUs), their families and the community as a whole.
CDC estimates that intravenous drug use accounts for nearly one-third of all AIDS cases, and nearly half of all cases of Hepatitis C. Currently there are needle exchange programs in over 140 cities, and 13 states. Many respected national organizations support open access to sterile injection equipment. These organizations include: the American Bar Association, the Association of Pharmacists, the Center of Disease Control and Prevention (CDC), the American Medical Association, and the National Institutes of Health. Access to sterile injection equipment is crucial to preventing disease, and the U. S. Public Health Service has recommended the use of sterile syringes as an important risk reduction strategy. Providing access to sterile syringes has been shown to help, and does not hurt, efforts to reduce drug use and related social problems. CDC reports that IDUs share injection equipment primarily because of legal and regulatory barriers limiting access to, and possession of, injection equipment.

Safe disposal of used syringes is an important part of insuring an IDU will not reuse or share a blood-contaminated syringe. Therefore, removal of barriers to safe disposal of syringes is an integral part of any harm reduction program. Safe disposal of syringes would also address community fears regarding the risks of discarded syringes in neighborhoods, parks and other public places. After changing their legislation to permit possession and sale of up to 10 syringes to an individual, Connecticut has seen needle sharing among IDUs decrease by 40%, and needle stick injuries to police decrease by 66%. According to a March 2002 Grant Result Report from the Robert Wood Johnson Foundation, which studied Connecticut's needle exchange program, "the program reduced the incidence of HIV transmission by an estimated 33%, and assisted more than 1,000 clients in entering drug treatment during the RWJF-funded period."

Currently the Cabinet has implemented a limited harm reduction program, to the extent possible under present legislation.[21] However, to fully implement an effective harm reduction program in Kentucky will require revision and/or repeal of selected existing legislation. Therefore, KHPAC makes the following recommendations to the legislature, for legislative reform during the 2008 legislative session:

- KRS 217.177 Sale and disposal of hypodermic syringes or needles – Repeal
- KRS 218A.500 Drug Paraphernalia Definitions – Revise; remove "syringes used for disease prevention purposes."
- KRS 218A.1404 Controlled Substances – Revise; allow for an exception for residue found in injecting equipment when such equipment has been properly disposed of in a puncture proof container.

[21] Appendix 13

I. HIV/AIDS Continuing Medical Education Requirements

HIV/AIDS Planning and Advisory Council Recommendation:

Support legislation and programs that strongly encourage timely and relevant directed continuing medical education for all providers delivering health care to people with HIV and AIDS.

KHPAC continues to strongly encourage timely continuing medical education (CME) for all providers delivering health care to people with HIV and AIDS. Primary care providers, including internists, family practice physicians, pediatricians, and obstetricians, are caring for patients on a daily basis, who are either currently infected, or at risk of becoming infected. In February 2001, the legislature changed requirements for specific education for HIV/AIDS from every two years, to every ten years (KRS 214.610).[22] As disease management continues to be a complex and ever-changing field, an interval of ten years for up-to-date education is both inadequate and inappropriate. The health care community's ability to deliver appropriate care to people living with HIV/AIDS and to those at risk of acquiring HIV disease has been significantly impaired by the 2001 Legislative action.

KHPAC supports a two-tiered system of CME for medical providers in order to facilitate patient provider educational needs. Tier one would consist of basic HIV education, stressing current scientific updates in HIV disease, recognition of patient signs and symptoms, patient risk factors, state reporting requirements and occupational exposure prophylaxis. Tier two would be a more intensive HIV management course targeting Kentucky physicians rendering primary and specialty HIV care for infected Kentuckians. These medical providers would be encouraged to complete American Academy HIV Medicine (AAHIVM) certification to ensure quality HIV care for all infected Kentuckians.

The U.S. Department of Health and Human Services through the Health Resources and Services Administration has developed the AIDS Education Training Centers Program (AETC), which supports a national network of regional centers that conduct clinical HIV education, and training programs for health care providers. Kentucky is associated with the Southeast AETC (SEATEC), and is currently developing programs throughout the state to accomplish this mission. Such programming must reflect the socioeconomic, cultural, and clinical aspects of the epidemic as seen in the state of Kentucky. Health care providers must avail themselves of this education, and apply it to the care of their patients. Educational opportunities exist in many venues, and these should continue to be developed and promoted to providers throughout the state.

KHPAC holds to the following key points:

- CME courses should be flexible to allow for targeting of the addressed audience
- 10 year requirement must still be addressed as too long
- HIV certification is the national benchmark

[22] Appendix 14

- CME requirements need to reach generalized and ER doctors who do not necessarily work with HIV on a daily basis
- CME must be profession specific

KHPAC recommends that all providers of care to patients with HIV/AIDS or at risk of becoming infected with HIV, be required to have relevant, timely and profession specific education on HIV/AIDS every two years, and that this be facilitated through the individual licensing board or certifying entity which pursuant to KRS 214.610 has the authority to require more frequent completion of CME. The licensure boards will work in cooperation with the Cabinet to determine the course content.

Section II

REGULATORY ACTION

A. Disease Surveillance

HIV/AIDS Planning and Advisory Council Recommendation:

Clarify regulation *902 KAR 2:020. Disease Surveillance* to clearly identify what entities are required to report new HIV and AIDS cases.

KHPAC recommends that the Cabinet revise 902 KAR 2:020 Section 7 (1) so that the regulation is more inclusive, regarding which healthcare providers and facilities are required to report diagnosed cases of HIV and AIDS.

Currently 902 KAR 2:020 Section 7 (1) reads, "Physicians and Medical Laboratories shall report:"[23] Because of this wording, there has been some confusion as to who is required to report HIV and AIDS cases. Therefore KHPAC recommends that the regulation be revised to make the regulation language clearer and more inclusive regarding who is required to report diagnosed cases of HIV and AIDS.

KHPAC is fully aware that the Cabinet maintains a professional staff experienced at writing and revising statues and regulations. Therefore KHPAC recommends that the Cabinet and its staff be responsible for these revisions. KHPAC would appreciate the opportunity to be part of the review and edit of 902 KAR 2:020 allowing for input into the revised language before it is finalized. The goal of this input will be to provide the Cabinet with a greater understanding of the problems encountered with the current language and offer suggestions for revising the regulation.

[23] Appendix 15.

B. Re-Entry Programs; Correction to Community

HIV/AIDS Planning and Advisory Council Recommendation:

The Cabinet of Health and Family Services and the Department of Corrections assess current re-entry plans and create mechanisms which foster greater levels of cooperation between HIV care and services providers and state correctional centers when an inmate is exiting a correctional facility and returning to his/her community .[24]

[24] Appendix 16

SECTION III

OTHER HOT TOPICS

A. Increase Access to HIV Information

HIV/AIDS Planning and Advisory Council Recommendation:

Amend KRS 214.620 subsection 4 to expand the type of facilities covered in the statute and to include additional information related to HIV testing.

KRS 214.620 Subsection 4[25] ensures that Kentuckians will have access to information related to HIV infection when receiving services through certain identified facilities. KHPAC is concerned that several treatment facilities are not currently covered under KRS 214.620 and that critical information related to HIV testing is not mandated under the statute as written. However in July of this year we learned that such a requirement may already exist so KHPAC is in the process of reviewing this new information and determining if this concern has previously been addressed through legislation or regulatory action. Therefore KHPAC reiterates its concerns here in the 2007 report, but cautions on any action until a better understanding of any gaps is determined.

The following information if provided to further explain the issue being examined. The proposed change follows:
"*Information on the human immunodeficiency virus infection shall be presented to any person who receives treatment at any hospital, however named, skilled nursing facilities, primary-care centers, rural health clinics, outpatient clinics, ambulatory-care facilities, ambulatory surgical centers, emergency-care centers, substance abuse inpatient and outpatient treatment centers, mental health impatient and outpatient facilities, primary care medical offices, adult daycare facilities, senior citizen assisted living facilities and homeless shelters licensed pursuant to KRS Chapter 216B. The information shall include but not be limited to methods of transmission and prevention and appropriate behavior and attitude change, and HIV testing availability and/or sites available for free and/or sliding fee scale financial consideration and/or anonymous and/or confidential testing."*

The original statute was enacted in 1990, with amendments being made in 1998, 2001 and 2002. KHPAC's recommendation is based on current knowledge of HIV risk factors and new technology in HIV testing. If KHPAC determines that no additional action has been taken and gaps in access to HIV information still exists, KHPAC believes that the changes contained in this recommendation will increase the usefulness of the statute or regulation. KHPAC believes the broadening of KRS 214.620 Subsection 4 can be accomplished by regulatory action. The Centers for Disease Control and Prevention (CDC) estimates that of the estimated 1.2 million persons living with HIV, 252,000 to 312,000 (24-27%) are unaware that they are infected.[26] Expanding access points for HIV information to include sites of high risk populations such as those found in substance abuse treatment facilities, mental health facilities, and homeless shelters will help to identify HIV infection in early, less cost consuming stages. Making this information available to

[25] Appendix 17
[26] MMWR, June 2, 2006/ 55(21); 589-592

primary care offices will address the April 18, 2003 CDC initiative[27] for primary care medical providers to incorporate HIV risk assessment and /or testing into routine health maintenance thereby addressing the increasing rates of infection. Rapid HIV tests are now available nationally, for use on site, with preliminary test results returned in 20 minutes. This technology coupled with the broadening of KRS 214.620 Subsection 4 can help primary care physicians promote early identification of HIV positive Kentuckians, and reinforce risk reduction behaviors in those Kentuckians currently HIV negative.

[27] Appendix 18

B. School-Based Youth Educational Programs

HIV/AIDS Planning and Advisory Council Recommendation:

KHPAC is exploring partnerships with local school-based decision making councils to develop school-based youth educational programs that provide age-appropriate HIV education as required by the Kentucky Department of Education's Program of Studies, revised 2006.

Recently, studies and peer reviews have questioned the effectiveness of abstinence only programs in schools. Teen pregnancy and sexually transmitted disease in our youth are a concern that KHPAC began to explore more thoroughly this year, and as a result of this exploration, KHPAC concludes that there are available actions that can be taken to benefit Kentucky's young people. But at the same time KHPAC is keenly aware that each school and school district has a unique set of circumstances that need to be considered when developing effective educational tools to address HIV education as required by the Kentucky Department of Education's Program of Studies, revised 2006.[28] In the coming years, KHPAC envisions a partnership with the Department of Education, Department for Public Health and school-based decision making councils to develop educational programs that are appropriate to specific communities' needs.

Several highly effective and research proven models of HIV education are available, and some of these materials have a history of being used in Kentucky, but there are many obstacles to assuring that these models are being used effectively, and being used with the support of administrators and local site-based councils. KHPAC members have heard stories of teachers being threatened with the loss of their job for answering students' unprompted questions about condoms and other birth control practices. Such actions are deplorable when you consider that such education is required by KDE's Program of Studies!

There are many sides to this issue, but what is obvious to KHPAC is that not every student has access to the information and guidance needed to make informed decisions that protects him/her from sexually transmitted diseases and thus, puts more people at risk. KHPAC agrees that abstinence until marriage is the most effective risk reduction behavior a student can live by, but walk into most high schools and many middle schools, or talk with middle school and high school teachers, and you will become all too aware of the fact that there are pregnant high school and junior high school students. If students are getting pregnant, they are at risk of exposure to HIV, and just as importantly, students can be involved in other behaviors (injection drug use) that put them at risk of exposure to HIV. Subsequently, KHPAC plans to work toward influencing the provision of age-appropriate HIV education within the school setting through collaboration with the Department of Education, Department for Public Health and local school-based decision making councils.

[28] Appendix 19, pp 502-503, 2001

C. Condom Accessibility in School Settings

HIV/AIDS Planning and Advisory Council Recommendation:

KHPAC will continue to evaluate with the Department of Education and local school-based decision making councils the appropriateness of having condoms available for students within certain school districts to reduce the risk of pregnancy and exposure to HIV and other sexually transmitted diseases.

Is making condoms available in school settings an appropriate activity? If you just consider two conclusions to this question, you probably answered yes or no, but the issue is one that is much more complicated as a review of the referenced materials below suggests. KHPAC believes that there are Kentucky schools where making condoms available to students should be practiced, but determining which schools is not a simple matter as the references also indicate. In a continued effort to assure the health of our young people KHPAC has identified condom accessibility in school settings as a "hot" topic, which requires our attention and action in the coming years.

Teen pregnancies and the incidence of youth diagnosed with sexually transmitted diseases are indicators that condom distribution programs might be needed. Teen risk surveys show high numbers of youth engaged in sexual and drug seeking behaviors putting them at risk of exposure to HIV, other communicable diseases and pregnancy. Collaborating with the Department for Public Health, the Department of Education and local school-based decision making councils, KHPAC foresees identifying schools and/or school districts where condom distribution programs might be advantageous to the youth, school and community. Working collaboratively with those same partners, KHPAC is certain that these programs can be implemented to fit the dynamics of the school/school district, and as indicated by the references below increase condom use among sexually active individuals thus reducing the risk of pregnancy, and exposure to HIV and other sexually transmitted diseases.

References

American Academy of Pediatrics Takes Position on School Condom Programs, Pediatrics, June 2006, http://www.healthinschools.org/ejournal/june01_1.htm

On the Safe Side: School Condom Distribution helps prevent STDs, The Michigan Daily, April 16, 1998, http://www.pub.umich.edu/daily/1998/apr/04-16-98/edit/edit2.html.

Patterns of Condom Use Among Adolescents; The Impact of Mother-Adolescent Communication, American Journal of Public Health, October 1, 1998. http://www.cdc.gov/nchstp/dstd/Condom_Use_Among_Adolescents.htm.

Schuster, Mark A; Bell, Robert M; Berry, Sandra H. and Kanouse, David E. *Impact of a High School Condom Availability Program on Sexual Attitudes and Behaviors*, Family Planning Perspectives, Volume 30, Number 2, March/April 1998. http://www.guttmacher.org/pubs/jornals/3006798.html.

Advocates for Youth, *The Facts: School Condom Availability*, http://www.advocatesforyouth.org/publications/factsheets/fsschcon.htm, May 24, 2007.

Appendices

KENTUCKY
HIV/AIDS PLANNING AND ADVISORY COUNCIL

YEAR-END REPORT
SEPTEMBER 2007

Appendix 1

June 7, 2007

The Kentucky Department for Public Health's HIV/AIDS branch is writing to ask for your support for state funding to bring HIV/AIDS core surveillance activities to an adequate level. We would also like to ask for funding to establish a collaborative program with the Department of Corrections for inmate HIV prevention and testing initiatives, as well as linkages to medical care for exiting inmates. We appreciate your past support for public health HIV prevention and care activities that are critical to preventing new infections and to the provision of much needed care and treatment to the citizens of Kentucky who are infected or affected by HIV/AIDS. The 2006 increase, of $70,000, in state funding for the Kentucky AIDS Drug Assistance Program was one of the reasons that allowed us to eliminate our Waiting List for HIV medication assistance and expand the program to cover over 300 more clients.

As you craft the FY2008 Appropriations legislation, we urge you to consider the following critical funding priorities:

1. Support Core HIV/AIDS Surveillance: *While we have **identified a need of $250,000**, we respectfully **request state funding allocations of at least $100,000** to be directed to statewide core surveillance activities that are currently receiving no state funding and have been federally flat funded (at $130,000) for a decade, significantly eroding the program over time and resulting in a continuous struggle to provide comprehensive HIV/AIDS surveillance. HIV/AIDS surveillance activities are critical in order to monitor the epidemic and provide data for the targeting of HIV prevention and care services, as well as a central component of the Department of Health and Human Services' Ryan White Treatment funding formulas use to allocate for medical treatment and care service funding to local jurisdictions.*

Currently, due to limitations in funding, there are only three (3) HIV/AIDS surveillance staff covering all the 120 counties of Kentucky and are responsible for collecting detailed exhaustive case reports, including data such as mode of exposure, on every single confirmed positive HIV test in the state. As a result, the program has to depend mostly on self-reporting by private and public testing sites and medical facilities. Needless to say, most facilities fail to report cases resulting in great under reporting of both HIV and AIDS cases. Also, most reported cases fail to include information on patient risk factor or mode of infection. These issues undermine the effectiveness of our statewide response to the AIDS epidemic, as the lack of true measurements of the disease incidence and the lack of adequate data identifying the modes by which persons are being infected cripples our ability to effectively identify and direct preventative efforts and care delivery services to the populations and jurisdictions highest at risk.

Based on the low number of reported cases, federal funding agencies underestimate the Commonwealth of Kentucky's true funding needs for medical treatment, care services and prevention initiatives resulting in the under-funding of state and other HIV/AIDS programs in our jurisdiction. For example, the State of South Carolina, with a comparable population to Kentucky of 4.14 million, reported 7,060 HIV infections and 6,483 living AIDS cases through 2005 with a total federal funding of $37,878,981; while only 1,038 HIV infections and 2,479 living AIDS cases were reported by Kentucky resulting in a total federal funding of $18,300,420. As a matter of fact, Kentucky is the least funded state among the 4 states that rank 23rd – 26th in population size, with the next least funded state, Alabama, receiving about $11.48 million more in federal funds.

Due to current trends of funding attrition at the federal level, state funds will need to be allocated to address the above stated issues. Funds will be utilized to expand the program and allow for a more adequate case finding and data collection process that will include a wider and more representative visit schedule to major reporting sites around the state to educate HIV/AIDS providers on reporting

requirements and proper reporting procedures as well as conduct extensive patient chart reviews in order to ensure proper identification of infection routes. A medical provider reporting certification training program will also be implemented and provided to local health practitioners around the state. In addition, a more aggressive interstate reporting program will be developed to collaborate with other state's programs to capture HIV and AIDS cases that were initially diagnosed in Kentucky but currently reside in other jurisdictions.

***2. Support HIV and Hepatitis C Initiatives for Correctional Facilities*:** Such initiatives are necessary to reduce the impact of incarceration on the spread of HIV, especially among disproportionately represented groups such as African Americans who make up 40% of US inmate populations. Therefore to be effective, efforts to address the AIDS epidemic in Kentucky, and any other jurisdiction, must include well implemented programs for correctional facilities. **A need of $20,646,056 million** was identified, but we **are requesting funding allocations of at least $3.5 million**. There is an urgent need for HIV and Hepatitis C initiatives in all inmate populations, and Kentucky prisons are no exception. **See the statistics cited below**. Research has proven that providing **routine** HIV testing, and Hepatitis C testing, for prisoners upon entry, during incarceration, as well as exit; expanding re-entry programs to help prisoners transition back into society; utilizing harm reduction techniques; and ensuring that their HIV prevention, substance abuse, mental health and housing needs are met prior to release are key to reducing the risk of inmates transmitting HIV/AIDS to their spouses or other persons in the community following release from prison, specifically the African-American community which is disproportionately represented in U.S. prisons. The funding allocations will be utilized to support the following:

- A comprehensive educational program on HIV and Hepatitis C prevention for inmates and staff at correctional facilities, including information on risks associated with male to male sex, Injection Drug Use, Tattooing and other high risk behaviors. **KRS 197.055 requires collaborations between DOC and CHFS to implement a mandatory introductory and continuing education program on HIV/AIDS. Due to lack of funding, no such collaborative and uniform continuing education program is currently in place.**
- An HIV and Hepatitis C testing program for inmates upon entry, periodic voluntary testing while incarcerated, treatment and care while incarcerated and testing prior to release.
- An HIV discharge planning program, for exiting inmates, which includes preventative education specifically designed to prepare them for community re-entry and tracked referrals to sources of care and services; including enrollment into the Kentucky AIDS Drug Assistance Program (KADAP), the Kentucky HIV/AIDS Care Coordination & Case Management program (KHCCP) and the Housing Opportunities for Persons With AIDS (HOPWA) program prior to discharge so that medications and services are not interrupted.

Appendix 2

Kentucky Legislature

SB 201

WWW Version

The hyperlink to a bill draft that precedes a summary contains the most recent version (Introduced/GA/Enacted) of the bill. If the session has ended, the hyperlink contains the latest version of the bill at the time of sine die adjournment. Note that the summary pertains to the bill as introduced, which is often different from the most recent version.

Includes opposite chamber sponsors where requested by primary sponsors of substantially similar bills in both chambers and jointly approved by the Committee on Committees of both chambers. Opposite chamber sponsors are represented in italics.

SB 201/CI (BR 1682) - D. Seum

AN ACT relating to inmates.
Amend KRS 197.055 to require that the Department of Corrections administer an HIV/AIDS test to all penitentiary inmates no less than 30 days prior to release; require that a copy of the results be sent to the inmate, the warden of the penitentiary, the secretary of the cabinet, and the legal spouse of the inmate by registered mail within five days of the department receiving the results; require that the results not be public record but be a part of the inmate's medical file.

SB 201 - AMENDMENTS

SFA (1, D. Seum) - Retain original provisions clarifying that Department of Corrections inmates in county jails are also subject to testing and reporting.

SFA (2, D. Mongiardo) - Retain original provisions; insert provision requiring all penitentiary inmates to be tested for HIV/AIDS no more than 30 days after incarceration; insert provision requiring penitentiary inmates to be tested for HIV/AIDS no less than 30 days prior to release provided that the inmate did not test positive for HIV/AIDS during the test administered by the department upon incarceration; insert provision requiring the department to provide for adequate medical treatment for inmates who test positive for HIV/AIDS.
Feb 15-introduced in Senate
Feb 20-to Judiciary (S)
Feb 22-reported favorably, 1st reading, to Calendar; floor amendment (1) filed
Feb 23-2nd reading, to Rules
Feb 26-posted for passage in the Regular Orders of the Day for Tuesday, February 27, 2007
Feb 27-3rd reading; floor amendment (1) adopted ; recommitted to Judiciary (S)
Mar 7-floor amendment (2) filed

http://www.lrc.ky.gov/record/07rs/sb201.htm

AN ACT relating to inmates.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:
Section 1. KRS 197.055 is amended to read as follows:

(1) The Department of Corrections, in conjunction with the Cabinet for Health and Family Services, shall establish a mandatory introductory and continuing education program on human immunodeficiency virus and acquired immunodeficiency syndrome for all inmates. Programs shall be specifically designed for inmates while incarcerated and in preparation for release into the community. Consideration shall be given to cultural and other relevant differences among inmates in the development of educational materials and shall include emphasis on behavior and attitude change. The education program shall be continuously updated to reflect the latest medical information available.

(2) ***The department shall administer a test to detect the human immunodeficiency virus and the acquired immunodeficiency syndrome to all inmates of a penitentiary, as defined in KRS 197.010, no less than thirty (30) days prior to the inmate's release. The test shall be consistent with guidelines of the Centers for Disease Control and recommendations of the correctional medical authority.***

(a) A copy of the results of these tests, once known by the department, shall be sent within five (5) business days via registered mail to the following:

(1) The inmate;

(2) The warden of the appropriate penitentiary;

(3) The secretary of the Justice Cabinet; and

(4) The current legal spouse, if any, of the inmate at his or her last known mailing address.

(b) The results of the tests shall not be public record. The results of the tests shall become a part of the inmate's medical file, accessible only to persons designated by agency administrative regulations.

(3) If there is evidence that an inmate, while in the custody of the department, has engaged in behavior which places the inmate at a high risk of transmitting or contracting a human immunodeficiency disorder, the department shall begin a testing program which is consistent with guidelines of the Centers for Disease Control and recommendations of the correctional medical authority and shall target persons who have been involved in or reasonably thought to have been involved in a high-risk behavior. For purposes of this subsection, "high-risk behavior" includes:

(a) Sexual contact with any person within the institution;
(b) The use of intravenous drugs;
(c) Tattooing; and
(d) Any other activity medically known to transmit the virus.

(4) ~~[(3)]~~ The results of the tests shall become a part of that inmate's medical file, accessible only to persons designated by agency administrative regulations.

(5) ~~[(4)]~~ The department shall establish policies consistent with guidelines of the Centers for Disease Control and recommendations of the correctional medical authority on the housing, physical contact, dining, recreation, and exercise hours or locations for inmates with immunodeficiency disorders as are medically indicated and consistent with the proper operation of its facilities.

(6) ~~[(5)]~~The department shall report to the General Assembly by July 1 each year as to the implementation of this program and the participation by inmates and staff.
(7) ~~[(6)]~~If an inmate is involved in a situation with a department employee which could result, according to the institution's physician, in the transmission of the human immunodeficiency virus infection, the inmate shall be tested.
(8) ~~[(7)]~~All testing procedures, disclosure, and payment shall be pursuant to KRS 438.250.

PUBLIC HEALTH & CORRECTIONS

CONNECTING CARE, CONNECTING COMMUNITIES

March 2003

• FACT SHEET •

HIV Prevention Community Planning Groups and Correctional Institutions: A Collaboration for All

The disproportionately high prevalence of HIV infection among the incarcerated has been well documented for many years. HIV rates are fourteen times higher in this population than the general U.S. population. Thirteen to 19 percent of people living with HIV in the general population have been incarcerated at some time. These data have been validated in a landmark report delivered to Congress.

In 1997, the U.S. Congress instructed the U.S. Department of Justice (DOJ) to investigate the health status of soon-to-be-released inmates. At question was the extent that changes in correctional health care might be able to improve the public health of communities at large. The National Institute of Justice (NIJ), the research arm of DOJ, entered into a cooperative agreement with the National Commission on Correctional Health Care (NCCHC) to study the problem and prepare a report for Congress. Following extensive research and deliberation by expert panels, NCCHC submitted a report to NIJ in May 2000. *The Health Status of Soon-to-be-Released Inmates—A Report to Congress* was released to Congress in July 2002.

The report identified high rates of HIV infection among the incarcerated and substantial barriers, including a lack of resources to address HIV and AIDS within correctional facilities. These findings demonstrate a clear need for better collaboration between correctional institutions and community planning bodies. HIV prevention planning bodies should consider the needs of the incarcerated and soon-to-be-released populations.

Jurisdictions Required to Follow CDC's HIV Prevention Community Planning Process

All 50 U.S. States

The District of Columbia

Cities/Counties:

- Chicago
- Houston
- Los Angeles
- New York
- Philadelphia
- San Francisco

Territories:

- Puerto Rico
- U.S. Virgin Islands

The U.S.-affiliated Pacific Islands also participate in the community planning process. However, they follow separate standards that are more appropriate to their settings and resources.

Source: Academy for Educational Development. *HIV Prevention Community Planning: An Orientation Guide.* Centers for Disease Control and Prevention. January 1999.

What is HIV Prevention Community Planning?

In 1993, the Centers for Disease Control and Prevention (CDC) issued the Guidance for HIV Prevention Community Planning to help programs better respond to the evolving epidemic and growing body of scientific evidence about HIV prevention. Its purpose is to ensure that federal funds for HIV prevention target communities most at risk for HIV infection with prevention interventions that are based on sound science and public health practice.

The process, developed in partnership with governmental and non-governmental organizations, is utilized to plan the allocation of federal prevention funds in all 50 states, the District of Columbia, eight territories and six major U.S. cities and counties. In fiscal years 2001 and 2002, the community planning process was responsible for guiding the utilization of $315 million of federal HIV prevention funds annually at the state and local level.

The CDC's Guidance for HIV Prevention Community Planning outlines a process in which the health department administering HIV prevention funds, representatives of the infected and affected communities, and epidemiologists and behavioral scientists work together to identify high priority prevention needs which serve as the basis for an HIV prevention plan. It requires health departments to work in collaboration with community planning groups (CPGs) to design local prevention plans that best represent the needs of the various communities at risk for, or infected with HIV.

Who Should be Involved in the Community Planning Process?

According to CDC's Guidance for HIV Prevention Community Planning, the process calls for the active involvement of representatives from communities infected and affected, state and local health departments, state and local education agencies, other relevant governmental agencies (e.g., substance abuse prevention and treatment, sexually transmitted disease prevention and treatment, mental health services, and corrections), representatives of key non-governmental organizations, and other stakeholders who provide necessary prevention and related services within the jurisdiction.

How Does the Planning Process Work?

The primary task of the CPG is to develop a comprehensive HIV prevention plan based on scientific evidence and community values. It is based on the epidemiologic profile of the jurisdiction and a community service assessment (which describes prevention needs of populations at risk for HIV infection, the prevention activities/interventions implemented to address these needs, and service gaps). This information is used to set priorities for funding HIV interventions.

The plan is designed to be the driving force in the health departments' allocation of prevention resources throughout the communities they serve. Health departments follow the comprehensive HIV prevention plan when deciding which programs they will support and fund.

The Need for Inclusion of Correctional Institutions in Community Planning

There are many ties that connect the community with correctional institutions. Millions of individuals flow in and out of the nation's prisons and jails each year. As of 2000, the occupancy of our nation's correctional institutions at any one time exceeded two million people. But this population is not static; in 1998 alone, more than five times that number (11.5 million individuals) were released from prisons and jails. One half of the people who are booked at a police station are released into the community within 24-48 hours; even among individuals serving longer sentences in prison, most will eventually return to their communities.

The lack of broad disease prevention programs within correctional facilities may contribute to the transmission of communicable diseases outside of prison. In 1996, 17% of all AIDS cases and 13% of all HIV cases reported in the U.S. were in people released from correctional facilities. Few prison or jail systems have implemented comprehensive HIV prevention programs. As a result, HIV-positive individuals are often released back into communities without the needed knowledge, skills, or access to resources to stop the transmission of the virus, and others remain at high risk of becoming infected.

If correctional facilities are overlooked as a venue for HIV case finding and for fostering HIV prevention skills among individuals, the risk of infection being introduced back into the community will continue.

Corrections cannot provide a continuum of care for inmates as they are leaving jails and prisons without the ongoing help and support of public health departments.

Source: Positive Populations. *Experts See Unmistakable Link Between Corrections and Communities.* Martin Medical Services, Inc. Roche Labs. 2001; 3 (2) 3.

Community Planning and Correctional Health Care: How They Can Work Together

The primary task of the CPG is to develop a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities/interventions. There are a number of strategies by which CPGs can assure that correctional populations are included in their jurisdiction's HIV prevention plan.

The community planning group's comprehensive HIV prevention plan should include details of these key components:

- Epidemiological profile
- Community services assessment
- Prioritized target populations
- Appropriate science-based prevention activities/interventions
- Letters of concurrence / concurrence with reservations / non-concurrence

The incarcerated population should be considered at each step in the planning process. Specifically, as CPGs look to assess gaps and prioritize populations for HIV prevention resources, they must recognize correctional institutions as a part of the equation. Epidemiological profiles should include the burden of disease among the incarcerated population, and community services assessments should look at the needs and resources both within and outside of corrections. Where gaps are noted among correctional facilities, potential strategies for addressing such gaps should be identified.

The community planning process is designed to assure parity, inclusion, and representation. Community planning groups should include representatives from correctional facilities and those familiar with the correctional health care system (e.g., former inmates, correctional health care workers, parole and probation officers) as part of their community planning process.

Interventions specifically designed to address the "soon-to-be-released" and "incarcerated" HIV populations should be considered for inclusion in the comprehensive plan. Skills building programs, pre-release planning, re-entry initiatives, and prevention case management programs can serve as effective interventions to reduce the risk of HIV transmission among incarcerated populations and the general population at large.

Example: CPGs and Corrections—Working Together

In Chicago/Cook County, Illinois, a representative of the city health department's STD program serves on the HIV Prevention Planning Group. This former advocate for correctional needs presented corrections data to the planning group and successfully lobbied for resources. As a result, two additional staff were hired for the jail's STD program.

The Rhode Island Department of Health's Office of HIV & AIDS Community Planning Group includes staff from the state Department of Corrections and a former offender. Focus groups and needs assessments have been utilized to successfully define the limited HIV/AIDS access in the community for released African American and Latino women. Steps have been taken to address this issue. There is also an HIV team that trains correctional officers, health care, and community-corrections professionals to ensure that in addition to counseling and testing, an education component is included in the HIV prevention program.

Through [the CDC/HRSA-funded Corrections Demonstration Project], seven state health departments are carrying out innovative continuity-of-care programs for inmates infected with HIV, STDs, tuberculosis (TB), or hepatitis who are being released from a prison, jail, or juvenile detention center.

Source: Centers for Disease Control and Prevention, Department of Health and Human Services. Helping Inmates Return to the Community. IDU/HIV Prevention. August 2001. www.cdc.gov/idu/criminaljustice.htm#7. Additional revisions based on comments provided by Hugh Potter, Ph.D. (Program Consultant) CDC/NCHSTP/OD/PSO on January 30, 2003.

Iowa's Department of Health has a representative from the Department of Corrections on their CPG. Their involvement resulted in a focus group being conducted with one of Iowa's high-risk populations for HIV prevention—incarcerated injection drug users (IDUs). The result was increased awareness of IDUs' understanding of HIV prevention and perceived barriers to prevention. This information was used in the development of the CPG's comprehensive HIV prevention plan.

Resources

Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention: Community Corrections Public Health—State and local departments of corrections. Speak with the state Medical Director. Ask about the HIV prevention programs and how to contact the information officers, education directors, and medical directors in your local correctional facilities. www.cdc.gov/nchstp/od/cccwg/State_Departments_of_Corrections.htm

Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention: Division of HIV/AIDS Prevention www.cdc.gov/hiv/partners/policy-planning.htm

National Alliance of State and Territorial AIDS Directors—State and local AIDS directors at departments of health. Speak with the state and local HIV/AIDS Director or Program Manager and ask about programs in corrections including community organizations and state and local HIV Prevention CPGs. www.hivaidsta.org/staying_connected/aids_directors.htm

National Commission on Correctional Health Care: www.ncchc.org

National Minority AIDS Council—Prison Initiative: www.nmac.org (click on Treatment, Prison Initiative)

References

Academy for Educational Development (AED), Center for Community-Based Health Strategies. *HIV prevention community planning: An orientation guide.* Washington (DC): AED; January 1999.

Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. *Helping inmates return to the community.* IDU/HIV Prevention, August 2001. #7. www.cdc.gov/idu/criminaljustice.htm#7

Iowa Comprehensive HIV Prevention Plan 2001-2003. *Needs assessment and prioritization of target populations.* 2002.

Loberti, P.G. *Breaking into jail—Rhode Island's experience.* Rhode Island Department of Health, Office of HIV & AIDS. 2002.

Positive Populations. *Experts see unmistakable link between corrections and communities.* Martin Medical Services, Inc. Roche Labs. 2001; 3 (2)

ABOUT THIS SERIES

Improvement in the health status of inmates in jails and prisons requires the active involvement of many stakeholders, including correctional and juvenile agencies, community-based health and social service providers, community planning bodies, health departments, parole and pre-probation agencies and policy makers.

This fact sheet is part of a series addressing correctional health. Other publications in the series include an overview of the key findings from *The Health Status of Soon-to-be-Released Inmates—A Report to Congress*; policy recommendations from the report designed to improve disease prevention, screening, and treatment programs in jails and prisons; and other fact sheets that provide recommendations by sector.

This series is produced by the Center for Community-Based Health Strategies (CCHS) at the Academy for Educational Development, with funding from the Centers for Disease Control and Prevention, under contract #200-97-0605, task order 38. All publications in this series can be downloaded from the CCHS Web site: **www.healthstrategies.org**.

For a complete copy of the report, *The Health Status of Soon-to-be Released Inmates*, contact the National Commission on Correctional Health Care on-line at: **www.ncchc.org/pubs_stbr.html**.

AED
Academy for Educational Development

Center for Community-Based Health Strategies
at the Academy for Educational Development

Appendix 4

Stop AIDS in Prison Act of 2006 (Introduced in House)

HR 6038 IH

109th CONGRESS
2d Session
H. R. 6038

To provide for an effective HIV/AIDS program in Federal prisons.

IN THE HOUSE OF REPRESENTATIVES

Introduced by Rep. Maxine Waters

September 6, 2006

Ms. WATERS introduced the following bill; which was referred to the Committee on the Judiciary

---

A BILL

To provide for an effective HIV/AIDS program in Federal prisons.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the `Stop AIDS in Prison Act of 2006'.

SEC. 2. COMPREHENSIVE HIV/AIDS POLICY.

(a) In General- The Bureau of Prisons (hereinafter in this section referred to as the `Bureau') shall develop a comprehensive policy to coordinate HIV/AIDS testing, treatment, and prevention for inmates within the correctional setting and upon reentry.

(b) Purpose- The purposes of this policy shall be as follows:

(1) To stop the spread of HIV/AIDS among inmates.

(2) To protect prison guards and other personnel from HIV/AIDS infection.

(3) To provide comprehensive, timely, and compassionate medical treatment to inmates who are living with HIV/AIDS.

(4) To promote HIV/AIDS awareness and prevention among inmates.

(5) To encourage inmates to take personal responsibility for their health, find out if they have been infected with HIV/AIDS, and reward behavior that reduces the risks of HIV/AIDS transmission.

(6) To reduce the risk that inmates will transmit HIV/AIDS to their spouses or other persons in the community following their release from prison.

(c) Consultation- The Bureau shall consult with appropriate officials of the Department of Health and Human Services, the Office of National Drug Control Policy, and the Centers for Disease Control regarding the development of this policy.

(d) Time Limit- The Bureau shall draft appropriate regulations to implement this policy within not more than 1 year from the enactment of this Act.

SEC. 3. REQUIREMENTS FOR POLICY.

The policy created under section 2 shall do the following:

(1) TESTING AND COUNSELING UPON INTAKE-

(A) Medical personnel shall provide routine HIV/AIDS testing to all inmates as a part of a comprehensive medical examination immediately following admission to a facility.

(B) Medical personnel shall provide immediate confidential, post-test counseling to all inmates who test positive for HIV/AIDS.

(2) HIV/AIDS PREVENTION EDUCATION- Medical personnel shall educate all inmates on the risk of HIV/AIDS transmission; promote HIV/AIDS awareness; and encourage behavior that reduces the risk of HIV/AIDS transmission through frequent and appropriate educational programs. This education shall include the risks of HIV/AIDS transmission through tattooing, sexual contact, and intravenous drug use.

(3) VOLUNTARY HIV/AIDS TESTING-

(A) Medical personnel shall allow inmates to obtain HIV/AIDS tests upon request once per year or whenever an inmate has a reason to believe the inmate may have been exposed to HIV/AIDS. Inmates shall be informed of their right to obtain these tests.

(B) Medical personnel shall encourage inmates to request HIV/AIDS tests if the inmate is sexually active, uses intravenous drugs, or if the inmate is concerned that the inmate may have been exposed to HIV/AIDS.

(4) PROTECTION OF CONFIDENTIALITY- In order to ensure inmate confidentiality and encourage inmates to seek HIV/AIDS tests without the knowledge or suspicion of other inmates, the Bureau of Prisons shall develop procedures for inmates confidentially to request HIV/AIDS counseling and tests. HIV/AIDS counseling and tests shall be provided in a setting where other routine health services are provided

and in a manner that allows the inmate to request and obtain these services as routine medical services.

(5) COMPREHENSIVE TREATMENT- Medical personnel shall provide all inmates who test positive for HIV/AIDS--

(A) comprehensive medical treatment; and

(B) confidential counseling on managing their medical condition and preventing its transmission to other persons.

(6) TESTING, COUNSELING, AND REFERRAL PRIOR TO REENTRY-

(A) Medical personnel shall provide routine HIV/AIDS testing to all inmates prior to their release and reentry into the community. (Inmates who are already known to be infected need not be tested again.)

(B) To all inmates who test positive for HIV/AIDS and all inmates who already are known to have HIV/AIDS, BOP medical personnel shall provide--

(i) confidential prerelease counseling on managing their medical condition in the community, accessing appropriate treatment and services in the community, and preventing the transmission of their condition to family members and other persons in the community; and

(ii) referrals to appropriate health care providers and social service agencies in the community that meet the inmate's individual needs.

(7) OPT-OUT PROVISION- If an inmate refuses a routine test for HIV/AIDS, medical personnel shall make a note of the inmate's refusal in the inmate's confidential medical records. However, the inmate's refusal shall not be considered a violation of prison rules or result in disciplinary action.

SEC. 4. CHANGES IN EXISTING LAW.

(a) Screening in General- Section 4014(a) of title 18, United States Code, is amended--

(1) by striking `for a period of 6 months or more';

(2) by striking `, as appropriate,'; and

(3) by striking `if such individual is determined to be at risk for infection with such virus in accordance with the guidelines issued by the Bureau of Prisons relating to infectious disease management' and inserting `unless the individual declines. The Attorney General shall also cause such individual to be so tested before release unless the individual declines.'.

(b) Screening as Part of Routine Screening- Section 4014(e) of title 18, United States Code, is amended by adding at the end the following: `Such rules shall also provide that the initial test under this section be performed as part of the routine health screening conducted at intake.'.

Appendix 5

Published: March 11, 2007

Daviess jail tests inmates for HIV

MOVE WILL SAVE MONEY, JAILER SAYS

ASSOCIATED PRESS

OWENSBORO — Daviess County isn't waiting for state legislators to decide whether prison inmates throughout the state should receive HIV-testing.

Officials at the Daviess County Detention Center have opted to begin HIV-testing for all inmates while also training prison employees on how to administer test results and help inmates modify their behavior to avoid contracting the virus.

Jailer David Osborne said the testing, which is provided free of charge by the Daviess County Health Center, helps the prison and the surrounding community in a number of ways.

"The test is providing more safety to the community," Osborne said. "We've got a free service offered to us that will help inmates make better choices."

By letting the inmates know their status, Osborne believes inmates will take better care of themselves and avoid situations where they could be infected, a move that would also save taxpayers' money. It can cost up to $2,700 a month to medically treat an HIV-positive inmate.

Training prison employees on how to tell inmates their HIV-status also saves the prison the cost of transporting the inmates to a health care facility to learn their test results.

Vicki Isom, a nurse at the jail, said telling someone they've tested positive for HIV goes beyond a simple explanation.

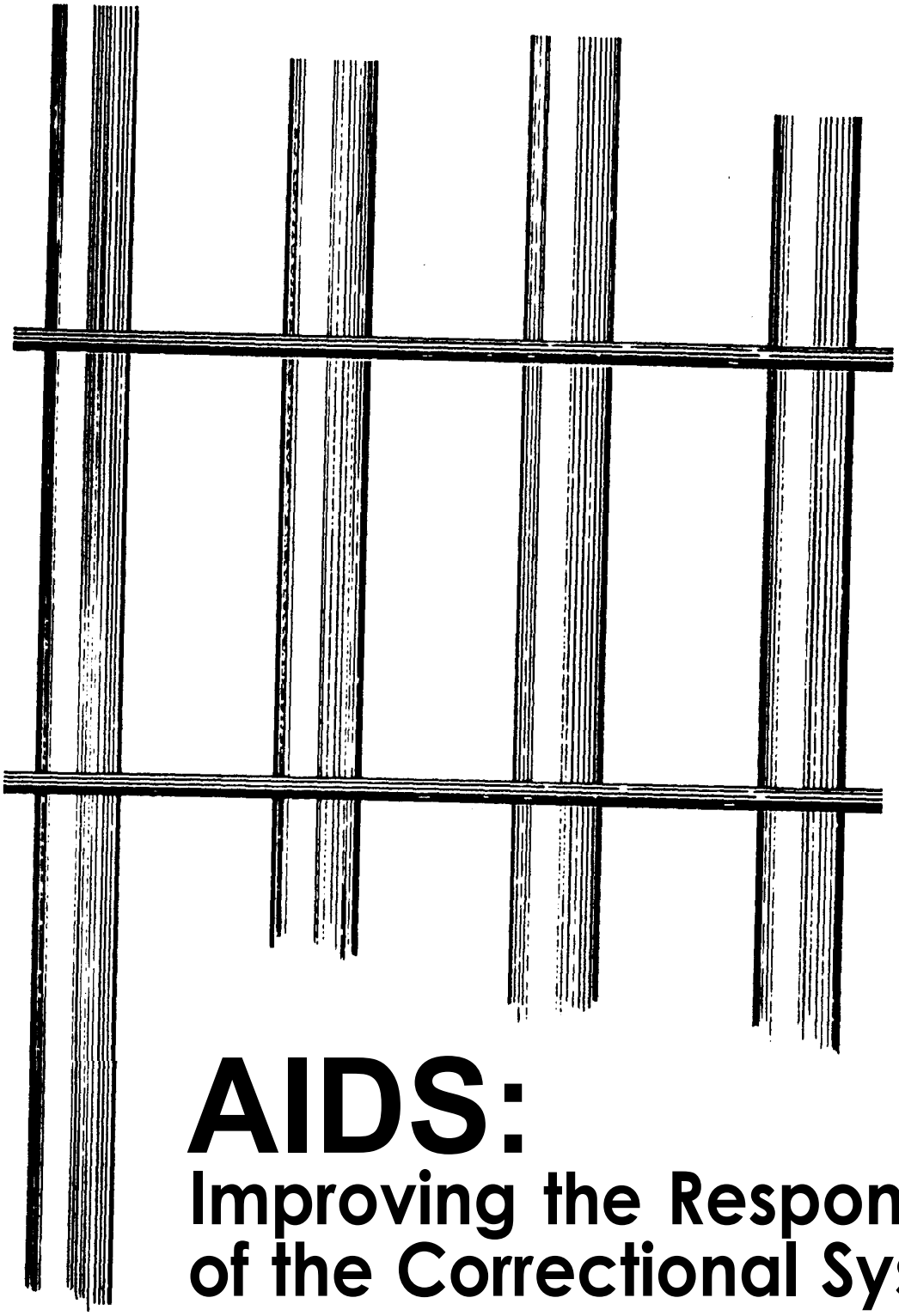
"We don't just say it's positive or negative and leave it at that," Isom said. "We remind them what made them contract the virus and set up goals to reduce at-risk behaviors."

During training, the employees role-played to see what it was like to be the person receiving results from a test while also developing effective ways of handling their reactions.

"To go from a nurse role of 'teach, teach, teach,' to listening, it's very difficult because I'm used to saying 'you have to do this' and instructing them," Isom said. "Now I'll be listening and helping them set their own behavior reductions."

Currently, only two inmates at the jail have the virus, but officers said they have received several brushes with inmates who have been infected. Lt. Bill Billings said he once encountered an inmate who used to cut his hand so he could spray workers with his blood.

"Everybody has the potential to be exposed here, and we'd like to be as ready as we can," Billings said. "Now we assume at any time that everyone has it. But it would be good to know."



AIDS:
Improving the Response of the Correctional System

SECOND EDITION

AIDS:

IMPROVING THE RESPONSE OF THE CORRECTIONAL SYSTEM

Second Edition

Anna T. Laszlo

and

Marilyn B. Ayres

September 1990

This monograph was initially prepared under Grant Number GL-8 (1986) from the National Institute of Corrections, U.S. Department of Justice. Points of view or opinions stated are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

**For the nation's correctional officers,
whose commitment makes it possible
to meet the challenge of AIDS.**

A mind once stretched by a new idea; never regains its original shape."

-Oliver Wendell Holmes

Library of Congress Catalog Card Number 90-61363

TABLE OF CONTENTS

Figures

FOREWORD

Acquired immune deficiency syndrome (AIDS) presents a set of very special issues for the criminal justice system. From initial response, to incarceration and release, the treatment of HIV-infected individuals must be based on medical facts, legal considerations, and professionalism, all of which drive the American correctional system.

The first edition of this text was written in 1986, in response to a number of questions about AIDS from correctional officers, administrators, medical and mental health staff, and court officials. Since 1986, medical research has made unprecedented strides toward our understanding of HIV disease, including its manifestations, the treatment options available to those infected, and the progress toward vaccine development. Additionally, legal protections in the areas of anti-discrimination, employment, and confidentiality of medical information continue to be clarified by the courts.

The authors have prepared this second edition of ***AIDS: Improving the Response of the Correctional system*** to update correctional officials on the medical and legal developments surrounding HIV disease. Correctional officials must use current medical and legal facts to allay fears and misconceptions about HIV disease and to develop effective strategies for the treatment of those infected. We believe this monograph will serve as an impetus for these officials to do just that.

M. Wayne Huggins, Director
National Institute of Corrections

Charles "Bud" Meeks, Executive Director
National Sheriffs' Association

ACKNOWLEDGMENTS

Writing a text of this scope and nature is never an easy task. Just keeping abreast of the medical and legal developments surrounding HIV disease has been a full-time endeavor for both of us since 1986. Perhaps our greatest challenge, however, has been assisting local correctional agencies in developing appropriate responses to address the myriad of problems presented by HIV disease.

Throughout this effort, a number of individuals contributed their time and expertise to keep our medical information current, to explain the legal implications of case decisions, to discuss AIDS-related policies and practices within their correctional systems, and to provide a wealth of materials for our use. Most of all, these individuals have served as examples of the "best and the brightest" among their professions; and when we needed it most, they lent friendly encouragement for our work.

To the following individuals we shall always be grateful:

- Sheriff J. Michael Hennessey, J.D., San Francisco County, California;
- Dr. Vonda Reeves-D'Arby, University of Texas Medical Center at Galveston;
- Dr. Alan Lifson, San Francisco Department of Public Health;
- Michael Smith, J.D., Institute of Government, University of North Carolina at Chapel Hill;
- Robert McCluskey, Tennessee Correctional Institute;
- Jim Byrd, J.D., Jail Administrator, Wayne County, Michigan.

In addition, we appreciate the assistance of the National Institute of Corrections in making this book available to criminal justice professionals nationwide. We would also like to thank the staff of the National Sheriffs' Association; in particular, Walter Bacak, Theresa Seemiller, and Judy Smith, who never let us lose sight of our task or our sense of humor.

Finally, our thanks to the countless correctional officers who so generously shared their knowledge and experience with us. The credit for this work belongs to all who assisted us through this effort.

Anna T. Laszlo
and
Marilyn B. Ayres

SECTION ONE

BACKGROUND:

THE HUMAN IMMUNODEFICIENCY VIRUS

CHAPTER I

INTRODUCTION AND PURPOSE

The human immunodeficiency virus (HIV) epidemic presents a series of enormously difficult issues for the local correctional system. Nearly a decade after identification of the virus which causes acquired immune deficiency syndrome (AIDS), the disease remains a major cause of morbidity and mortality in the United States and is the leading cause of death among hemophiliacs and users of illegal intravenous (IV) drugs (Heyward and Curran, 1988). The Federal Centers for Disease Control (CDC) projects that by 1992, 365,000 people will have been diagnosed with the disease. Most of those affected in the future will be homosexual/bisexual men, IV drug users, or the sexual partners and children of these groups. A significant proportion of those affected will be blacks and Hispanics.

While the rate of ***new*** infection among homosexual/bisexual men has dropped significantly (under 4 percent since 1984), the steady rise of new infection among IV drug users and their sexual partners (an increase of up to 60 percent in the Northeast since 1984) will place increased burden upon the criminal justice system in the decade to come. Policy issues surrounding testing, housing, confidentiality, availability of protective equipment, and the rights of employees occupationally exposed to HIV are complex and controversial.

To date, much has been written about the sociopolitical and economic consequences of HIV disease (Altman, 1986; Griggs, 1987). Additionally, various public and private agencies have issued guidelines related to the disease (CDC, 1988; U.S. Department of Justice, 1988, Presidential Commission on the HIV Epidemic, 1988). To a lesser extent, criminal justice practitioners have commented on policy implications or have developed procedures addressing the management of individuals suspected of or diagnosed with the disease (Des Jarlais and Hunt, 1988; Laszlo and Ayres, 1986, Wish, et al., 1988).

Despite the wealth of information about HIV disease, many correctional agencies have yet to implement policies that address such issues as universal blood precautions, anti-discrimination in hiring practices, confidentiality of inmate and employee HIV status, inmate and employee testing, and inmate and employee training and education, to name just a few. Yet, such policies are essential for all correctional agencies if they are to effectively respond to HIV-infected individuals.

THE SHERIFFS ROLE IN THE MANAGEMENT OF HIV INFECTION

As the administrator of the local correctional facility, the sheriff has a specific responsibility for the health and safety of both inmates and employees. There are a number of specific issues that face sheriffs regarding the appropriate response to HIV-infected individuals. These include:

Response of Arresting/Responding Officers

- What should responding and arresting officers do if they believe or know that a suspect is HIV-infected?
- What types of actions are appropriate with HIV-infected individuals, particularly with regard to searches and cardiopulmonary resuscitation (CPR)?
- What procedures should be followed when transporting an individual who may be HIV-infected?

HIV Antibody Testing for Employees and Inmates

- Under what circumstances should arrestees/inmates be tested for HIV antibodies?

- Under what circumstances should employees be tested for HIV antibodies?

Jail Administration

- How should correctional officers handle individuals who may be HIV infected?
- What reasonable health precautions should be taken in correctional facilities to ensure both inmate and employee health and safety?
- What types of housing arrangements should be made for inmates with HIV disease?
- What types of job assignments should be made to HIV-infected inmates, including those participating in work release programs?
- What types of visiting rights should HIV-infected inmates be allowed?

Medical Issues

- What are appropriate methods for identifying and treating individuals with HIV infection?
- What are appropriate precautions for health unit staff, including medical and laboratory staff, assigned to the facility?

Legal Issues

- What is the jail administrator's liability for alleged transmission of HIV disease within the facility?
- What are the reporting and confidentiality requirements in these cases?
- What protection against discrimination do persons with HIV infection have?
- What is "reasonable accommodation" for an HIV-infected employee?
- Can correctional officers be tested for HIV infection as a condition of employment?

Clearly, the correctional administrator must be informed of the latest medical and legal information regarding HIV disease to develop sound policies and procedures for the facility. Likewise, staff charged with transportation, intake screening, custody, and inmate medical/mental health treatment must keep abreast of the most current information as it relates to their functional responsibilities within the facility.

Inmates, too, must be informed, on a continuing basis, of the latest medical information regarding the transmission and prevention of HIV infection to minimize myths and fears and to encourage behavior modification.

The intent of ***AIDS: Improving the Response of*** the Correctional system is to serve as a resource for: (1) correctional administrators as they develop and implement HIV-related policies for their agencies; (2) officers as they work with HIV-infected persons, both inmates and fellow officers; and (3) trainers who are tasked with developing and implementing AIDS-related training programs for staff and inmates.

Section One provides the epidemiological, medical, and legal framework for the development of HIV-related policies.

Section two addresses specific issues of infection control and specific guidelines for all correctional personnel.

CHAPTER II

HIV INFECTION IN THE UNITED STATES

The epidemiology of HIV infection in the United State-s provides policymakers with the information necessary to identify the populations at greatest risk for infection and consequently to plan effective management strategies for all those affected by the disease.

BACKGROUND

The Centers for Disease Control (CDC) compiles surveillance data from routine infection and disease reports from state and local health departments. It was one of these reports, in June 1981, that described how cases of an extremely rare form of pneumonia, caused by pneumocystis carinii, had been diagnosed among five young homosexual men. Simultaneously, CDC received reports of an increased incidence of a rare type of cancer called Kaposi's sarcoma. Scientists soon learned that the connection between the cases of pneumocystis carinii and Kaposi's sarcoma--both opportunistic infections--was a severely impaired immune system. By late 1981, the term "acquired immunodeficiency syndrome" (AIDS) was coined (Gottlieb, et al., 1981). By 1982, CDC had given the condition a narrow clinical definition to track its appearance throughout the nation.'

The surveillance program revealed that cases of AIDS were concentrated in large, urban centers on the East and West Coasts. Further, cases appeared to be predominant in specific "high-risk" groups: homosexual/bisexual men; male or female users of illicit IV-drugs, hemophiliacs, blood transfusion recipients, sexual partners of these individuals, and children born to AIDS diagnosed mothers (CDC, 1982). Since the disease appeared to be transmitted through the exchange of blood or through sexual contact, scientists were convinced by late 1982 that the cause of AIDS was a bloodborne virus, a hypothesis which was confirmed a year later when HIV was isolated and identified by French and American researchers.

Thus, while epidemiologists refer to "high-risk" groups in their discussion of the prevalence of HIV infection and disease, it is the "high-risk" behaviors in which these groups of persons engage that place them at risk for infection. The extent to which risk-related behaviors are eliminated will affect the prevalence of future infection and disease within the population.

GEOGRAPHIC AND DEMOGRAPHIC CHARACTERISTICS OF HIV INFECTION

Geographic Distribution

The distribution of both fully diagnosed AIDS cases and HIV infection in the United States varies substantially by geographic area. Figure 2.1 shows the annual incidence rates per 100,000 population through June 1990.

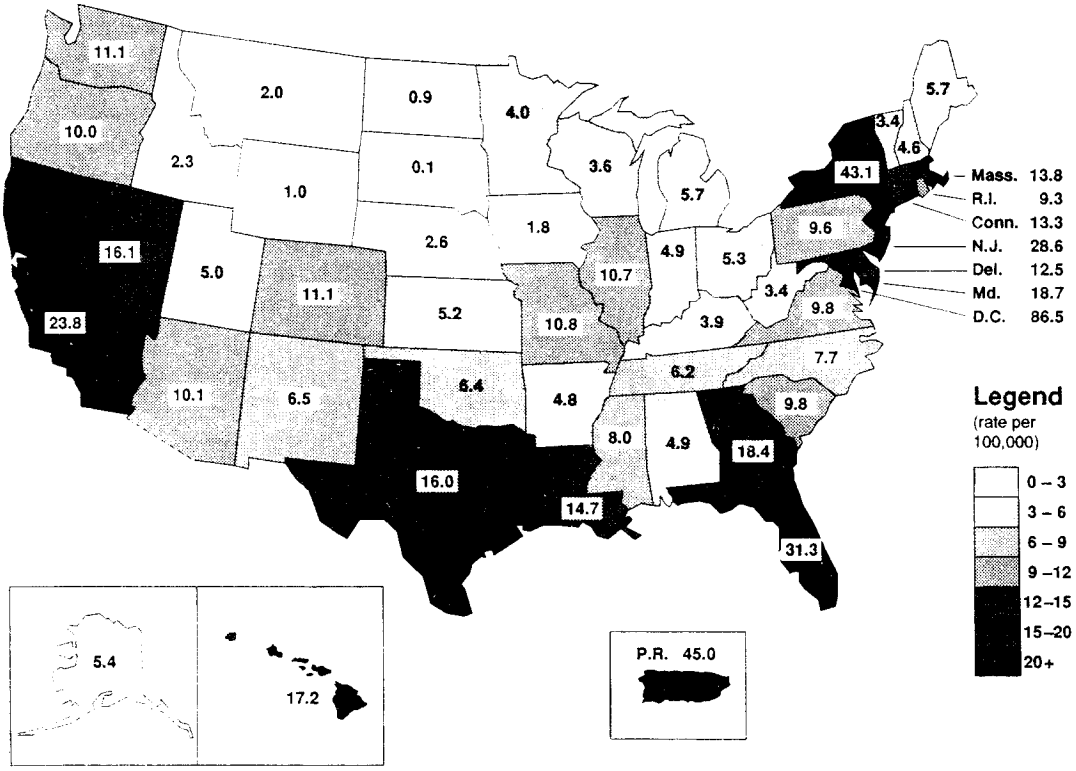
The number of AIDS cases is an indication of the larger epidemic of HIV infection. An estimated 1-1.5 million persons are infected with HIV in the United States, with recent seroprevalence studies suggesting an actual number closer to the lower end of the range, A cohort study of homosexual/bisexual men in San Francisco suggests that 54 percent of infected persons will develop AIDS within 10 years after infection and that up to 99 percent will eventually develop AIDS. Therefore, the number of persons with AIDS and other severe manifestations of HIV infection will continue to increase.

---

[1] For national reporting purposes, CDC defined AIDS as a disease at least moderately predictive of a defect in cell-mediated immunity; e.g., Kaposi's sarcoma, pneumocystis carinii pneumonia, and certain other specified opportunistic infections in previously healthy persons less than 60 years of age. In 1987, CDC revised its case surveillance definition of AIDS (CDC, *MMWR,* Vol. 36, No. lS, 1987).

Figure 2.1

AIDS annual rates per 100,000 population, for cases reported July 1989 through June 1990, United States



Source: Centers for Disease Control. ***HIV/AIDS Surveillance Report.*** July 1990.

The geographic distribution of HIV infection differs among the specific risk groups, with the exception of hemophiliacs, who indicate similar high levels of infection regardless of the area. The prevalence levels vary more among homosexual and bisexual men, with the highest levels in California and the Northeast and somewhat lower levels elsewhere in the nation. Similarly, HIV infection among IV drug users varies widely, with the highest levels in the New York City area and Puerto Rico, moderately high elsewhere on the East Coast and California, and generally below 5 percent in most other areas of the country (CDC, 1990).

Demographic Distribution

Cases of fully-diagnosed AIDS and HIV infection are largely among persons in the sexually active and IV drug-using age range (CDC, 1990). However, the fastest growing group of reported AIDS cases are children (Heyward and Curran, 1988). Most of these children were born to mothers who use IV drugs or are the sexual partners of male IV drug users, with only 19 percent the result of a blood transfusion (Heyward and Curran, 1988).

Compared with whites, AIDS cases are disproportionately high among blacks (3 to 1) and Hispanics (2.6 to 1). When homosexual and bisexual men with AIDS are excluded from the count, the ratio of AIDS cases is 12 blacks to 1 white and 9.3 Hispanics to 1 white. The HIV infection rate is notably higher among black and Hispanic IV-drug users and prostitutes than among whites engaging in similar activities.

Homosexual and Bisexual Men

Homosexual and bisexual men remain the largest group at risk for HIV infection, representing approximately 60 percent of the total AIDS cases reported to CDC, with the highest prevalence rates of infection in California. Information regarding HIV infection among homosexual and bisexual men is gathered from sexually transmitted disease (STD) clinics, which provide services to individuals whose sexual behavior has placed them at risk for a variety of STDs, including HIV infection. Little data is available regarding the prevalence of HIV infection among homosexual and bisexual men who do not seek medical care, including those who may be at lower risk for infection (CDC, 1987).

IV Drug Users

IV drug users are the second largest group of persons at risk for HIV infection, representing approximately 17 percent of the total AIDS cases reported to CDC. Given the documented high prevalence of illicit drug use in arrestee-s in U.S. urban areas (Wish, et al., 1988), IV drug users will continue to represent a significant portion of the HIV-infected individuals within the criminal justice system.

The largest percentage of HIV-infected IV drug users (50-60 percent) are in New York City, New Jersey and Puerto Rico. However, given the rapid spread of the virus among IV drug users (Des Jarlais and Friedman, 1987), a low prevalence rate among this group in a specific area should not be considered a stable situation (Des Jarlais and Hunt, 1988).

Data regarding HIV infection among drug users are obtained from drug abuse treatment facilities, which treat only 15 percent of the estimated 1.1 million IV drug abusers in the nation. In addition, it should be noted that drug-related HIV infection affects not only the user, but also his or her sexual partner and children. Thus, IV drug abuse is the major source of HIV transmission in heterosexuals as well as from mother to infant (Chamberland and Dondero, 1987).

Heterosexual Partners of Persons with HIV Infection or at Recognized Risk

A number of studies have examined the prevalence of HIV infection among persons who are heterosexual sex partners of HIV-infected persons but who have no other identified risk factor. The prevalence of infection among these individuals has varied from 10-60 percent. This variance may be due to several factors: (1) the presence of other infections, such as genital ulcers, in one or both persons; (2) the length of infection of the "source" partner, since recent studies indicate that persons diagnosed with AIDS or symptomatic with HIV infection are more likely to transmit the virus than persons in earlier stages of infection (Goedert, et al., 1987); (3) the frequency and type of sexual contact; and (4) the source of infection. For example, the rate of infection has been reported to be significantly higher among female partners of IV drug abusers than it is among female partners of bisexual men and hemophiliacs (Heyward and Curran, 1988).

Researchers have also noted that many heterosexual sex partners of HIV-infected persons remain uninfected despite long-term sexual relations without precautions to avoid infection. Thus, it appears that

biological factors may contribute to HIV infection; i.e., that some individuals are more efficient transmitters of infection and the infectiousness may vary with time (Peterman, et al., 1988; Heyward and Curran, 1988).

Newborn Infants, Children

The risk of HIV transmission from an infected mother to her offspring is estimated at 30-50 percent (Rogers, 1985; Scott, et al., 1987). Of the total number of pediatric AIDS cases, children born to HIV-infected mothers represent 78 percent. It is important to note that maternal antibodies may be present in a newborn's blood for up to 12 months after birth and may not necessarily represent infection in the child. Therefore, CDC recommends that children born to HIV-infected mothers be carefully monitored for HIV disease for the first year after birth.

Today, most children with AIDS were born with HIV infection into families living in poverty, in which one or both parents are HIV-infected and drug-dependent. Although children represent only 2 percent of all officially reported cases of AIDS, HIV infection among women and children is growing faster than among any other population. According to the U.S. Public Health Service, for every child diagnosed with AIDS, another 2 to 10 are infected with HIV. An estimated 3,000 children are born with HIV infection every year, and AIDS is becoming the leading cause of death among children and young adults. The twin phenomena of children born with HIV infection and drug dependency is causing a "boarder baby crisis," with increasing numbers of children being abandoned in hospitals because they have neither families nor foster care available to them. Finally, children with AIDS become sicker and die faster than do adults. On the average, their hospital stays are longer and their bills are higher.

Adolescents

Only 1 percent of the total number of AIDS cases in the U.S. are adolescents. However, the problem within this population may be vastly underestimated, for a number of reasons: (1) adolescents often do not seek health services on a regular basis, thus making the identification of HIV disease in this population difficult; (2) given the lengthy incubation period of HIV, many of the 20-29-year-olds with AIDS (who account for 21 percent of all cases) were probably infected as adolescents; and (3) adolescents may engage in behaviors that place them at high risk for infection, including non-monogamous sexual activity and IV drug use.

Of particular concern for the criminal justice system is HIV infection among runaway, homeless, and sexually exploited youth. While the incidence and prevalence of HIV infection among this population is yet to be determined, a 1986 study found that approximately 1 million adolescents run away each year; and of these, an estimated 187,500 are involved in illegal drug use, prostitution, and drug trafficking (U.S. Department of Health and Human Services, 1986). Thus, these youth are at increased risk for HIV infection. Youth living in areas where there are high rates of HIV infection, such as New York, Los Angeles; Washington, D.C.; San Francisco; Houston; and Miami are at greatest risk for infection (CDC, 1987).

Developing an effective response to HIV disease among high-risk youth will require: (1) an accurate understanding of the incidence and prevalence of infection among this population; (2) an assessment of promising programmatic approaches for reaching this population, including crisis intervention and intermediate and long-term care; (3) the development of education strategies which effectively motivate youth to modify high-risk behaviors; (4) the development of policies addressing the confidentiality of youths' HIV status and protecting them from discriminatory practices; and (5) the development of mechanisms to deliver quality health care to infected youth.

HIV INFECTION AMONG SPECIAL POPULATIONS WITH IN THE CRIMINALJUSTICE SYSTEM

Criminal justice policymakers have for some time been concerned about the prevalence of HIV infection among special populations, such as prisoners, including those with diagnosed tuberculosis (TB); prostitutes; and sexual offenders.

Prisoners

The results of a 1988 survey of correctional facilities indicate that the incidence of AIDS among prisoners is higher than that in the general population, most likely because inmates may over-represent past or current IV drug users (Hammett, et al., 1989). There remains little information on the overall HIV seroprevalency rate among prisoners within federal, state, and local correctional institutions since most facilities are not conducting mass-screening programs. A limited number of blind seroprevalency studies have reaffirmed the high rate of infection among IV drug users and homosexual/bisexual men (Singleton, et al., 1989; Truman, et al., 1988).

There also remains little information regarding HIV transmission within correctional institutions. Preliminary studies have reported relatively low rates of transmission; further, they have been very careful to note that the studies have had methodological problems (Hammett, et al., 1989).

HIV infection among prisoners raises some other health care issues which affect the care and treatment of inmates within state and local facilities. In particular, TB may occur as an opportunistic disease in HIV-infected persons. Increased incidence of TB, specifically in areas of the country with high levels of HIV infection, have particularly concerned correctional and public health officials (CDC, 1989). TB is an airborne, contagious disease; thus, its control within a correctional setting is of utmost importance. Correctional administrators should review the CDC guidelines for the prevention and control of TB (Appendix A) and implement the recommendations regarding TB testing and treatment (CDC, 1989).

Prostitutes

Prostitutes are at risk for HIV infection due to frequent IV drug use and multiple sexual exposures (Wish and Johnson, 1986). A study of HIV prevalence among prostitutes in the United States indicated that HIV infection is three to four times higher in prostitutes who use IV drugs than among those who do not. HIV prevalence among prostitutes varies from 0-45 percent, with the highest rates in large inner-city areas where IV drug use is common. HIV infection among black and Hispanic prostitutes is approximately 50 percent higher than among white prostitutes (CDC, 1987).

Sexual Offenders

The prevalence of HIV infection among sexual offenders has not been documented, although sex offenders have multiple sexual deviations and practices which may place them at risk for HIV infection (Ressler, et al., 1988). To date, no seroprevalency studies of either victims of sexual abuse or sex offenders have been conducted. However, increasingly, victims of sexual abuse are expressing concerns about their risk for HIV disease, thus placing added emphasis on the role of the criminal justice system to establish effective means of responding to these concerns (Burgess and Grant, 1988).

CHAPTER III

THE MEDICAL ISSUES: AN OVERVIEW

Acquired immunodeficiency syndrome (AIDS) is a life-threatening disease caused by a ***retrovirus,*** called the human immunodeficiency virus (HIV). The virus reduces the ability of the body's immune system to fight off infections and diseases. As a result, the infected individual dies not of AIDS but from infections and cancers that can thrive in a body with a compromised immune system. To understand how HIV affects the body, its modes of transmission, and the prospect for prevention and treatment, it is essential to understand a few elementary facts about viruses in general, and retroviruses in particular.

Viruses are tiny particles, much smaller than any bacteria. Partly due to their small size, viruses are able to move from the bloodstream to other cells, where they can remain dormant for periods of time, immune from the body's natural defenses or from medications (Haseltine and Wong-Staal, 1988). While some viruses have relatively minor effects, such as those that cause the common cold, others have much more devastating effects, such as those that cause hepatitis and polio.

Viruses are not capable of independent life. They are "alive" and capable of reproducing themselves only when they are inside living cells of higher organisms. They can infect only cells to which they can attach themselves; and for infection to occur, virus-to-cell attachment must take place in a liquid environment compatible with cells survival (Krim, 1987). Thus, in order for HIV to infect a person, very specific conditions must exist.

THE HUMAN IMMUNODIFICIENCY VIRUS

HIV is one of a class of retroviruses, so named for their ability to reverse the ordinary flow of genetic information within the infected cell (Gallo and Montagnier, 1988). Retroviruses and their cancer-causing potential are not new to scientists, having previously been identified in animals (Essex and Kanki, 1988). However, only with the isolation of the first human retrovirus did scientists begin to unfold the insidious nature and lethal effects of HIV (Gallo, 1986; Clavel, et al., 1986).

HIV mainly infects two types of white blood cells: a group of lymphocytes called T4 cells and a group of phagocytes, called macrophages. Both of these cells are integral parts of the body's immune system. The T cells act to stimulate the body's immune system when it is invaded by a foreign substance, while the macrophages serve as the first line of defense against bacterial and other infections. The virus behaves differently in each of these cells.

In the T cells, HIV may lie dormant for long periods of time, until it is stimulated to reproduce itself and kill its host cells. It then "buds" out of the T cell to find additional cells to infect. In the macrophages, the virus grows constantly, albeit slowly, not destroying the cell but probably altering its function (Haseltine and Wong-Staal, 1988). Scientists believe that it is through the macrophages, which can cross the blood-brain barrier, that the virus enters the brain, causing the dementia often seen in individuals with HIV disease (Gallo and Montagnier, 1988).

Infection begins when the virus attaches itself to a molecule called CD4. While the CD4 is primarily on the T cells, other cells of the body also carry the molecule.

HIV INFECTION AND DISEASE

HIV infection causes a progressive derangement of the immune system, with a wide range of manifestations and consequences. AIDS is just one late manifestation of that process. The CDC divides HIV disease into four mutually exclusive stages:

CDC I: Often within three weeks of exposure to HIV, many people experience the symptoms of acute infection, characterized by fever, swollen glands, fatigue, other mononucleosis-like symptoms, and occasionally

a rash. In addition, disorders of the central nervous system may be noted, most commonly headaches and encephalitis (inflammation of the brain tissue). These symptoms disappear within a few weeks.

CDC II: Following the initial infection period and after seroconversion (a positive HIV antibody blood test), most HIV-infected individuals remain asymptomatic for varying lengths of time. However, these individuals are infectious and may transmit HIV through the exchange of blood and through sexual contact.

CDC III: A proportion of HIV-infected individuals with no other symptoms do have generalized lymphadenopathy (swelling of the lymph nodes). This swelling persists over time and is often referred to as PGL **persistent generalized lymphadenopathy.**

CDC IV: HIV-infected individuals with symptoms may be divided into several groups based upon their type and degree of symptoms. Some persons suffer from constitutional symptoms, such as fever, weight loss, and diarrhea, which persist and are not associated with an identifiable cause other than HIV infection. While this stage has often been referred to **as AIDS-Related Complex (ARC),** the term **ARC** is non-specific and tends to obscure the life-threatening aspects of this stage of HIV disease. Therefore, scientists favor using the CDC classification.

CDC IV-B: Other individuals suffer from neurological manifestations, including dementia and other cognitive and sensory disorders which cannot be explained by any other illness than HIV. Still other persons suffer from one or more of the opportunistic infections, most often pneumocystis carinii pneumonia and Kaposi's sarcoma, which are associated with immune deficiency.'

Understanding the full spectrum of HIV disease allows medical researchers to investigate the efficacy of vaccines and drug therapies to combat HIV and allows policymakers to plan prevention and education strategies targeted at specific populations which may be at risk for infection.

HIV Transmission

Perhaps the greatest fear and misunderstanding about HIV disease relates to its modes of transmission. The major routes of transmission--blood and blood products, intimate sexual contact, and mother to fetus--have been well established.

Blood and Blood Products. Transmission through blood and blood-products has been documented in studies of IV-drug users and recipients of blood transfusions (Small, et al,, 1983; Masur, et al., 1984; Friedland, et al., 1985; Curran, et al., 1984). The incidence of infection among transfusion recipients has significantly decreased since 1985, when a test to detect HIV antibodies was applied to all donated blood. However, the high prevalence of HIV infection among IV-drug users reflects the efficiency of shared hypodermic needles in HIV transmission and infection.

Sexual Contact. HIV is also transmitted through intimate sexual contact, both homosexual and heterosexual. In the United States, most sexual transmission of HIV has been among homosexual men; although the disease remains predominantly a heterosexually transmitted one in Africa, the Caribbean, and some areas of South America (Mann, et al, 1986). HIV has been isolated in both semen and vaginal secretions, making unprotected sexual intercourse ***of any kind*** a conducive environment for HIV infection (Curran, et al., 1985). Furthermore, the presence of another sexually transmitted disease, genital herpes, increases the HIV transmission rate (Burgess and Grant, 1988; Heyward and Curran, 1988).

[1] For the complete CDC case surveillance definition of AIDS (CDC IV-C, D, E), see: CDC, MMWR, Vol. 36, No. lS, 1987.

Perinatal Transmission. Another mode of HIV infection is through perinatal transmission, in utero through the mother's circulatory system, during labor and delivery, or after birth through infected breast milk (CDC, December 1987).

Non-Routes of Transmission

While HIV has been isolated in saliva, the concentrations are so insignificant that saliva does not represent a risk of transmission (Lifson, 1988). In addition, extensive research has overwhelmingly documented that HIV infection is not transmitted in any body fluids ***not containing visible blood,*** nor is it transmitted through casual contact, including hugging, shaking hands, sharing of household items, and workplace interactions (Friedland, 1986).

OCCUPATIONAL EXPOSURE TO HIV

The possibility of HIV transmission through accidental exposure to contaminated blood is of concern to professionals within health care, emergency medical services, and public safety. However, numerous studies have confirmed that such transmission represents a small occupational risk.

For example, in a national study conducted by CDC of 870 health care workers who had accidentally received needlestick injuries or cuts with sharp objects (i.e., parenteral exposures) and were thus exposed to blood from patients known to be HIV-infected, four later tested positive, yielding a seroprevalence rate of 0.47 percent. Of 103 workers whose nonintact skin or mucous membranes had been exposed to contaminated blood, none became infected (CDC AND NIOSH, 1989).

In another study, as of April 1988, the National Institutes of Health had tested 983 health care workers, 137 with documented needlestick injuries and 345 with mucous membrane exposures to blood or other body fluids of HIV-infected patients; none had seroconverted. Since that date, one worker has reportedly experienced an occupational HIV seroconversion. As of March 15, 1988, a similar study at the University of California of 212 health care workers with 625 documented accidental parenteral exposures involving HIV-infected patients had identified one seroconversion following a needlestick (CDC and NIOSH, 1989).

As of this writing, no cases of occupational transmission among criminal justice personnel have been substantiated, although a number of cases have been reported and investigated. Despite this fact, concerns remain about possible occupational exposure. Therefore, agencies should develop policies which specify post-exposure testing, counseling, and followup for personnel who have been exposed not only to HIV but also to hepatitis B (HBV).

HIV ANTIBODY TESTING

In March 1985, the Food and Drug Administration licensed a blood test system for screening donated blood. The enzyme-linked-immunosorbent-assay, or ELISA test, and the confirmatory "Western Blot" test are very effective in detecting HIV infection in individuals who show no clinical symptoms and in confirming diagnoses of AIDS and other HIV-related conditions. The tests have also enabled researchers to study both the prevalence and incidence of HIV infection. Most importantly, the tests have been invaluable as a mechanism to screen donated blood.*

The tests, however, do have certain limitations, which relate to the time period between exposure to HIV and the development of antibodies to HIV. Antibodies to HIV develop slowly over weeks or months, and their detection in the blood is not immediately possible. In most individuals, antibodies to HIV may be detected 6-12 weeks after initial infection. However, in some persons, this seroconversion may occur as early as 2 weeks; and in others, it may take as long as 6 months, or in rare cases, even longer. Thus, antibody testing may yield a false "negative" result, making it necessary to repeat the tests at 6 weeks, 12 weeks, 6 months, and 12 months after exposure.

---

[2] For a detailed discussion of the Western Blot. see: CDC, MMWR, Vol. 38, No. S-7, July 21, 1989.

Such limitations make mass screening programs, particularly among the general population, a costly and ineffective method of detecting infection. Furthermore, the many false "negative" results, which are to be expected among persons recently infected with HIV, may lead to a false sense of security for both the persons suspected of being infected and the persons with whom they come in contact.

HIV Antigen Testing

The Food and Drug Administration has approved the marketing of the first diagnostic test to detect HIV antigens; i.e., proteins produced by the HIV virus. While antibodies are first detectable in most persons about 6-12 weeks after infection, antigens can appear temporarily as early as two weeks after infection. The antigen test is an enzyme immunoassay that directly detects at least one antigen, or protein, produced by HIV. Researchers have discovered that not only are HIV antigens generally detectable earlier than antibodies, but that the detection of antigens correlates to the development of clinical complications, such as AIDS, AIDS-related complex or other forms of immune deficiency related to HIV infection.

The antigen test has been very useful in monitoring and treating individuals who participate in clinical trials of anti-viral drugs.

PROGRESS TOWARD VACCINE AND TREATMENT

Certainly, the best way of combatting any disease is to prevent it; and vaccination is one of the most effective methods of prevention. Medical research has produced vaccinations against such diseases as smallpox, polio, measles, yellow fever, and the mumps. While the development of a safe vaccine against HIV remains the highest research priority, the very nature of HIV makes vaccine development and testing the most challenging of tasks. For a vaccine to be effective it would have to: (1) prevent HIV from infecting the T cells and the macrophages; (2) stop HIV from infecting the central nervous system, where it becomes invulnerable to the immune system; (3) ensure that the immune system will recognize the virus as it mutates within the body; (4) be effective for all recipients regardless of age and extent of exposure to HIV, and (5) be free of any risk of causing AIDS (Matthews and Bolognesi, 1988).

Three factors are particularly important in understanding the difficulties of vaccine research: (1) the ability of HIV to "hide" in cells and change its composition and replace the host cell's genes with its own genes; (2) the lack of animal models for the disease which may be used in testing potential vaccines; and (3) the difficulties of recruiting and the serious ethical concerns about using human subjects for trial vaccines. Despite these difficulties, a number of research efforts are currently underway to develop and test vaccine candidates as experts remain cautiously optimistic about the prospects of a vaccine.

Treatment of HIV disease remains the more promising approach. Several drugs have been effective in laboratory studies in either interfering with HIV's ability to replicate itself or its ability to attach itself to host cells (deClerq, 1986; Robbins, 1986). To date, the drug AZT has been shown to be effective for persons with diagnosed AIDS and in delaying disease progression in HIV-infected persons with less than 500 T4 cells. However, the drug must be taken every four hours; remains very costly; and may have potentially life threatening side-effects, such as the suppressing of bone marrow in some patients. Furthermore, in some cases, HIV has "adapted" itself to AZT, making the drug ineffective over time. Currently, a number of research projects are examining the possible advantages of administering AZT at earlier stages of the disease.

Other antiviral drugs continue to be studied, as are combinations of AZT with other drugs. However, no current drug therapies have proven effective at early stages of infection or once HIV has infected a host cell. Furthermore, researchers have yet to develop therapies which would restore an immune system destroyed by HIV, although certain combinations of interleukins and interferons seem to hold promise (Krim, 1988).

In addition to the purely medical issues surrounding HIV disease, there are a number of critical psychological problems experienced by infected persons. For a detailed discussion of these issues, see Chapter X.

CHAPTER IV

THE LEGAL ISSUES: AN OVERVIEW

Michael R. Smith, J.D.

It is essential that corrections officials know their legal rights and obligations in handling inmates with HIV disease. It is becoming more and more likely that, on any given day, most prisons and jails will hold such inmates. As a result, increasing numbers of questions are being raised. For example, when may inmates be tested for HIV? May infected inmates be housed separately from other inmates? Who may be told that an inmate is HIV infected?

The federal courts have started to address these and related questions, although their answers sometimes provide only tentative guidance. This chapter focuses on federal law; however, many state legislatures have passed laws dealing with AIDS. Since the application of state law may produce a completely different answer, correctional administrators must consider it before implementing any AIDS-related policy.

This chapter is not intended as a comprehensive or definitive treatment of the many legal questions surrounding AIDS. Instead, it discusses federal court decisions in the most important areas of correctional policy and draws some limited conclusions.[1] In addition, it focuses on law rather than policy. Federal courts may allow certain policies affecting HIV-positive inmates, but administrators must decide for themselves whether those policies represent sound correctional practice. The law is still developing in this important area, and policymakers should consult their attorneys for up-to-date legal advice.[2]

TESTING INMATES FOR HIV

The Fourth Amendment protects all persons, including pretrial detainees and convicted inmates, against unreasonable searches.[3] This protection applies to conventional searches, as when a correctional officer frisks a newly admitted inmate. It also applies in a less obvious context; for example, a mandatory blood test is considered a search, which does not mean that it is prohibited, but only that it must be reasonable.[4] The critical question for corrections policymakers is whether mandatory testing of inmates for HIV is reasonable under the Fourth Amendment.

Inmates' Privacy Rights

In evaluating the validity of HIV testing of inmates, a federal court will decide if the reason given by corrections officials for testing outweighs an inmate's right to privacy. In the corrections context, this probably means only that the justification for testing must not be arbitrary.[5] The application of this legal standard does not always produce clear and obvious results, and the outcome may be complex. In two recent decisions, however--Dunn v. ***White*** and Harris v. Thigpen--federal courts ruled that the mandatory testing of inmates for HIV is reasonable.

Dunn v. White. In ***Dunn*** v. ***White,*** an inmate filed a lawsuit claiming that prison officials violated his Fourth Amendment right to privacy by forcing him to submit to a blood test for HIV.[6] After recognizing that inmates retain a limited privacy interest in not having their blood tested, the federal court of appeals nevertheless concluded that the "prison's interest in responding to the threat of AIDS" was more important than the inmate's privacy.[7] The court emphasized generally the need to control the spread of HIV disease inside prison, and it approved mandatory HIV testing as a necessary first step in assessing the scope of the problem. In addition. the court found that testing was a crucial tool for helping prison officials meet their legal duty to provide medical care for HIV-infected inmates. The court allowed testing even though "the prison [did] not currently use the information it gathers either to treat or control the spread of AIDS."[8]

The decision in ***Dunn*** is important not just because it permits HIV testing, but also for the circumstances under which it allows it. It found that the operation of a prison presents "special needs"; and

when conducting searches of inmates, those needs "justify departures from the usual warrant and probable-cause requirements."[9] In other words, corrections officials may test an inmate for HIV even if there is no particular reason to believe that he or she is infected. Not only will testing be considered reasonable in the complete absence of suspicion, but it also means that a search warrant is not required.

This decision is significant for another reason. The court accepted the general justifications for testing put forward by prison officials, and it never required them to specify how they would use the identification of HIV-infected inmates to limit the spread of AIDS. Further, the court did not require details about the medical treatment program the officials might implement. Instead, the court apparently upheld the testing because prison officials at some point might use the HIV status of inmates to make decisions about segregated housing assignments and medical treatment.

Harris v. Thigpen. Another recent federal court decision, ***Harris v. Thigpen,***[10] involved a class action lawsuit by inmates challenging an Alabama statute that requires HIV testing for all inmates upon admission to prison and within 30 days of their release. The trial court upheld the mandatory testing program, finding that the need to protect other inmates and prison officers against the spread of AIDS was more important than the limited privacy rights of HIV-infected inmates. Alabama prison officials had concluded that placing HIV-positive inmates in segregated housing units was the best way to protect other inmates against infection. The court found that testing inmates was reasonable, as it was the only way to identify those inmates requiring segregation.

The ***Harris*** decision circles the legal issues in a way that is sometimes difficult to follow, but the one thread that holds the issues together is the fact that it was extremely important to the court that prison officials "may face liability for exposing others to a dread disease . . . . "[11] The decision to allow testing rests primarily on that factor, although the court never mentions the practical barriers facing inmates who bring lawsuits alleging that corrections officials failed to protect them from other inmates.[12] Instead, it accepted the opinion of prison officials that no one can "reasonably guess how those having the capabilities to transfer that dread disease may use that awesome weapon against their weaker fellow inmates who think they are not infected."[13] In order to minimize the possibility of lawsuits by inmates alleging that they became infected through homosexual rapes in prison, the court approved the segregation of HIV-infected inmates. It then necessarily approved HIV testing as a legitimate way to identify those inmates in need of segregated housing. In fact, the court even suggested that allowing HIV-positive inmates to remain in the general population might violate the rights of other inmates.[14]

It is important to recall that the HIV test looks only for antibodies to the virus, not for HIV or AIDS. The court in ***Harris*** recognized that a significant window of time exists between HIV infection and the appearance of antibodies. This period is usually between six weeks and three months, and it means that a person who tests negative during this critical period still may be infected and capable of transmitting the virus to others. For purposes of Alabama's mandatory testing program, it also means that an unknown number of HIV-infected inmates will test negative and remain in the general prison population. Even though confronted with this serious limitation on the ability of prison officials to identity and isolate HIV-infected inmates, the court nevertheless allowed mandatory HIV testing for all inmates.

Additional Issues Affecting Inmate Testing

In part, the decisions in ***Dunn*** and ***Harris*** to permit mandatory HIV testing can be explained by the deference accorded corrections policymakers by the federal courts.[15] The courts recognize how difficult it is to operate prisons and jails, and therefore they are reluctant to second-guess the policy choices of their administrators. On the other hand, it is possible that this usual deference is exaggerated in these cases by unreasonable fears about AIDS. In ***Harris,*** for example, the court noted that "AIDS now ***appears*** not to be an air-borne disease," a statement that may reflect lingering skepticism about how HIV is transmitted.[16] There is another factor involved in these decisions. The privacy interest violated by a blood test is relatively slight, and that probably made the courts more willing to accept the vague and sometimes inconsistent justifications offered for the testing.[17] It is dangerous to draw final conclusions about mandatory HIV testing based on these early decisions, and corrections administrators should note their limited scope. These

decisions provide that HIV testing does not violate the Fourth Amendment rights of inmates, but they do ***not*** require corrections officials to test inmates. In fact, the federal courts consistently have rejected claims by inmates that a failure to test all newly-admitted inmates violates their Eighth Amendment right to be free from cruel and unusual punishment.[18] The inmates bringing these lawsuits have been concerned mostly about being assaulted by HIV-infected inmates, and they have argued that testing is the only way to identify and segregate those inmates who might infect them.

In ***Feigley v. Fulcomer,*** for example, a federal court held that the rights of an inmate were not violated by failing to test all other inmates for HIV infection. The court relied on the testimony of a medical expert, who stated, "It is impossible to effectively separate infected from uninfected inmates."[19] There is no way to guarantee complete separation due to the window of time between HIV infection and the development of antibodies. Given this limit on the usefulness of testing as a way to identify HIV-infected inmates, the medical expert encouraged prison officials to treat all inmates as if they are infected. In other words, they should take universal precautions against possible infection, rather than taking only precautions with those inmates who test positive.[20] After considering the medical evidence, the court refused to find that the prison officials, by ***failing*** to test all inmates, had deliberately ignored their duty to protect inmates from HIV infection.

State Laws' Impact on Testing. State legislatures have addressed many of the complex issues surrounding AIDS, including ***when*** persons may be tested. Therefore, administrators ***must be cautious*** when preparing to establish testing policies; since even if the Fourth Amendment does not prevent inmate testing, individual ***state law may prohibit involuntary HIV testing.*** For example, it is possible that a state law will flatly prohibit HIV testing without a person's consent. In the absence of an exception for inmates or a separate law that permits their involuntary testing, it would therefore be unlawful in that state to test inmates for HIV. This is true even though the Fourth Amendment might allow the testing of inmates as a reasonable invasion of their privacy. The U.S. Constitution outlines the minimum privacy rights enjoyed by all citizens, including inmates; but a state may grant its residents greater protection against invasions of privacy. This possibility makes it important for administrators to consult their legal advisors about the impact of state law on HIV testing.

INMATE HOUSING

Segregation Issues

HIV testing of inmates, as the preceding section indicated. is usually connected directly to a policy of segregation of those who test positive. Federal courts in several cases have upheld the separate housing of HIV-positive inmates, even those who are asymptomatic, for such purposes as diagnosis, medical treatment, and security.

In ***Muhammad v. Carlson,*** for example, an inmate, Muhammad, was transferred to a federal medical center for evaluation of physical coordination problems; and blood tests revealed that he was HIV infected.[21] Prison officials immediately placed him in a restricted AIDS unit that was isolated from the general inmate population. No hearing was conducted. Muhammad was returned to the general inmate population after the Bureau of Prisons changed its policy of automatically segregating HIV-infected inmates.[22] He filed a federal lawsuit alleging that his transfer to the restricted AIDS unit had violated his constitutional rights.

Due Process Clause Issues. The primary legal question was whether the transfer and segregation violated Muhammad's federally protected right to due process of law. In other words, Muhammad claimed that federal law required prison officials to give him notice of the reasons for the transfer and an opportunity to challenge those reasons. The court rejected his claim, finding that the Due Process Clause gives inmates no protection against a transfer to more restrictive quarters for nonpunitive reasons.[23] Put another way, inmates have no constitutional right to remain in the general population. The court found that Muhammad's transfer was not for punitive reasons, and therefore it fell within the broad discretion enjoyed by corrections administrators. Instead, his transfer had "the legitimate purpose of isolating suspected AIDS

carriers for diagnostic, treatment and security purposes."[24]

In addition to the above, the decision in ***Muhammad*** v. ***Carlson*** addresses the following legal challenge to the transfer: Federal prison officials had adopted regulations that narrowly limited their authority to transfer HIV-infected inmates to segregated housing; and once they had placed ***mandatory restrictions*** on their ability to make those transfers, Muhammad argued that inmates reasonably expected the regulations to be followed. Because the Due Process Clause protects reasonable expectations created by mandatory regulations,[25] Muhammad concluded that he was entitled to notice of the reasons for his transfer and an informal opportunity to challenge them.

The court's analysis of Muhammad's argument offers valuable guidance for administrators. After recognizing the validity of Muhammad's general legal theory, the court ruled against him because the theory simply did not fit his case. The federal regulations in question did not place any limitations on transfers to segregated housing for medical reasons. Since medical reasons were the basis for Muhammad's transfer, the prison regulations gave him no reason to "expect that he would not be transferred to the AIDS unit without a chance to challenge his medical classification. . . ."[26] Absent a mandatory restriction on the discretion of federal officials to make transfers for medical reasons, the Due Process Clause did not entitle Muhammad to challenge his move to more restrictive quarters.

The decision in ***Muhammad v. Carlson*** is significant. It provides that inmates, even those who are HIV infected, have no federally protected right to remain in the general inmate population. However, if local regulations impose mandatory restrictions on transfers, the Due Process Clause offers inmates limited protection, requiring officials to tell inmates why they are being removed from the general population and allowing inmates an informal opportunity to question the transfer. Thus, if corrections officials have voluntarily restricted their authority to make transfers, they are obligated to follow limited due process requirements; and they must be careful in writing policies for housing HIV-infected inmates.[27] The language used in any policy should indicate clearly whether and under what circumstances infected inmates may be segregated for diagnosis, treatment, or security.

Equal Protection Clause Issues. HIV-infected inmates have challenged segregated housing policies on other legal grounds, charging that their confinement in isolated units violates the Equal Protection Clause. This differs from a lawsuit based on a violation of due process. In essence, the legal argument is that transferring seropositive inmates to segregated housing, even with notice and a hearing, is arbitrary and therefore violates their right to equal treatment. However, the Equal Protection Clause does not absolutely prohibit corrections officials from treating one group of inmates differently than other inmates. Instead, it usually requires only a good reason for the different treatment, or--in legal terms--the different treatment must be rationally related to a "legitimate government purpose."

The courts have analyzed these equal protection challenges in slightly different ways, but each has concluded that segregating HIV-infected inmates was reasonable and therefore not a constitutional violation. In ***Judd v. Packard,*** for example, an inmate filed a lawsuit after he was placed in medical isolation on three separate occasions for AIDS-related testing and treatment. The court concluded that, "It is perfectly reasonable to isolate suspected carriers medically for diagnostic and treatment purposes in a prison hospital setting."[28] Other courts have concluded that safety and security are reasonable justifications for a special housing policy.[29] For example, one court upheld segregated housing as a reasonable way "to protect both the AIDS victims and other prisoners from the tensions and harm that could result from the fears of other inmates."[30]

Access to Programs, Services. HIV-infected inmates frequently have raised another legal question following their isolation from the general inmate population. Are segregated inmates entitled to receive the same access to programs and services as other inmates in the facility? The answer is not entirely clear; therefore, corrections officials should be cautious in their approach to this issue.

In ***Powell v. Department*** of ***Corrections,*** the issue was raised by an HIV-infected inmate who claimed that he was denied the following privileges during his isolation: visitation with his family, attendance at worship services, adequate physical exercise, and access to a law library.[31] The court upheld the inmate's isolation in separate quarters, but only because the conditions in those quarters did not otherwise violate

his federal rights. In finding that the inmate's rights were not violated, it was important to the court that he was "provided limited access to all programs and services at the institution."[32] For example, the inmate was not allowed to worship with the rest of the prison population, but he did have regular access to the prison chaplain. The court found that the restriction was a reasonable way to maintain the health of other inmates and protect the HIV-infected inmate from harm. It might have reached a different decision, however, if prison officials had ***completely*** denied the inmate access to programs and services.[33]

This same issue was addressed in the recent case of ***Harris v. Thigpen.***[34] HIV-infected inmates claimed that Alabama prison officials violated their federal rights by denying them meaningful access to the courts. The court indicated that even "[i]nmates infected with the AIDS virus have a constitutional right to access to the law library or, in the alternative, to the assistance of a person with legal training."[35] In rejecting the inmates' claim, however, the court emphasized that the inmates already received some access to the law library and stated that it was reluctant to order any more.[36] At the same time, however, the court recommended that prison officials formulate a plan that would give the inmates even greater access to the law library. It is possible that the court, if faced with a policy that completely denied access to the courts, would have found that the policy violated the rights of HIV-infected inmates.[37]

It is important to emphasize that the law on access to programs by infected inmates is not completely settled, which means that the federal courts do not always reach predictable results. In ***Harris v. Thigpen,*** the trial court also considered a policy that apparently made HIV-infected inmates completely ineligible for certain community programs. For example, the inmates were not allowed to leave the facility and participate in work-release programs. The court found that the policy did not violate the rights of seropositive inmates, even though it was a complete denial of access rather than a limitation.[38]

Conjugal visitation. In another case, a prison inmate was denied participation in a conjugal visitation program after he was diagnosed as suffering from AIDS.[39] This complete denial was upheld against a claim that it violated the inmate's constitutional right to equal protection of the law. It was not a violation because the court decided that prison officials had a good reason for the policy, which was to prevent the spread of a communicable disease.[40] Compare that case with one in which prison officials refused to allow an inmate with AIDS to leave the prison on a temporary furlough.[41] The court found that denying his participation in the program was not supported by the evidence; therefore, it held the policy unconstitutional as applied to the inmate. The inmate had been receiving the drug AZT in an experimental program, and officials unreasonably concluded that a seven-day furlough would interfere with his continued medical treatment.[42]

In the absence of a clear legal rule, the safest approach for corrections policymakers is to give HIV-infected inmates at least limited access to prison programs and services. For example, the Connecticut Department of Correction recently settled a lawsuit by agreeing to grant limited privileges to HIV-infected inmates confined in a prison hospital.[43] Absent special medical or security considerations, the officials consented to provide the inmates with reasonable hours of visitation and at least weekly meetings with the prison's religious staff.

It should be noted, however, that federal courts, in narrow circumstances, may uphold a policy that completely denies inmates access to certain programs, especially if the program involves releasing infected inmates into the community or giving them contact with persons from outside the facility. In this area, as in many others involving AIDS-related legal issues, corrections administrators are advised to consult with legal advisors before implementing policy.

A final word about segregating HIV-infected inmates follows: The federal courts have concluded that a segregation policy does not violate the rights of inmates; but at the same time, they have ***not mandated*** an isolation policy for HIV-infected inmates. In a number of lawsuits, courts have denied claims by healthy inmates that officials have violated their constitutional rights by failing to segregate all inmates with AIDS. One federal court stated that "[t]he problem of protecting prisoners from AIDS is best left to the legislature and prison administrators."[44] Like the decision to test inmates for HIV, the ultimate policy choice on housing rests within the sound discretion of prison and jail administrators.

CONFIDENTIALITY OF MEDICAL, INFORMATION

The legal questions surrounding the confidentiality of information about an inmate's HIV status are complex and largely unsettled. Corrections administrators and officers frequently want to know if an inmate in their custody is seropositive, and sometimes they want to tell other people who may come into contact with the inmate. It is not always easy to evaluate whether officials have a legitimate need to know an inmate's HIV status, or, on the other hand, whether they simply want to know because of unreasonable fears about contracting HIV disease. Only a handful of court decisions have discussed the confidentiality question; and at best they offer broad, tentative conclusions.

State Legislation

Many state legislatures have enacted confidentiality statutes that strictly limit the circumstances under which information about HIV may be revealed. In this area, it therefore is especially important that prison and jail officials review their state laws.

Federal Court Decisions

Federal courts have gradually recognized that a constitutional right to privacy protects HIV-infected inmates against the unnecessary disclosure of medical information. In ***Woods*** v. ***White,*** for example, an inmate sued prison medical personnel, alleging they violated his right to privacy by telling custodial officers and other inmates that he had tested positive for HIV.[45] The court first had to decide whether there was a right to privacy that protected the inmate. Other federal courts had identified a right to privacy in certain types of personal information; and in ***Woods,*** the court relied on these precedents in holding that the inmate had "a constitutional right to privacy in information relating to AIDS."[46] In addition, the court found that the inmate did not lose that right just because he was confined in prison.

The court declared that the right to privacy was not absolute, however; and in an appropriate case, the need for disclosure by corrections officials might outweigh an inmate's right to confidentiality. In ***Woods,*** however, the court was not required to determine the scope of the inmate's right to privacy. The medical personnel simply made "no claim that any important public interest was served in their discussion of [the inmate's] positive test for the AIDS virus."[47] Because they offered no justification for the disclosure, the court could not find that the medical staff had a legitimate reason for violating the inmate's right to privacy. After deciding that a jury could hold the medical officers liable, the court also ruled that qualified immunity did not shield them from individual liability. The defense was not available to help them because the "[c]asual, unjustified dissemination of confidential information to non-medical staff and other prisoners" fell far outside of their responsibilities.[48]

The decision in ***Woods*** means that directly revealing an inmate's HIV status without any good reason violates the person's federally protected right to confidentiality. Unfortunately, the decision offers little guidance on what courts might recognize as a legitimate justification for disclosure. It is difficult to know exactly what happened from the sparse facts reported in ***Woods,*** although the medical staff may have been merely engaging in gossip. The court makes it clear that gossip and idle interest are not good enough reasons for divulging an inmate's HIV status.

What if the reason given for disclosing an inmate's HIV status is to protect detention officers and other inmates from contracting the disease? The medical evidence may undercut that justification, even though it is appealing at first glance. Given that HIV is not transmitted through casual contact, and given the recommendation that correctional officers use safety precautions in dealing with all inmates--not just those known to be HIV-infected--how will knowledge about an inmate's HIV status protect officers against infection?

On the other hand, corrections administrators might respond that officers sometimes fail to use universal safety precautions and that the officers will be more consistent in protecting themselves if known HIV-infected inmates are identified.[49] There is no reliable way to predict whether the federal courts will accept that argument for directly releasing an inmate's HIV status. In ***Baez v. Rapping,*** the federal court

came close to considering that justification; but the question was slightly different because the inmate's condition was not directly divulged.[50] After an inmate was hospitalized for a blood clot in his leg, tests revealed that he was HIV infected. When the inmate was returned to jail, the hospital "issued a medical precaution sheet . . . concerning the necessity of avoiding [the inmate's] body fluids."[51] The inmate then sued the doctor who released the warning. It is significant that the sheet did ***not*** specifically state that the inmate had tested positive for HIV. After emphasizing that inmates have only a limited right to privacy, the court held that it is "not infringed when a medical director reports the condition of an inmate in the most limited way possible to the corrections department."[52]

Unlike the situation in ***Woods*** there was no direct violation of privacy in ***Baez;*** as the medical report did not expressly reveal that the inmate was HIV infected. In addition, the doctor in ***Baez*** put forward a reason for his disclosure--the safety of jail officers. It is important to remember that no reason at all was offered in ***Woods.*** For that combination of factors, the court decided that the limited disclosure was more important than the slight infringement of the inmate's privacy.[53] This case does not necessarily mean that a court will uphold the direct disclosure of an inmate's HIV status, even for the alleged purpose of protecting staff. It must be emphasized that the warning in ***Baez*** was discrete, only advising the jail staff to avoid contact with the inmate's body fluids. Further, the warning was made for public health reasons by trained medical personnel, not corrections officers, and that may have influenced the court's decision.

The inmate in ***Baez*** also tried to argue that the medical warning, although limited and discrete, ***indirectly*** revealed that he was HIV infected. There are other health reasons for avoiding contact with an inmate's body fluids, but it seems likely that most officers, upon hearing such a warning, would assume an inmate is HIV infected. In ***Baez,*** the court never really focused on the possible breach of confidentiality associated with the indirect disclosure of an inmate's medical condition. Federal courts now may be turning their attention to this slippery aspect of confidentiality.

In ***Doe v. Coughlin,*** prison policy required the involuntary transfer of all HIV-infected inmates to a special dormitory for improved medical treatment.[54] A seropositive inmate filed a lawsuit against the policy, alleging that placing him in a segregated housing unit would ***indirectly*** disclose his medical condition and therefore violate his constitutional right to privacy. For example, "family members visiting the inmate might be told by other visitors or by guards that the inmate is housed in the 'AIDS dorm'";[55] or "inmates released from prison may return to their communities and 'spread the word.'"[56] It is significant that the inmate never claimed prison officials would purposefully release his medical diagnosis.

After finding that HIV-infected inmates have a limited right to keep their medical diagnosis confidential, the court in ***Doe v. Coughlin*** also found that the prison officials had legitimate reasons for the proposed transfer policy.[57] HIV-infected inmates would receive improved medical treatment at a special clinic, and the policy would reduce transportation costs associated with treatment.[58] In the end, however, the court ruled that those benefits did not outweigh the inmate's right to privacy. It therefore found that inmates must be afforded some protection against the non-consensual disclosure of their HIV status. For example, the court indicated that perhaps inmates should be allowed to decide whether they will be housed in the special unit. In essence, such a choice would amount to an "informed decision as to a waiver of their constitutional right to privacy."[59] Although the court did not reach a final decision, it temporarily ordered prison officials to stop the involuntary transfer of HIV-infected inmates to the special dormitory.[60]

The decision may not extend beyond its own facts, but it still casts some light on the issue of confidentiality. First, the court found that the inmate's privacy was more important than the acknowledged benefits of the transfer policy. This is a remarkable outcome in light of the deference usually afforded prison administrators by the federal courts. In addition, the court elected to protect the inmate's confidentiality against ***indirect*** disclosure, even though it was incidental to the implementation of an otherwise legitimate policy.

Given how few courts have addressed the maze of issues surrounding confidentiality, it is dangerous to draw broad legal conclusions.[61] The prudent approach for policymakers is to exercise caution against disclosing an inmate's medical condition. State law in most cases will prohibit ***direct*** disclosure, except in carefully limited circumstances; and the decision in ***Woods*** indicates that federal law also requires a good reason before an inmate's condition is directly revealed.

In addition, the decision in ***Doe v. Coughlin*** suggests that administrators should be careful not to

implement policies that ***indirectly*** reveal a person's HIV status. For example, the issue of confidentiality may be used in the future as a sword to attack policies that segregate inmates solely because they are HIV positive.[62] The case suggests that corrections officials may not without good reason involuntarily transfer an HIV-infected inmate to segregated housing if it would indirectly reveal his or her medical condition, particularly if their legitimate objectives can be reached some other way. Corrections officials should develop policies that address these confidentiality issues before problems arise, and they should consult their legal advisors about the impact of state laws.

FAILURE TO PROTECT INMATES FROM ASSAULTS

Corrections administrators frequently worry about possible liability if an HIV-infected inmate sexually assaults another inmate and transmits the disease. This is one of the reasons many facilities isolate seropositive inmates from the general population.

Officials Not Responsible for All Inmate Acts of Violence

It is important for officials to realize that they will not be held responsible for all acts of violence between inmates, even if one of the inmates has AIDS. The courts recognize that some level of violence will take place regardless of the preventive measures taken.[63] On the other hand, the federal courts have ruled that inmates have a constitutional right to be protected against violence under certain circumstances. For example, corrections officials must anticipate and prevent assaults by inmates if an extensive risk of violence exists in the facility.[64] Even if violence among inmates is not rampant, corrections officers still must protect inmates who are exposed to a specific risk of violence.[65]

One reported decision has addressed the issue of liability in a lawsuit brought by an inmate who was assaulted by an HIV-infected inmate, and it dismissed the lawsuit in favor of prison officials.[66] The seropositive inmate, Stroud, attacked another inmate, Cameron, apparently without provocation.[67] Stroud bit into Cameron's index finger "until the wound was bone deep,"[68] and he made it clear that the assault was premeditated. Cameron was called to the prison clinic a week after the attack, where the medical director told him he may have contracted HIV, as Stroud "had been diagnosed before the altercation as a carrier of the virus."[69] Cameron filed a federal lawsuit against the medical director and two prison administrators, alleging that their failure to protect him from the assault violated his constitutional right to personal safety. The inmate did not claim that the virus actually was transmitted by the bite.

In dismissing the inmate's lawsuit, it is significant that the court applied the same analysis that always is applied in claims involving inmate violence; i.e., it did not apply a special legal rule just because one of the inmates was HIV infected.[70] The law provides that an inmate cannot prevail in this type of lawsuit without proving that prison officials were deliberately indifferent to his or her need for protection. This is a difficult hurdle for inmates, as it means showing more than carelessness (negligence) or recklessness on the part of corrections officers. In this case, Cameron claimed that the prison officials knew or should have known Stroud was predatory and violent, as he was in prison for a crime of violence and had been disciplined by officials for assaultive behavior; and they let him stay in the general inmate population even though he was also HIV infected. The court held that these allegations were not enough to impose liability against prison officials, and therefore it dismissed the inmate's lawsuit.[71]

Protecting Against Violence by Addressing Causes

This is another area in which it is difficult to draw firm conclusions, especially on the basis of one court decision. The threat of liability for failure to protect inmates from assaults is a good reason for isolating all violent inmates, not just HIV-infected inmates who are violent. In addition, officials should protect against violence by addressing its recognized causes. For example, officers should conduct adequate supervision rounds and should also classify inmates in ways designed to reduce violence. It is possible that officials will be held liable if a seropositive inmate sexually assaults another inmate and transmits the virus,

but only if the officials clearly should have prevented the assault.[72] The best way for policymakers to avoid liability is for them to take all reasonable and necessary steps to protect inmates from risks of violence.

LIABILITY FOR FAILURE TO PROVIDE AIDS TRAINING

Case of Doe v. Borough of Barrington Provides Valuable Lesson

The recent ***case*** of ***Doe v. Borough of Barrington***[73] offers a valuable lesson on the connection between AIDS-related training and the avoidance of civil liability. The court held that a police officer violated an arrestee's constitutional right to privacy by disclosing to another person that the arrestee had AIDS. In addition to finding that the officer who released the information was liable, the court ruled that his government employer also must answer for the violation. The local government was held responsible because it had failed to provide training about AIDS or the need for confidentiality when dealing with HIV-infected arrestees.[74] This particular case involved a police officer, but the same legal principles will govern liability for a failure to train detention officers. It combines a number of important AIDS-related legal issues, including liability for inadequate training and confidentiality; therefore, the decision will be considered at length.

Case Background. On March 25, 1987, John Doe and his wife, Jane, along with a friend, James Tarvis, were driving in a pickup truck when they were stopped by Borough of Barrington police officers. John Doe was arrested for unlawful possession of a hypodermic needle. He was detained, and the truck was impounded. Doe advised the police officers to be careful in searching him, as he had tested positive for HIV and had "weeping lesions" on his body.

Later the same day, Jane Doe and James Tarvis drove to the Doe residence in the neighboring Borough of Runnemede. They left Tarvis's car running in the driveway, and somehow it slipped into gear, rolling backward and crashing into a neighbor's fence. One of the neighbors was Rita DiAngelo, a local school employee. While two Runnemede police officers were investigating the accident, an officer from the Barrington Police Department, Detective Preen, arrived and talked with one of them, Officer Van Camp. Preen told Van Camp that Jane Doe's husband had been arrested earlier and that he had AIDS. Officer Van Camp relayed this information to his partner, Officer Russell Smith.

After Jane Doe and Tatvis left the area, Smith told the DiAngelos that Doe's husband "had AIDS and that, to protect herself, Rita DiAngelo should wash with disinfectant." Rita DiAngelo became upset, in part because her daughter attended school with the four Doe children. DiAngelo contacted other parents with children in the school; and in addition, she contacted the media. The next day 11 parents removed their children from the school in a panic. Local newspapers and television stations covered the story, and at least one report mentioned the Doe family by name.

Jane Doe and her children sued Smith and the Borough of Runnemede in federal court under 42 U.S.C. {1983}, alleging that Smith violated their constitutional right to privacy when he told Rita DiAngelo that John Doe had AIDS. They argued that the disclosure had caused them to suffer "harassment, discrimination, and humiliation" and that they were "shunned by the community." The Doe family is seeking an award of money damages for its injuries.[75]

Constitutional Right to Privacy. The federal courts have struggled with whether there exists a constitutional right to privacy, but the court in ***Borough of Barrington*** not only identifies a privacy right but casts substantial light on its contours. It holds that the Fourteenth Amendment protects against unauthorized disclosure by government officials of sensitive personal matters, including medical records and medical information. The court declares that AIDS-related information is especially sensitive, and "the privacy interest in one's exposure to the AIDS virus is even greater than one's privacy interest in ordinary medical records because of the stigma that attaches with the disease."[76] This is consistent with the earlier discussion on the confidentiality of medical information, which means that corrections officials have a constitutional duty to avoid disclosing certain medical information, particularly the fact that a person is infected with HIV.[77]

Because revealing that a relative is HIV positive may cause the entire family to be ostracized, the court

in ***Borough of Barrington*** also holds that "[t]he right to privacy extends to members of the AIDS patient's immediate family."[78] In other words, the right to privacy not only protects John Doe, but it also covers Jane and the children. The court reached this conclusion after noting that the "hysteria surrounding AIDS extends beyond those who have the disease."[79] This is a highly significant step. It permits Doe and her children to sue Officer Smith and the Borough of Runnemede for a violation of their own right to privacy, not John Doe's privacy. Each family member should recover for his or her own injuries, which multiplies the amount of liability caused by Officer Smith's single disclosure.

The right to privacy in medical information, like other constitutional protections, is not absolute. The court noted that the information sometimes may be divulged, but only if the government's need to reveal it outweighs a person's interest in keeping it private.[80] In other words, Officer Smith needed a compelling reason to justify telling Rita DiAngelo that John Doe was infected with HIV. According to Officer Smith, the reason was to prevent transmission of the virus by advising DiAngelo to wash her hands with disinfectant. The public's need to avoid the spread of a deadly disease is compelling, and in the appropriate case it might justify a disclosure. But telling DiAngelo about Doe's medical condition was unrelated to that goal. The medical evidence clearly showed that Doe could not transmit HIV to the DiAngelos through casual contact. In the absence of a very good reason for turning a public spotlight on such sensitive information, the court found that Officer Smith had violated Doe's right to privacy.

This case is also significant because the court embraces current medical knowledge and rejects fear as the basis for its decision. Officer Smith had argued that "infection through causal contact cannot be ruled out" because "there are no conclusive facts about AIDS."[81] The court firmly rejected that argument. He subjectively may have believed that Doe could infect Rita DiAngelo simply by touching her and he may have thought that washing with disinfectant could stop this casual spread of HIV. Officer Smith's personal beliefs, no matter how strongly and sincerely held, did not justify his disclosure, because they had been disproved by current medical research.[82] The court declared that objective medical evidence is what matters in evaluating the actions of public officers, and research had clearly established that HIV is not spread through casual contact.[83]

Liability of officer Smith. The court ruled that Officer Smith was liable personally for revealing John Doe's medical condition to Rita DiAngelo. After finding that Jane Doe and her children had a right to keep that highly personal information to themselves, which was the most difficult hurdle to clear in this case, the court easily decided that Officer Smith had caused a violation of their privacy.

Qualified immunity is a valuable defense that sometimes shields public officers against personal liability. It protects them if a constitutional right is not clearly established at the time of their alleged misconduct, even if a court later finds that the right exists and interprets their action as a violation.[84] In this case qualified immunity might have shielded Officer Smith from liability, but for some reason the defense was not asserted, and, as a result, it was not considered by the court.[85]

Officer Smith raised another defense, however, arguing that Doe had waived his right to privacy and therefore could not complain about the disclosure. The argument was that a waiver occurred when Doe voluntarily told several police officers that he had tested positive for HIV, and this happened before Officer Smith talked to Rita DiAngelo. In rejecting this argument, the court found that Doe revealed his medical condition only because he thought the police might need to protect themselves against the possible transmission of HIV. The court noted that officers sometimes have more than casual contact with arrestees, as when they conduct frisk searches.[86] Doe divulged his medical condition to a few officers for their protection, a limited purpose, and he never authorized them to tell anyone else. If officers pass along confidential information that has been revealed for the public's protection, it will discourage others from disclosing sensitive information. For that reason, the court rejected Officer Smith's argument that Doe automatically waived his right to privacy by revealing his condition.

Liability of the Borough of Runnemede--Failure to Train. Jane Doe's lawsuit alleged that the Borough of Runnemede's failure to train its employees about AIDS and the importance of confidentiality caused a violation of her family's right to privacy. This was a difficult claim to prove.

In the summer of 1989, in ***City of Canton v. Harris,***[87] the U.S. Supreme Court narrowly limited the

circumstances under which local governments may be held liable for failing to train their officers. It ruled that a county is not responsible unless its training program is so bad that it reflects a deliberate and complete lack of concern for the federal rights of others. Jane Doe had to identify a deficiency in Runnemede's training program and prove that it made a constitutional violation inevitable. In addition, she had to show that the violation of her privacy was caused directly by the inadequate training. The court found that she satisfied these stringent requirements and ordered Runnemede to pay because its AIDS training was completely inadequate. In fact, it was nonexistent.

The court in ***Borough*** of ***Barrington*** reached the following conclusions before imposing liability against the Borough of Runnemede: It was obvious, even in 1987, that Officer Smith and other police officers would confront HIV-infected persons; they frequently came into contact with persons at high risk, such as intravenous drug users. Therefore, Officer Smith needed information about the disease and its method of transmission to protect himself when faced with blood or hypodermic needles. Given the hysteria and panic surrounding AIDS, "[t]he failure to instruct officers to keep information about AIDS carriers confidential was likely to result in disclosure and fan the flames of hysteria."[88] It was easy to anticipate the devastating consequences if Officer Smith disclosed that a person was HIV positive or had AIDS.

In holding the local government liable for providing inadequate training, the court found that the police chief "made a conscious decision not to train [his] officers about the disease."[89] He knew that they would confront HIV-infected persons, and he was aware that other police chiefs had taken precautions to protect their officers.[90] If Officer Smith had received even the most basic training about AIDS, he would have known that John and Jane Doe presented no risk to the DiAngelos; and presumably he would not have divulged Doe's medical condition. The chiefs failure to provide training revealed an attitude of complete indifference to the federally protected rights of HIV-infected persons, and Runnemede is liable for the tragic violation of privacy inevitably caused by its policy.

Case Summary. The U.S. Constitution includes a right to privacy that requires corrections officers to avoid unnecessary disclosure of highly sensitive information about a person. This privacy right especially covers AIDS-related information, and it even protects an infected person's immediate family. The right to privacy is not absolute, but public officers must have a compelling reason for revealing that a person is infected. This valuable right to privacy is not surrendered or waived just because a person tells an officer about his or her medical condition.

HIV is not transmitted through casual contact, and there is no medical reason to tell everyone that a particular person is infected. Federal courts will base their decisions about AIDS-related practices and policies on the most recent medical evidence, not on the unreasonable fears of prison and jail officers.

It is virtually certain that detention officers will come into contact with HIV-infected persons. Those who receive absolutely no training will make decisions based on ignorance and fear; and sooner or later, they will violate a person's right to privacy by disclosing to others that he or she is infected. A department that does not train its officers on how HIV is transmitted and on the need for confidentiality will be held civilly liable for those inevitable violations of privacy.

Case Conclusions. The decision in *Borough of Barrington* represents only the opinion of one federal court, and courts in other jurisdictions may disagree with some of its conclusions.[91] The basic lessons from this and other decisions, however, are likely to be accepted by most courts. Corrections administrators must provide AIDS training for their detention officers, emphasizing the need for confidentiality. In addition, each department should have written policies and procedures that cover the many medical, legal, and administrative issues associated with AIDS since it is likely today that officers will encounter HIV-infected persons. Failure to provide at least minimal training will ultimately lead to a violation of a person's federal right to privacy or some other protection, like an inmate's right to necessary medical care.[92] In such an event--particularly if the administrator has completely ignored AIDS training--it is highly likely that the administrator ***and*** the local government will face liability.

NOTES

1. For information on other legal issues, consult Takas and Hammett. "Legal Issues Affecting Offenders and Staff." AIDS ***Bulletin.*** National Institute of Justice, May 1989.

2. This section is not intended as legal advice; officials should consult local counsel when addressing a specific question about AIDS and the law. The correct answer will depend on the facts of the particular situation.

3. In Hudson v. Palmer, 468 U.S. 517 (1984), the U.S. Supreme Court ruled that inmates have no legitimate expectation of privacy in their prison cells; therefore, the Fourth Amendment does not protect them there against even unreasonable searches. On the other hand, the lower federal courts subsequently have decided that inmates retain at least a limited right to privacy in their bodies. Dunn v. White, 880 F.2d 1188 (10th Cir. 1989).

4. Schmerber v. California, 384 U.S. 757 (1966)(taking a blood sample from a defendant after an auto accident to determine alcohol content). In one of its recent decisions on drug testing in the workplace, the U.S. Supreme Court stated that "this physical intrusion, penetrating beneath the skin, infringes an expectation of privacy that society is prepared to recognize as reasonable." Skinner v. Railway Labor Executives' Association, U . S . - , 109 S.Ct. 1402, 1412, 103 L.Ed.2d 639 (1989). (At the time of this book's publication, this case had not yet appeared in the Supreme Court Report.)

5. Turner v. Safley, 482 U.S. 78 (1987).

6. Dunn v. White, 880 F.2d 1188 (10th Cir. 1989).

7. Id. at 1195.

8. Id. at 1196.

9. Id. at 1194. This approach is borrowed from recent court decisions holding that certain public jobs involve "special needs" that justify employee drug-testing. Skinner v. Railway Labor Executives' Association, - U . S . - , 109 S.Ct. 1402, 103 L.Ed.2d 639 (1989); National Treasury Employees Union v. Von Raab, - U . S . -) 109 S.Ct. 1384, 103 L.Ed.2d 685 (1989). (At the time of this book's publication, this case had not yet appeared in the Supreme Court Report.)

10. 727 F. Supp. 1564 (M.D. Ala. 1990).

11. Id. at 1571.

12. For a discussion of the significant barriers to liability, see the section in this chapter on Failure to Protect Inmates from Assaults.

13. Id. at 1575.

14. Id. at 1572. A related justification for segregation was that healthy inmates might protect themselves against infection by hurting HIV-infected inmates.

15. Turner v. Safley, 482 U.S. 78 (1987).

16. Harris v. Thigpen, 727 F. Supp. 1564, 1567 (M.D. Ala. 1990)(emphasis added).

17. The privacy interest might have been considered as more than the physical penetration of an inmate's skin by a needle to draw a blood sample. That interest is treated essentially as nonintrusive and commonplace. Dunn v. White, 880 F.2d 1188, 1197 (10th Cir. 1989). For example, it is possible to view it as the substantial interest in protecting sensitive medical information that might be revealed by an HIV test. If the privacy interest had been characterized in that way, the court might have required prison officials

to produce a greater justification for the testing. In these cases, however, the courts took a narrow view of the privacy interest at stake.

18. Feigley v. Fulcomer, 720 F. Supp. 475 (M.D. Pa. 1989).

19. Id. at 479.

20. It is possible that reliance on HIV testing will create a false sense of security. For example, detention officers might take fewer precautions with inmates who test negative on the assumption that they pose no health risk, even though the inmates still could be infected with HIV and transmit the virus to others.

21. 845 F.2d 175 (8th Cir. 1988).

22. Id. at 177.

23. Hewitt v. Helms, 459 U.S. 460 (1983).

24. Muhammad v. Carlson, 845 F.2d 175, 178 (8th Cir. 1988).

25. Hewitt v. Helms, 459 U.S. 460 (1983).

26. 845 F.2d at 178.

27. Another case illustrates the potential impact of regulations and how carefully a court will interpret their language. In a lawsuit against North Carolina's Department of Correction, an inmate alleged that the prison's policy on AIDS required his transfer to a special medical unit. This is a different twist on the argument raised in ***Muhammad*** v. ***Carlson,*** where the inmate argued that a policy prevented his transfer. Applying the due process principles discussed in ***Muhammad,*** the court recognized that mandatory language in the prison housing policy created certain rights for inmates suspected of having AIDS. The inmate in question had tested positive for HIV, but he had not been diagnosed as having AIDS. The court ruled against the inmate by narrowly restricting the policy, and therefore any due process protections it may have created, to inmates diagnosed as having AIDS. Tatum v. Daniea, No. 87-733-CRT (E.D.N.C. Sept. 28, 1988). The lesson is that corrections officials should carefully identify the inmates covered by a policy, and the policy should indicate which inmates, if any, require special housing. These choices are extremely important, as the courts ultimately may require officials to comply with mandatory provisions in a housing policy.

28. ***669*** F. Supp. 741, 743 (D. Md. 1987). The inmate in Judd argued that he was treated differently because he was handicapped, and that his unequal treatment on that basis violated the Equal Protection Clause. In rejecting his claim, the court pointed out that isolation for public health reasons was justifiable; and it hinted that separate housing could also be ordered for administrative and security reasons. The court's decision in this case, like several other early decisions, seems influenced by how little was known about AIDS. For instance, the court emphasized that "[m]uch is still unknown about AIDS, but any serious-minded individual can readily appreciate its potential for causing a plague of (or beyond) Biblical proportions." 669 F. Supp at 743.

29. Although it is unclear whether its judgment about the segregation of HIV-infected inmates is based on equal protection grounds, the recent decision in *Harris* v. *Thigpen* relied heavily on safety and security grounds in upholding the policy by the Alabama Department of Corrections. In reaching its conclusion that the isolation was reasonable, the court emphasized the importance of protecting "the safety of other inmates and custodian officers and the security of the institution from spread of the disease. . . . " Id. at 1574.

30. Cordero v. Coughlin, 607 F. Supp. 9, 10 (S.D.N.Y. 1984). The court in ***Cordero*** put forward a slightly different analysis of the inmates' equal protection claim. It found that the Equal Protection Clause protects inmates who are not treated the same as other inmates, but only if the two groups of inmates are similarly

situated. Thus, it is reasonable to treat HIV-infected inmates and other inmates differently because there are significant differences between them. The court denied the inmate's claim. In ***Powell v. Department*** of ***Corrections,*** 647 F. Supp. 968 (N.D. Okla. 1986), the court used the same analysis, except it added that even the treatment of similarly situated inmates cannot be arbitrary. No matter which equal protection analysis is used, a federal court apparently will let corrections officials treat HIV-infected inmates differently if they have a good reason that promotes medical treatment or inmate safety.

31. 647 F. Supp. 968 (N.D. Okla. 1986).

32. Id. at 970.

33. In *Cordero v. Coughlin,* 607 F. Supp. 9 (S.D.N.Y. 1984), a group of HIV-infected inmates alleged that they had been denied social, recreational and rehabilitative opportunities during their isolation from the general population. The court rejected the claim, stating that "in a case such as this, defendants cannot be compelled to provide plaintiffs with the ***identical*** privileges available to the other inmates." Id. at 11 (emphasis added). The court's language suggests that a complete denial of privileges for isolated inmates might violate their federal rights.

34. 727 F. Supp. 1564 (M.D. Ala. 1990).

35. Id. at 1578.

36. The prison policy allowed HIV-infected inmates to use the law library from 9:00 p.m. until 12:00 a.m., on Monday, Wednesday and Friday.

37. The inmates in this lawsuit also claimed that they were denied access to other programs and activities, including educational opportunities, vocational training, employment, religious services, and recreation. It is difficult to tell from the court's decision whether the inmates were completely denied the chance to participate in all of those activities. For example, the court noted in its opinion that the HIV-infected inmates were seeking "full and equal rights" with the other inmates. It is possible that those inmates were allowed to participate in some of the programs and their involvement simply fell short of "full and equal."

38. The court's reasoning in places is difficult to follow. In reaching its decision, the court seemed influenced by one decision that had relied on security and health concerns, along with another that had treated the opportunity to participate in community programs as a privilege rather than a right. The court also rejected an argument that the overall treatment of HIV-infected inmates, apparently even including denial of access to community programs, was handicap discrimination in violation of Section 504 of the Rehabilitation Act of 1973. The court concluded that HIV-infected inmates pose a significant risk of transmitting the disease even if prison officials make reasonable adjustment, and therefore they are not protected by the federal law. This conclusion was reached without specifically discussing how Section 504 applied to inmates working in the community, which is confusing since it has been used to protect the rights of HIV-infected employees in the workplace. See Doe v. Coughlin, 518 N.E.2d 536 (N.Y. App. 1987)(inmates with AIDS are not otherwise qualified to participate in a conjugal visitation program, and therefore excluding them does not violate Section 504).

39. Doe v. Coughlin, 518 N.E.2d 536 (N.Y. App. 1987).

40. The court upheld the prohibition even after the inmate agreed to completely eliminate the risk of transmission during the visits, either through safe sexual practices or by not engaging in sexual relations. Still, the ban was considered reasonable because "the possibility remains" that a conjugal visit might spread the disease. In fact, the risk was not limited to the inmate's wife. For instance, she might "become pregnant and transmit the disease to her child or . . . she may become single in the future, either by divorce or widowhood. . . ." 518 N.E.2d at 542.

41. Lopez v. Coughlin, 529 N.Y.S.2d 247 (Sup. 1988).

42. There is no way to know whether the court would have reached a different conclusion if another justification for the policy had been put forward. For example, what if officials had claimed that the reason for denying a furlough was to prevent the possible spread of a communicable disease? It is more likely that the policy would have been upheld, although the answer is not clear. In giving specific medical reasons for the denial, however, prison officials made it possible for the inmate to challenge those reasons and convince the court that they were inaccurate.

43. Smith v. Meachum, No. H-87-221 (D. Conn. Aug. 8, 1989). The consent judgment in the lawsuit also provided that "[i]nmates shall not be segregated from the general population solely due to being HIV seropositive or the status of their HIV infection." Id. at 7.

44. Jarrett v. Faulkner, 662 F. Supp. 928 (S.D. Ind. 1987). In an even more recent decision, *Harris* v. *Thigpen,* 727 F. Supp. 1564 (M.D. Ala. 1990), the court refused to recognize that prison officials have a constitutional duty to segregate seropositive inmates from the general population. Instead, it recognized "the considerable deference due the decisions of prison officials in regulating prison order and security. . . . " 727 F. Supp. at 1579. See abo Glick v. Henderson, 855 F.2d 536 (8th Cir. 1988); Feigley v. Fulcomer, 720 F. Supp. 475 (M.D. Pa. 1989); LaRocca v. Dalsheim, 120 Misc.2d 697, 467 N.Y.S.2d 302 (N.Y.Sup. 1983); Hays v. Idaho Department of Corrections, No. HC-2799 (D. Iowa Sept. 27, 1989).

45. 689 F. Supp. 874 (W.D. Wis. 1988).

46. Id. at 876. The court observed that "it is difficult to argue that information about this disease is not information of the most personal kind, or that an individual would not have an interest in protecting against the dissemination of such information." Id.

47. Id.

48. Id. at 877.

49. In *Doe v. Borough of Barrington,* 729 F. Supp. 376 (D.N.J. 1990), for example, a federal court in another context recognized that "an arrestee's disclosure to police that he or she has AIDS is preferable to nondisclosure." Id. at 387. It approved the disclosure so that "[p]olice can take whatever precautions are necessary to prevent transmission of the disease." Id. And in ***Department of Correction v. Delaware Public Employees Council*** 82, No. 8462 (Del. Ct. of Chancery Jan. 7, 1987), a state court upheld a labor arbitrator's interpretation of a collective bargaining agreement which required the Department of Correction to notify the union whenever an inmate has a communicable disease. The reason for the provision was to provide for the safety of corrections officers covered by the agreement. Of course, a problem with this argument is that the HIV test cannot identify all of the inmates who are seropositive.

50. 680 F. Supp. 112 (S.D.N.Y. 1988).

51. Id. at 113.

52. Id. at 115.

53. In fact, the court stated that "failure to issue a warning to prison officials to avoid contact with the body fluids of an AIDS carrier might itself be deemed a failure to perform official duties." Id,

54. 697 F. Supp. 1234 (N.D.N.Y. 1988). Cost reduction was offered as another reason for the transfers, because the special dormitory is located near a medical center used for the treatment of infected inmates, and therefore it would reduce transportation expenses.

55. Id. at 1237, n. 5.

56. Id.

57. In deciding that HIV-infected inmates have a limited right to privacy that protects against the disclosure of their condition, the court stressed that "there are few matters of a more personal nature, and there are few decisions over which a person could have a greater desire to exercise control, than the manner in which

he reveals that diagnosis to others." Id. at 1237. The court also emphasized the history of discrimination caused by "[i]gnorance and prejudice concerning the disease. . . . " Id. at 1238.

58. The specific justifications put forward for the policy were critical to the court's decision. There was "no suggestion that [the] prisoners are being segregated in order to protect others from infection with the virus." Id. at 1240. In addition, there was only an "incidental security rationale" for the transfer policy, and the court did not find it persuasive. Id. The main reason for the policy was improved treatment for HIV-infected inmates, and the court ultimately indicated that the inmates themselves should decide whether better treatment was more important than maintaining their privacy. The outcome might have been different if prison officials had put forward legitimate safety and security justifications for the policy.

59. Id. at 1241.

60. The inmate sought a temporary order to stop the transfers until the court could fully evaluate the case and reach a final decision on the merits. In granting the order, the court decided that the inmate was likely to prevail on the merits of the underlying controversy.

61. In the recent case of *Harris v. Thigpen,* 727 F. Supp. 1564 (M.D. Ala. 1990), for example, the court declared that it knew of "no case holding that any AIDS-related patient has any constitutional right to confidentiality of his condition." Id. at 1570, n. 2. This comment fails to mention the decisions on confidentiality discussed in this section, and it is a difficult oversight to understand. On the other hand, it offers further evidence that this area of the law is unsettled.

62. The court noted that HIV-infected inmates have failed in their attacks against segregated housing. It then speculated that "[p]erhaps chastened by the uniform failure of these attacks, [the inmate] has chosen the less travelled path marked by the uncertain borders of the constitutionally protected right to privacy." 697 F. Supp. at 1236. This same confidentiality-based argument against isolation has been made by seropositive inmates in at least two other lawsuits. See Does l-6 v. California Department of Corrections, No. SACV 89-598 (C.D. Calif. Aug. 29, 1989); Smith v. Meachum, No. H-87-221 (D. Conn. Aug. 31, 1989).

63. Penn v. Oliver, 351 F. Supp. 1292 (E.D. Va. 1972).

64. Stokes v. Delcambre, 710 F.2d 1120 (5th Cir. 1983); Woodhaus v. Virginia, 487 F.2d 889 (4th Cir. 1973).

65. Withers v. Levine, 615 F.2d 158 (4th Cir. 1980).

66. Cameron v. Metcuz, 705 F. Supp. 454 (N.D. Ind. 1989).

67. One week earlier, Stroud and another inmate had been arguing near Cameron's bunk. The noise bothered Cameron and he asked them to take their argument somewhere else.

68. 705 F. Supp. at 456.

69. Id. at 456.

70. This is true even though the court recognized that the lawsuit was "on the cutting edge in regard to working out the parameters of deliberate indifference in the context of the Acquired Immune Deficiency Syndrome, commonly known as AIDS, in the prison setting." Id. at 459.

71. The court dismissed the inmate's lawsuit without prejudice, which means that he may supplement his initial allegations and file the lawsuit again. The inmate apparently has already refiled the lawsuit (Takas and Hammett, 1989).

72. The transmission of the deadly virus will be an element of damages in a successful lawsuit, although the legal standard of deliberate indifference offers substantial protection against liability. Fear of increased liability following a successful lawsuit, even though it is unlikely, is responsible for many of the policies that isolate HIV-infected inmates from the general inmate population.

73. 729 F. Supp. 376 (D.N.J. 1990).

74. This case was decided on the basis of written materials filed with the court before trial, including deposition testimony and legal arguments. After finding that there was no disagreement about what had happened, the judge imposed liability without submitting the case to a jury. The judge entered judgment against the officer and the government because he decided that application of the relevant law to the facts required a finding of liability. If the decision withstands review on appeal, a jury will decide how much money is owed as damages.

75. John Doe died six months after Officer Smith revealed his condition to Rita DiAngelo. The lawsuit also named the Borough of Barrington and Rita DiAngelo as defendants. The pretrial motions that led to this decision did not involve those defendants, and for that reason, the court did not address their liability. The lawsuit is still pending against them.

76. 729 F. Supp. 376, 384 (D.N.J. 1990).

77. Other federal courts have recognized a constitutional right to privacy that protects against the disclosure of medical information about AIDS. In *Woods v. White,* 689 F. Supp. 874 (W.D. Wis. 1988), for example, a federal court held that prison medical personnel violated an inmate's right to privacy by telling non-medical staff and other inmates that he had tested positive for HIV. See Doe v. Coughlin, 697 F. Supp. 1234 (N.D.N.Y. 1988)(right to privacy protects inmates against non-consensual disclosure that they have tested HIV positive). One decision swims against this mild current, however, apparently finding that inmates have no constitutionally protected right to privacy in this information. Harris v. Thigpen, 727 F. Supp. 1564 (M.D. Ala. 1990).

78. 729 F. Supp. 376, 385 (D.N.J. 1990).

79. Id. at 384.

80. Most states have enacted laws that address the confidentiality of information about HIV and AIDS, and many of them are extremely restrictive. Policymakers should review their own state laws for guidance on when, if ever, they may disclose that an inmate or arrestee is HIV-infected.

81. Id. at 381.

82. In another context, a leading federal court decision concluded that the risk of a person's contracting HIV, even if scratched or bitten by persons who are infected, is "minuscule, trivial, extremely low, extraordinarily low, theoretical, and approaches zero." Glover v. Eastern Nebraska Community Office of Retardation, 867 F.2d 461, 464 (8th Cir. 1989).

83. The court emphasized that it "must take medical science as it finds it; its decision may not be based on speculation of what the state of medical science may be in the future." 729 F. Supp. at 381. This approach is consistent with the one taken by federal courts in other contexts. For example, one federal court of appeals declared that a trial court, in evaluating a personnel decision about an HIV-infected public employee, erred when it "rejected the overwhelming consensus of medical opinion and improperly relied on speculation for which there was no credible evidence. . . . " Chalk v. United States District Court, 840 F.2d 701, 708 (9th Cir. 1988).

84. Anderson v. Creighton, 483 U.S. 635 (1987); Harlow v. Fitzgerald, 457 U.S. 800 (1982).

85. It might have been possible for Officer Smith to argue successfully that at the time he talked to Rita DiAngelo, in 1987, the courts had not clearly recognized a federal right to privacy in sensitive medical information. In *Woods v. White,* 689 F. Supp. 874 (W.D. Wis. 1988) however, the court suggested that the right to protect medical information against unwarranted disclosure had been recognized before 1986. That finding was not essential to the decision in *Woods,* as the court ultimately resolved the immunity issue by adopting an unusual approach. It held that qualified immunity did not protect medical personnel for the "[c]asual, unjustified dissemination of confidential medical information to non-medical staff and other prisoners," even if the exact contours of the right to privacy were not clear; because the disclosure fell far outside of their responsibilities. In this case, Officer Smith might have received qualified immunity by focusing narrowly on the federal right allegedly violated. Even if court decisions in 1987 had clearly

identified a right to privacy that protected a person infected with HIV, for example, it probably was not clear that the right also protected the person's immediate family. The availability of qualified immunity as a defense depends on whether the asserted federal right was clearly established in the context of an officer's specific conduct. Anderson v. Creighton, 483 U.S. 635 (1987). In this case, again, the defense was not raised.

86. The court stated that disclosure should be encouraged because officers "may come into contact with hypodermic needles" while frisking an arrestee. It is likely that officers will be extremely careful in carrying out their duties if a person discloses that he or she is HIV infected. In promoting safety for officers, however, the court fails to mention an important point. Officers should use safety precautions in dealing with all arrestees, not just those who reveal that they are HIV-infected.

87. 109 s. ct. 1197 (1989).

88. 729 F. Supp. 376, 389 (D.N.J. 1990).

89. Id.

90. According to the court, the police chief "should have known that officers untrained as to the medical facts about AIDS would act out of panic, ignorance, and fear when confronted with a person having or suspected of having AIDS, and that such a confrontation was likely to occur." 729 F. Supp. at 389.

91. For instance, it is possible that other courts will decide that the federal right to privacy does not protect the immediate family of HIV-infected persons. There may be other differences. In fact, this decision may not be upheld on appeal. The basic legal principles that it announces are consistent with other court decisions involving AIDS-related issues, though, and it seems likely that those principles will survive in this and other cases.

92. Inmates and detainees have a constitutional right to receive adequate care for their serious medical problems. Estelle v. Gamble, 429 U.S. 97 (1976). Federal courts are beginning to decide what this legal obligation means in the context of AIDS. In the recent decision of ***Hawley v. Evans,*** 716 F. Supp. 601 (N.D. Ga. 1989), for example, a federal court ruled that treatment of HIV-infected inmates with the drug AZT satisfies the constitutional duty to provide care if it conforms to currently acceptable medical practice. See Harris v. Thigpen, 727 F. Supp. 1564 (M.D. Ala. 1990). In another decision, the court ruled that prison medical personnel might be held liable for their failure to diagnose and treat an inmate who died of AIDS. Maynard v. New Jersey, 719 F. Supp. 292 (D.N.J. 1989).

CHAPTER V

INFECTIOUS DISEASE CONTROL PROCEDURES

Infectious disease control procedures should be based on the principle that **all blood,** regardless of an individual's known health status, must be considered potentially infectious. Such a policy takes into account not only possible exposure to HIV but also to hepatitis B (HBV). Both of these bloodborne viruses present very real occupational risks to law enforcement and correctional officers, who may be exposed to blood as a result of violent confrontations with infected persons, accidental inoculation with contaminated hypodermic needles or weapons, or homicide/suicide investigations.

CDC has developed **specific** guidelines for reducing the risk of acquiring HIV and HBV for forensic laboratory workers, law enforcement and correctional officers, and persons performing autopsies and handling deceased persons. All these guidelines rely on the principles of universal blood and body fluid precautions (CDC, 1982, 1986, 1987, 1988, 1989).

UNIVERSAL PRECAUTIONS

Universal precautions, as established by CDC[1] provide the framework for an effective infection control policy. These precautions are not only comprehensive but also recognize that infectious disease control policies should be occupationally-specific. For example, criminal justice personnel who work in forensic laboratories or who conduct autopsies should take additional precautions that may not be necessary for personnel who do not **routinely** come in contact with contaminated blood.

Universal precautions also recognize that cardiopulmonary resuscitation (CPR) is not a method of HIV transmission but ***may*** be a mode of transmission of other infectious diseases. Thus, the precautions recommend that CPR masks with one-way valves be made available to all criminal justice personnel who may engage in emergency response.

Universal precautions, which apply to blood and other body fluids containing **visible** blood, semen, and vaginal secretions, are summarized as follows:

- Gloves should be worn for touching blood and body fluids and should be changed after each contact. Whenever practical, masks and protective eyewear, gowns, or aprons should be worn during procedures that generate splashes of blood or other body fluids;

- Hands and skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed. Contaminated surfaces may be effectively cleaned with a dilution of 1:100 bleach to water;

- Workers should take precautions to prevent injuries caused by needles and other sharp instruments. Needles should not be recapped, bent or broken by hand. After use needles should be disposed of in puncture-resistant containers;

- Although saliva has not been implicated in HIV transmission, mouthpieces or other ventilation devices should be available for use in resuscitation, in response to workers' concerns;

- Workers who have open sores or weeping dermatitis should refrain from direct contact with blood or body fluids until the condition is resolved. Cuts should be covered with adhesive bandages that repel liquids;

[1] For a detailed discussion of universal precautions, see: CDC, MMWR, Vol. 36, No. 2S, 1987.

- Pregnant workers are not known to be at greater risk of contracting HIV infection than workers who are not pregnant; however, if HIV infection develops during pregnancy, the infant is at risk of infection. Thus, pregnant workers should be especially familiar with and adhere to precautions.

While universal precautions **do not** apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus which do not contain visible blood, good hygiene dictates that officers use proper equipment whenever they place their hands into ***any*** body fluid.

ELEMENTS OF AN INFECTIOUS DISEASE CONTROL POLICY

Infection control policies should encompass the following elements:

- **Purpose** of the policy. The purposes of any infection control policy are to inform employees of the appropriate precautions to prevent disease transmission within the workplace and to describe the procedures for reporting infectious disease exposure within the workplace;

- Definitions of terms. This section should **operationally** define terms referred to in the policy. These terms should minimally include: "infectious disease," which may be defined according to statutory guidelines; "pocket mask," "gloves," "body fluids," and "exposure";

- **Policy Statement.** This should be a statement of the agency's commitment to preventing infectious disease exposure, including a commitment to provide necessary equipment and relevant training/education. The policy should state the agency's adherence to federal, state and local laws addressing infectious diseases;

- **Procedures** This section should specify the procedures to be used in the handling, clean-up and disposal of blood, body fluids, and contaminated materials. It should, in detail, describe the conduct of duties that will reduce the risks of exposure to infectious diseases; identify the protective equipment to be provided to employees; and delineate the process for reporting occupational exposure of an infectious disease.

Infection control policies may also include a discussion of the confidentiality of employee and inmate medical records and the requirement that correctional officers provide emergency medical care and CPR. These provisions may also be incorporated into other agency policies which address privacy and confidentiality of medical records or detail specific job descriptions/responsibilities of employees. (For a sample comprehensive infectious disease control policy, see Appendix B.)

Some agencies have provided support services for employees who have experienced an incident of occupational exposure to infectious diseases. Recognizing that pre- and post-test counseling is a critical component of any such support services, departments may wish to use existing psychological services to provide pre- and post-test counseling and followup services to employees and their families. Figure 5.1 is a checklist of procedures developed by the Prince George's County (MD) Police Department.

Prevention and Control of Tuberculosis in Correctional Institutions

Tuberculosis (TB) remains a problem in correctional institutions, where the environment is often conducive to airborne transmission of infection. In a survey of TB cases reported during 1984-1985 by 29 state health departments, the incidence of TB among inmates in correctional facilities was more than three times higher than that for nonincarcerated adults aged 15-64 years (CDC, unpublished data). The incidence of TB has increased dramatically in correctional institutions since 1985, especially in large facilities. HIV infection among prisoners heightens the need for TB control among inmates (Hammett, 1989; CDC, 1989). Therefore, CDC has issued guidelines for the prevention and control of TB in correctional institutions, including recommended procedures for assessment, diagnosis, isolation, treatment and preventative therapy (see

Appendix A). State and local correctional facilities should be familiar with and implement these CDC guidelines.

Vaccination for Hepatitis B

While most law enforcement and correctional agencies do not require that all employees be vaccinated for HBV, administrators may wish to consider such a requirement for employees who are in daily contact with large quantities of blood or body fluids.

A safe and effective vaccine to prevent hepatitis B has been available since 1982. Available vaccines stimulate active immunity against HBV infection and provide over 90 percent protection for seven or more years following vaccination. HBV vaccines are also 70-88 percent effective when given one week after HBV exposure. HBV immune globulin (HBIG) provides temporary protection following exposure to HBV, however, a combination treatment with HBV vaccine and HBIG is over 90 percent effective in preventing infection following an exposure (CDC, NIOSH, 1989).

Figure 5.1

CHECKLIST OF PROCEDURES FOR OFFICERS WHO SUSTAIN

ACCIDENTAL EXPOSURE TO INFECTIOUS DISEASES

1. An officer should report an exposure incident to his or her first line supervisor. The supervisor will determine the significance of the exposure and when necessary will contact the Psychological Services Unit for assistance.

2. In the event that the exposure appears significant, the officer will complete a report of injury and make an appointment at Psychological Services for pre-test counseling.

3. The officer should be scheduled for pre-test counseling within one working day unless he or she prefers to be scheduled later.

4. Pre-test counseling addresses the significance of the exposure and the need for the required series of blood tests to determine the presence of HIV antibodies.

5. The test series includes a baseline test within two weeks after exposure and follow-up testing at three month intervals for one year.

6. All blood test results will be hand carried to Psychological Services, and the officer will be contacted for a post-test counseling appointment to discuss the results. No test results will be given over the telephone.

7. All blood test results are to be kept in a separate confidential file at Psychological Services for at least one year. Results are recorded on the Infectious Disease Exposure Notification Form, which may be accessed by the officer should the need arise.

8. This protocol does not limit the officer from seeking additional medical advice or treatment from a private physician or other medical services.

9. This protocol may be amended in response to medical research and/or legal requirements.

SECTION TWO

GUIDELINES FOR CRIMINAL JUSTICE

AND MEDICAL PERSONNEL

CHAPTER VI

GUIDELINES FOR RESPONDING AND ARRESTING OFFICERS

Sheriffs and deputies often have both law enforcement and correctional functions. This chapter discusses issues confronting all criminal justice professionals who are responsible for initial response and arrest activities involving persons suspected of or diagnosed with HIV disease. Officers in many jurisdictions have often been apprehensive about contracting HIV disease from such persons, particularly:

- From suspects or arrestees who bite or spit;
- While searching, handcuffing, or transporting arrestees;
- When responding to violent incidents or disturbances;
- During crime scene investigations involving exposed blood or other body fluids;
- While performing CPR or other first aid.

GUIDELINES FOR RESPONDING AND ARRESTING OFFICERS

To perform their duties effectively and without fear, it is critical for responding and arresting officers to understand that HIV infection may be transmitted ***only*** through blood and blood products, semen, vaginal secretions, and body fluids containing ***visible blood.***

Thus, officers are ***not*** at risk unless any of these fluids from a person infected with the virus ***directly enters their blood means.*** Officers are not at risk during ***any type of casual contact,*** such as occurs during routine searches, field interrogations and investigations, patdowns, handcuffing, or transporting of infected persons. Therefore, even in cases of skin contact with an infected person's perspiration, urine, nasal secretions, saliva, vomitus, sputum, tears, or clothing, an officer need not fear HIV transmission. Further, extensive research has demonstrated that bites by infected persons have not transmitted HIV disease (Lifson, **1988).**

Universal Precautions

In the Introduction to this book, the following three questions were posed: 1) What should officers do if they know a suspect is infected with HIV? 2) What actions are appropriate with infected persons, particularly with regard to searches and CPR? 3) What procedures should be followed when transporting a person who may be infected with HIV?

All policies and procedures addressing the above as well as the myriad of other questions confronting responding and arresting officers should be based on the universal precautions established by CDC, discussed in Chapter V. Essentially, these precautions state that all blood and other body fluids containing visible blood and all semen and vaginal secretions should be treated as if they are infected. Thus, all officers should use strict precautions to avoid any exchange of these body fluids with ***any*** person, ***regardless of the person's apparent risk for HIV infection.***

For responding and arresting officers, universal precautions to avoid transmission of HIV must be utilized:

- During ***searches and patdowns*** of all persons;
- While performing CPR and other emergency medical treatment on all persons;

- While responding to violent incidents or disturbances;
- While transporting all persons;
- When responding to all crime scenes where blood or other body fluids are exposed;
- While cleaning up blood or other body fluid spills or while disposing of or cleaning contaminated materials or equipment.

Searches and Patdowns. Since HIV is not contracted through contact with skin or clothing, responding officers should not hesitate to search thoroughly and to handcuff all arrestees according to established departmental procedures. Searches are an extremely important component of all arrest proceedings, regardless of a suspect's health status. By understanding how HIV is and is not transmitted, officers will be able to fulfill their responsibilities during arrest proceedings without fear of infection. All officers should adhere to the following guidelines when performing patdowns and searches:

- Ensure that all breaks in their own skin (e.g., scratches, sores, cuts, rashes) are covered at all times with a clean, dry bandage;
- Wear disposable gloves when anticipating the handling of persons, equipment, or materials contaminated with blood, semen, vaginal secretions, other body fluids containing visible blood, or fluids that cannot be identified in emergency circumstances;
  - No one type of glove is appropriate for all situations; use judgment concerning whether to use latex gloves that protect against fluids or heavier gloves that offer more protection against sharp objects, while still allowing dexterity and efficiency. In some instances, a combination of gloves that offers protection against both fluids and sharp objects may be recommended;
  - Change gloves if they become tom or soiled;
  - While wearing gloves, avoid touching your face; eyes; other skin areas; or personal items, such as a comb or pen;
  - Change gloves between the handling of different people; e.g., when finishing with one accident victim, before touching another;
  - Before leaving the scene, always remove gloves in such a manner that prevents contamination of other surfaces by blood or other fluids on gloves (NIOSH, 1989);
- Take strict precautions to avoid punctures or scratches and cuts from needles, razors or other sharp instruments that may be contaminated with blood; place any such objects in puncture-resistant containers;
- Avoid blindly reaching into suspects' pockets or into car seats, under mattresses, clothing, and other hidden areas; conduct visual checks first, where possible (always carry a flashlight, even during daylight shifts, to search hidden areas); and have the suspect empty his or her own pockets;
- If searching a purse, carefully empty contents by turning it upside down over a flat surface;
- Wash hands thoroughly with soap and warm water following every search (if gloves are used, wash after removing gloves); when hand-washing facilities are not available, use a waterless antiseptic hand cleanser;

- Wash with warm water and soap any intact skin that comes into contact with a person's blood or other body fluids.

- Adhere strictly to established departmental procedures following an incident of possible transmission if ***non-intact*** skin (i.e., needlestick injuries, open sores, scratches, cuts, rashes, etc.) or mucous membranes (eyes, mouth, etc.) are exposed to the injured person's blood or semen. (See related discussion at the end of this chapter; for sample policies and procedures, see Figure 5.1 and Appendix B.)

Performing CPR and Other Emergency Medical Assistance. It is the responding and arresting officer's obligation under both law and oath of office to perform emergency medical care, including CPR, for anyone in need, regardless of that person's health status. An officer's refusal to give CPR to such a person can result in civil liability, criminal prosecution, or dismissal with cause.

While extensive research has demonstrated that HIV disease is not known to be transmitted through saliva, a number of airborne viruses and bacteria are present in saliva. Therefore, it is recommended that pocket masks with one-way valves be carried by or easily accessible to all officers and used during CPR on all persons. Officers should be trained in the use of these devices, which reduce the risk of transmitting all infectious diseases as well as the fear often associated with performing CPR.

In addition to protecting officers against diseases, pocket masks are also beneficial to inmates who require CPR--particularly those with HIV disease. Since persons with this disease have greatly suppressed immune systems, even viruses and bacteria that cause the common cold can be life-threatening to them.

In spite of efforts to ensure that pocket masks or other resuscitation devices are readily available at ***all times*** to every officer, emergencies could occur when no devices are available. At such times, officers must remember that, with or without a resuscitation device, they are legally responsible for sustaining life, and that even direct contact with a person's saliva ***has not been shown to pose a risk of transmitting HIV disease.*** Therefore, officers should not hesitate to take whatever action is necessary to save a person's life.

The pocket mask is marketed in a variety of styles with a diversity of features. Valuable assistance and information on the use of equipment during CPR can be obtained from local medical agencies.

Medical Assistance in the Presence of Blood, Body Fluids. Where persons requiring CPR or other emergency medical assistance are ***injured, bleeding or draining other body fluids,*** officers should avoid contact with such fluids by following the same universal precautions as recommended for patdowns and searches. In addition, officers should:

- Wear a waterproof gown, overalls, or apron if necessary to avoid soaking of clothes;

- Cover the bleeding person with a disposable gown (disposable gowns should be present on all vehicles that respond to medical emergencies or victim rescues);

- Adhere strictly to established departmental procedures following an incident of possible transmission if ***non-intact skin*** or mucous membranes are exposed to fluids that can transmit the virus;

- Follow departmental regulations regarding the cleaning of uniforms that become soiled with blood or other body fluids. (See Appendix B for related sample policy.)

Responding to Violent Incidents or Disturbances. Officers' responsibilities frequently require approaching violent situations and disruptive persons. In responding to such situations, officers should follow universal precautions; avoid bites, scratches, or other lacerations; and, as soon as possible, wash with soap and warm water any bites or wounds that draw blood, adhering to departmental regulations following an incident involving possible transmission.

Transporting of Suspects and Arrestees. All persons, regardless of health status, who have no open sores and who are not draining body fluids can be transported in the normal manner prescribed by departmental regulations during both initial arrest activities and ensuing court proceedings. Where persons are bleeding or draining body fluids, officers should follow the universal precautions as discussed. Further, efforts should be taken to prevent contamination of the vehicle by body fluids. In case of excessive bleeding, an ambulance should be utilized for transportation.

Responding to Crime Scenes. Officers responding to crime scenes where blood or other body fluids are exposed should:

- Follow universal precautions and wear a waterproof apron, overalls, or gown to avoid soaking of clothing; protective shoe coverings if there is massive blood contamination on floors; and protective eyewear and disposable masks if there is a chance of splashing;

- If cotton gloves are to be worn when working with evidence of potential latent fingerprint value at the crime scene, wear them over protective disposable gloves when exposure to blood may occur;

- Change gloves if they become torn or soiled;

- To avoid tearing gloves, seal evidence with tape instead of metal staples;

- Remove all protective items--gloves last--before leaving the scene;

- Follow local procedures for evidence handling; in general, items should be air dried before sealing in plastic (NIOSH);

- Clean or dispose of all contaminated items as discussed below.

Cleaning up Blood or Other Body Fluid Spills or Cleaning or Disposing of Contaminated Equipment, Uniforms. When cleaning up blood or other body fluid spills or disposing of contaminated equipment or uniforms, officers should:

- Remove all visible soil with paper towels; dispose of towels in plastic bag; use a solution of 1:100 household bleach to water to clean contaminated area;

- Use bleach solution to disinfect flashlights, crime scene kits, handcuffs, leg irons, patrol car seats, and other equipment that becomes soiled with body fluids;

  -- The virus can also be destroyed by hydrogen peroxide, a 40- to 70-percent alcohol-water mixture, hot water and detergent, sunlight, and heat from a clothes dryer;

- Remove disposable contaminated articles--gloves last--as well as clothing not intended to be reused, and place in a clearly marked plastic bag for incineration, according to jurisdictional regulations.'

[1] State environmental protection agency regulations prescribe the disposal of hazardous and biological wastes. Officers should be familiar with the regulations in their states.

-- Plastic bags should be included in crime scene kits or in the car that is to be used for the disposal of contaminated items; extra plastic bags should be stored in the car;

- Change uniforms that become soiled with blood or other body fluids as soon as possible and place them in clearly marked plastic bags to be transported and washed according to manufacturer's instructions; wipe shoes with disinfectant.

Guidelines Following Intact Skin Contact with Blood, Body Fluids

Even officers who adhere strictly to all recommended precautions may find that they have had accidental skin contact with a person's blood, semen, or other body fluids while performing their duties. The officer should remember that, despite its deadly effects on the human body, HIV is extremely fragile and is easily killed by soap and water. For this reason, as well as for simple good hygiene, officers should wash with warm water and soap any skin areas that have been in contact with any person's body fluids.

Since patrol officers do not always have immediate access to washing facilities, it is recommended that vehicles be equipped with pre-moistened towelettes or liquids that do not require running water or towels for drying.

Guidelines Following Incident Involving Possible Transmission

It is important to emphasize that while blood and other body fluids cannot enter another person's bloodstream through intact skin, they can enter through broken skin. Therefore, where there is actual contact between a person's blood, semen, vaginal fluids, or other fluids containing visible blood and an officer's broken skin or mucous membranes, the officer should ***immediately:*** 1) wash affected areas with soap and warm water, if possible; 2) seek medical attention; and 3) report the incident to his or her supervisor.

The officer should be counseled regarding the risk of infection and should receive a confidential, baseline blood test for HIV antibodies ***us soon us possible after the incident*** (in case, for workman's compensation benefits, it must later be shown that exposure occurred on the job). Following the initial test at the time of exposure, officers testing negative should be retested at 6 weeks, 12 weeks, 6 months, and 12 months after exposure. During the retesting period (especially the first 6-12 weeks after exposure, when most infected persons are expected to seroconvert), the officer should use appropriate precautions to prevent possible transmission of the virus to others. These precautions include refraining from donating blood and using appropriate protection during sexual intercourse (CDC and NIOSH, 1989). See Figure 5.1, "Checklist of Procedures for Officers who Sustain Accidental Exposure to Infectious Diseases." (For related sample policy, see Appendix B.)

CHAPTER VII

GUIDELINES FOR INTAKE OFFICERS AND INTAKE MEDICAL PERSONNEL

The booking and jail admissions process, a key part of the confinement procedure, involves legal, security, medical, and human relations issues. For correctional officers and intake medical personnel, these issues become increasingly complex when inmates with infectious diseases, including HIV, are accepted into the facility.

GUIDELINES FOR INTAKE OFFICERS

Admitting a person to the correctional facility is the responsibility of the intake officer, who must be well trained and familiar with proper screening processes. During initial screening procedures, the intake officer must determine the legality of the charge against the arrestee and also search, fingerprint, and photograph him or her. In smaller facilities, intake activities may also include medical screening and classification.

If the new inmate appears to be suffering from a serious injury or illness, he or she may or may ***no?*** be accepted into the jail, depending on jurisdictional laws. Ideally, the intake officer will not accept a truly ill or injured person until after the arresting officer has taken the person to receive proper medical treatment. After an inmate is accepted into the correctional facility, it is the administrator's responsibility to provide the inmate with adequate health care and to protect him or her from infectious diseases that may be brought in by other inmates.

Intake officers have often expressed fear about contracting HIV from new inmates, particularly during searches and fingerprinting, as well as when responding to violent incidents.

It is critical that intake officers understand the means by which HIV is and *is not* transmitted so they may perform their responsibilities efficiently and without fear. Since HIV is transmitted only through ***blood*** and ***blood products, semen, vaginal secretions,*** and body fluids containing ***visible blood,*** intake officers are at risk ***only*** if any of these particular fluids directly enter their bloodstreams. ***Officers are not at risk during the casual contact that occurs during normal intake procedures.*** Extensive research has shown that even bites by infected persons have not transmitted HIV disease, nor has skin contact with an infected person's perspiration, urine, nasal secretions, saliva, tears, or clothing.

Universal Precautions

As discussed in Chapter V, the critically important **universal precautions** established by CDC provide simple, ***yet*** effective guidelines for reducing the risk of HIV transmission. Intake officers should be familiar with and adhere to these precautions in the processing of ***each*** inmate, ***regardless of the inmate's apparent risk for HIV infection.*** For specific guidelines during fingerprinting and searches, see Chapter VI.

Health Screening

All inmates are at high risk for many infectious/contagious diseases, including tuberculosis (TB), hepatitis B (HBV), and HIV disease; therefore, careful, preliminary health screening is essential to help prevent medical emergencies in jail and to aid in the control of all illnesses. Qualified medical personnel should handle ***in-depth*** medical screening for all diseases, including HIV, and many larger facilities have medical staff on duty at all times, making thorough screening possible immediately after booking to identify diseases and other problems that require immediate attention.

However, many smaller facilities lack a 24-hour, professional medical staff; therefore, all ***initial, preliminary*** screening, including medical, is conducted by the intake officer. In such smaller facilities, administrators may wish to expand the intake officer's screening form to include HIV and AIDS-related questions and observations. Figure 7.1 is an example of a standard screening form that has been expanded to incorporate such questions and observations.

Figure 7.1

Name _____ Sex _____ Date _____

D.O.B. _____ Inmate No. _____ Time _____

Officer or Physician _____

BOOKING OFFICER'S OBSERVATIONS

1.	Is the inmate conscious?	YES	NO
2.	Does the inmate have obvious pain or bleeding or other symptoms suggesting need for emergency service?	YES	NO
3.	Are there visible signs of trauma or illness requiring immediate emergency or doctor's care?	YES	NO
4.	Is there obvious fever, swollen lymph nodes, jaundice, or other evidence of infection that might spread through the jail?	YES	NO
5.	Is the skin in good condition and free of vermin?	YES	NO
6.	Does the skin have purple or brown blotches or other discoloration?*	YES	NO
7.	Does the inmate have a persistent dry cough?*	YES	NO
8.	Does the inmate have white patches (thrush) on the tongue?*	YES	NO
9.	Does the inmate appear to be under the influence of alcohol?	YES	NO
10.	Does the inmate appear to be under the influence of barbiturates or other drugs?	YES	NO
11.	Are there visible signs of alcohol/ drug withdrawal?	YES	NO
12.	Does the inmate's behavior suggest the risk of suicide?	YES	NO

13. Does the inmate's behavior suggest the risk of assault to staff or other inmates? YES ***NO***

14. Is the inmate carrying medication or report being on medication that should be continuously administered or available? YES ***NO***

OFFICER-INMATE QUESTIONNAIRE

15. Are you presently taking medication for diabetes, heart disease, seizures, arthritis, asthma, ulcers, high blood pressure, or psychiatric disorders? (If yes, circle condition(s)) YES ***NO***

16. Do you have a special diet prescribed by a physician? Type _____ YES ***NO***

17. Do you have a history of venereal disease? YES ***NO***

18. Have you recently been hospitalized or seen a medical or psychiatric doctor for any illness? YES ***NO***

19. Are you allergic to any medication? List _____ YES ***NO***

20. Have you recently fainted or had a head injury? YES ***NO***

21. Do you have epilepsy? YES ***NO***

22. Do you have a history of tuberculosis?* YES ***NO***

23. Do you have diabetes? YES ***NO***

24. Do you have hepatitis? YES ***NO***

25. Are you pregnant or currently on birth control pills? YES ***NO***

26. Do you have a painful dental condition? YES ***NO***

27. Have you had recent weight loss of more than 10 pounds without dieting?* YES ***NO***

25. Do you have diarrhea? If yes, for how long?_____* YES ***NO***

29. Do you experience extreme night sweats?*	YES	NO
30. Do you experience shaking chills?*	YES	NO
31. Have you experienced a recent loss of appetite?*	YES	NO
32. Do you feel extremely tired for no apparent reason?*	YES	N O
33. Do you have a sore throat?*	YES	NO
34. Do you experience shortness of breath not related to smoking?*	YES	NO
35. Do you have unexplained bleeding from any body openings or from growths under the skin?*	YES	NO

*Additional AIDS-related observations as described in "Revision of the CDC Surveillance Case Definition for Acquired Immune Deficiency Syndrome," ***Morbidity and Mortality Weekly Report,*** Vol. 36, 1987.

It is important to stress that the intake officer ***should not draw conclusions with regard to an inmate's health status.*** Rather, he or she should utilize the expanded form screening form to assist in identifying persons who should receive further, in-depth screening by medical personnel to facilitate appropriate management.

An affirmative answer to any one of the HIV-related questions and observations in Figure 7.1 does ***not*** necessarily indicate that the inmate is infected with HIV, since the symptoms of this disease are similar to those of other diseases. (See Chapter III for a complete discussion of the symptoms as well as criteria for a diagnosis of HIV or AIDS.) However, if answers to two or more HIV-related questions and observations are yes, the intake officer should follow departmental policies and procedures with regard to notifying medical personnel and making housing assignments.'

Inmates with TB Histories or Symptoms. Intake officers should notify medical personnel promptly of any inmates who answer yes to the question concerning histories of TB or who are symptomatic of this disease. The incidence of TB in correctional facilities has risen dramatically during recent years; and it is clearly tied to HIV infection in many cases. Since TB, unlike HIV, is transmissible through air, it is critical that infected inmates be identified promptly to ensure appropriate treatment and housing and to prevent the rapid spread of this infection throughout the inmate population.

Inmates on Medication. When a new inmate informs the intake officer that he or she is already taking medication for an existing conditions, such as AZT for HIV disease, the officer must report this fact to medical personnel immediately. It is important to note that ***the jail is responsible for ensuring that the person continues to receive medication that had been prescribed by qualified medical personnel.***

---

[1] For a comprehensive discussion of the role of the intake officer in making housing assignments, see the following texts: National Sheriffs' Association, ***Jail Officer's Training Manual,*** Alexandria, VA: 1980; and Ayres, M.B., ***Jail Classification and Discipline,*** Alexandria, VA: National Sheriffs' Association, 1988.

Protecting the Confidentiality of Medical Information

Where an intake officer is told by the inmate that he or she has HIV disease, or where the officer suspects infection on the basis of the health screening results, it is critical that the officer protect the confidentiality of this information, releasing it only to ***designated medical personnel.*** Confidentiality protections are especially critical for inmates with HIV infection since such protections are necessary safeguards against discrimination and encourage the infected person to come forward for voluntary counseling, testing, and treatment.

Failure to protect the confidentiality of medical information can not only result in discrimination against the infected person by other inmates and by staff, it can also result in sanctions against the officer who divulged the information. (See Chapter IV for further discussion on confidentiality of medical information.)

ISSUES FOR MEDICAL PERSONNEL DURING INITIAL ASSESSMENT

In addition to protecting the confidentiality of inmate medical information and preventing discrimination, the highest priorities in the correctional system's response to HIV disease include: (1) ensuring that inmates who become ill with the disease receive timely, professional, compassionate medical care; and (2) ensuring that inmates who may be infected understand the importance of avoiding the spread of HIV to others.

Responding to Inmates Suspected of HIV Disease

Effective management of all diseases, including HIV, is a primary goal in all facilities. It is important that inmates who are seropositive understand the need and means to prevent transmission to others and that inmates who may actually be ill with life-threatening, HIV-related diseases receive appropriate medical attention and needed psychological support services. Therefore, where medical personnel suspect that a new inmate may be seropositive or may actually have an HIV-related illness, the inmate should be assessed to identify any past behavior that placed him or her at risk for HIV disease (homosexual/bisexual activities, IV drug use, transfusion history) or to determine if he or she has previously tested positive for HIV antibodies.

Further, medical personnel should identify any clinical manifestations of HIV disease; i.e., chronic diarrhea, enlarged lymph glands, recurring sore throats, fevers, sudden weight loss, etc. All high-risk inmates should then be counseled as to the importance of testing and referred for further, HIV-related counseling and voluntary testing. Inmates who refuse testing should be evaluated periodically for life-threatening illnesses.

Following initial medical assessment of new inmates, medical personnel should advise the facility administrator or classification supervisor if an inmate requires hospitalization or, in larger facilities, housing in the medical unit.

Responding to Inmates with "High-Risk" Lifestyles

In addition to encouraging testing and behavior modification for inmates suspected of having HIV disease, it is important that new inmates who are asymptomatic but whose lifestyles place them at high risk for HIV disease also be counseled about the importance of testing and of behavior modification to avoid future infection and transmission to others. Medical professionals in the jail setting can play a critical role in such counseling.

Further, determining and documenting which new inmates are homosexuals/bisexuals or IV drug users can guide the medical staff in identifying persons who may need followup monitoring for life-threatening symptoms of HIV disease or for drug withdrawal or who may need increased supervision to prevent continued drug use.

HIV Testing Issues

Since 1985, when the ELISA test was developed to detect the presence of the HIV antibody, there has been considerable controversy over whether this test should be administered to all new inmates (mass screening) or only to those with certain risk factors (focused screening).

While a few facilities have followed a policy of mass screening for HIV disease, many medical and correctional professionals question the value and advisability of testing all who enter the correctional facility (Hammett, 1988). For a full discussion on testing options, see Chapter IX.

Protecting the confidentiality of Medical Information

Once it has been determined that a new inmate has HIV disease, that information must be maintained in a confidential manner, accessible only to designated medical personnel. Confidentiality protections are necessary to safeguard the inmate against discrimination and to encourage him or her to be voluntarily counseled, tested, and treated. See Chapter IV for a complete discussion on confidentiality of medical information.

HIV Infection and TB

Recent medical research has documented a relationship between HIV infection and TB. Since persons with HIV infection have suppressed immune systems, they are more susceptible to TB infection and disease than persons with normal immune systems. The increased incidence of HIV infection has thus led directly to increased incidence of TB, particularly within correctional facilities, where the environment is often conducive to airborne transmission of infection among inmates, staff, and visitors.

In a survey of TB cases reported during 1984 and 1985 by 29 state health departments, the incidence of TB among inmates was more than three times higher than that for nonincarcerated adults ages 15 to 64 years. In New Jersey during 1987, the incidence of TB among state inmates was 109.9 per 100,000--a rate 11 times that of the general population of New Jersey that year (CDC, unpublished data, as reported in MMWR, May 12, 1989).

Recognizing the critical need for prompt identification and control of TB in correctional facilities, CDC has recommended new guidelines, including the following:

- Early case diagnosis and reporting to institutional records and to local or state health departments, as required by laws and regulations;

- Tuberculin skin testing of ***all*** inmates and staff, using the intracutaneous Mantoux tuberculin test (not multiple puncture tests) at entry or on employment, except persons providing documentation of a previous positive test reaction;

- Chest x-rays for those with positive skin tests or those symptomatic of TB (e.g., cough, anorexia, weight loss, fever) within 72 hours of skin test reading or identification of symptoms;

- Chest x-rays for all new inmates at risk for HIV infection, ***including*** those with nonreactive tuberculin skin tests (persons whose immune systems are suppressed for any reason, including HIV disease, may show little or no reaction to the tuberculin skin test, yet may still be infected with TB);

- Contact investigations (i.e., testing of persons who sleep, live, work, or otherwise share air with an infectious person through a common ventilation system), with followup therapy, as indicated;

- HIV antibody testing for all persons with positive tuberculin skin tests and all confirmed TB cases;

- Medical isolation of inmates with active TB;

- Careful adherence to appropriate medical treatment protocols (CDC, 1989).

Atypical Signs and Symptoms of TB in HIV-Infected Persons. Correctional health care personnel should be aware that HIV-infected persons often have atypical signs and symptoms of TB. In addition to atypical x-ray results, they may have false negative skin tests resulting from anergy, a condition commonly found in patients with clinical AIDS. Therefore, sputum smear and culture examination are especially important tools for identifying infectious cases of TB in such persons (Hammett, 1989).[2]

TB Diagnoses in Rapid Turnover Facilities. In jails with a rapid turnover of inmates, where authorities may decide not to tuberculin test new detainees who are unlikely to remain in the system or in that facility for more than seven days, CDC recommends that provision be made for appropriate diagnostic measures (e.g., sputum smear and culture and/or chest x-ray) for all persons who are symptomatic (CDC, 1989).

Housing for Persons with Suspected or Confirmed TB. Persons with suspected or confirmed TB who have pulmonary involvement on chest x-ray, cough, and/or a positive sputum smear should be immediately placed in respiratory isolation (e.g., housed in an area with separate ventilation to the outside, negative air pressure in relation to adjacent areas, and at least four to six room air exchanges per hour). It may be necessary to move a patient to another facility or hospital with a respiratory isolation facility (CDC, 1989).

[2] For further discussion on these issues, see Appendix A, CDC's "Prevention and Control of Tuberculosis in Correctional Institutions: Recommendations of the Advisory Committee for the Elimination of Tuberculosis." See also: Pitchenik, A.E., and Rubinson, H.A., "The Radiographic Appearance of Tuberculosis in Patients with Acquired Immune Deficiency Syndrome (AIDS) and pre-AIDS," ***American Review of Respiratory Diseases,*** Vol. 131, 1985; Salive, M., and Brewer, T.F., "Tuberculosis and HIV Infection: An Emerging Problem in Inmates," ***Journal of Prison Health,*** 1989; and Sunderam, G., et al., "Tuberculosis as a Manifestation of the Acquired Immunodeficiency Syndrome (AIDS)," ***JAMA,*** Vol. 256, 1986.

CHAPTER VIII

GUIDELINES FOR CORRECTIONAL OFFICERS

Correctional officers have many complex responsibilities involving the security, order, and well-being of entire inmate communities. These duties often bring officers into close physical contact with inmates, many of whom are at high risk for infectious/contagious diseases, including hepatitis B, tuberculosis, and HIV. Officers have often expressed concern about contracting diseases, particularly HIV, when performing body and cell searches or CPR and other first aid; or when responding to disturbances, including homicides or suicides.

To perform their duties effectively and without fear, correctional officers must understand that, since HIV disease is transmitted ***only*** through ***blood*** and ***blood products, semen, vaginal secretions,*** and other body fluids ***containing visible blood,*** they are at risk for contracting the disease ***only*** if any of these fluids from an infected person directly enters their bloodstreams. ***Officers are not at risk during the casual, non-sexual contact that occurs during daily custodial activities, even over long periods of time.*** Thus, officers need not fear HIV transmission from skin contact with an infected person's perspiration, urine, nasal secretions, saliva, tears, or clothing. Further, research has demonstrated that even bites by infected persons have not transmitted HIV disease (Lifson, 1988).

UNIVERSAL PRECAUTIONS

To minimize the risk of contracting HIV through those fluids that ***can*** transmit the virus, all correctional officers must be trained to understand and follow the universal precautions discussed in Chapter V. Officers should utilize these precautions while handling every inmate, ***regardless of the inmate's apparent risk for HIV infection:***

- During all body and cell searches;
- While performing CPR and other emergency medical treatment on all persons;
- When responding to inmate disturbances involving aggressive or violent inmates;
- When responding to homicides or suicides;
- When cleaning blood or body fluid spills;
- When disposing of or cleaning contaminated materials or equipment.

See Chapter VI for specific guidance in universal precautions during the performance of these duties.

RECOGNIZING SYMPTOMS OF HIV DISEASE

In addition to their numerous custodial responsibilities, correctional officers must be responsible for listening to inmates' medical complaints and for relaying them, through established departmental procedures, to the appropriate medical staff. Medical care is perhaps the most vital service provided by the correctional facility, and officers must be particularly alert to complaints of the following symptoms of HIV disease:

- Extreme tiredness, combined with headaches, dizziness, or lightheadedness;
- Continual night fever or night sweats;

- Weight loss of more than 10 pounds, not due to dieting or increased physical activity;
- Swollen glands in neck, armpits, or groin;
- Purple or discolored growths on skin or mucous membranes (inside mouth, anus, or nasal passages);
- Heavy, continual dry cough, too persistent to be a cold or flu;
- Continual bouts with diarrhea;
- Thrush--a thick, whitish coating on the tongue or in the throat that may be accompanied by a sore throat;
- Unexplained bleeding from any body opening or from growths on skin or mucous membranes;
- Bruising more easily than usual;
- Progressive shortness of breath.

PRECAUTIONS FOR SAFETY OF INMATE WITH HIV DISEASE

Persons in later stages of HIV disease who have one or more opportunistic infections are normally housed in medical units or hospitals (see Chapter III for a discussion on the progress of HIV disease). However, inmates in earlier stages of the disease may often be assigned to general population housing. Such persons may at times require protection from illnesses in staff or other inmates and from threats of violence from other inmates.

Protection from Opportunistic Infections

As previously discussed, HIV-infected persons have greatly suppressed immune systems that render them highly susceptible to infectious diseases that may not affect a healthy person. Mild viruses carried by other inmates or staff members can, if transmitted to the HIV-infected inmate, result in life-threatening illnesses.

Correctional officers should understand this danger to the infected inmate and be alert to signs of illness in other inmates and in staff members. These illnesses should be reported to the supervisor, and appropriate measures should be taken to protect the infected inmate.

Protection from Threats, Intimidation Violence

The inmate with HIV disease who is housed in the general population may also be the target of threats, intimidation, or violence. The correctional officer, who is in a position to be aware of inmates with aggressive tendencies toward the affected person, should report such tendencies to the supervisor. The infected inmate may require evaluation for protective custody.

STAFF WORK ASSIGNMENTS

Since there is no risk of transmitting HIV disease through casual contact, correctional personnel should not be excused at their own request from working with inmates with HIV. Pregnant officers are at no higher risk of contracting HIV disease than other persons; however, if a pregnant officer does contract the disease, she can transmit it to her child before, during, or after birth through breast milk. Because of this risk, pregnant officers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

CHAPTER IX

GUIDELINES FOR JAIL ADMINISTRATORS

Specific, ***written*** policies and procedures for the treatment of inmates and staff with HIV disease are fundamental to effective management of today's correctional facility. Written policies for inmate supervision will prevent arbitrary decisionmaking by correctional officers and other staff in their daily contact with inmates. Written employee policies that clarify the agency's work-related expectations, coupled with appropriate training, minimize the threat of disruptions and foster compassion and humane treatment for persons with HIV disease, from both management and line staff.

EFFECTIVE POLICY DEVELOPMENT

To develop and implement effective, enforceable HIV-related policies for inmates and staff, the administrator must balance the ***agency's responsibilities*** with the ***employees' concerns*** and the ***infected persons' legal rights.*** To achieve this goal, the administrator should: (1) closely follow HIV-related court cases and legislation, remaining flexible as laws evolve and change; (2) be aware of staff concerns, anticipating "crisis" incidents that may arise, such as an employee's refusal to work around someone perceived or known to be HIV-infected; (3) be committed to eliminating unwarranted fears by providing thorough, pertinent training for both inmates and staff in the causes, means of transmission, and prevention of HIV disease; and additional staff training in the complex legal and liability issues surrounding testing, confidentiality of medical information and discrimination; (4) ensure that supervisors are provided with adequate assistance to carry out their responsibilities appropriately, effectively, and humanely; and (5) be aware of the moral and ethical considerations inherent in supervising persons with HIV disease.

In addition to the above, the administrator must be prepared to systematically implement, regularly evaluate, and periodically update policies and procedures as new medical and legal information is received.

Policy Format

All written policies should include: (1) the policy statement; (2) a rationale for that policy; and (3) the strategy for implementing the policy. Reference materials supporting the policies should be maintained and updated, as necessary.

Policy Considerations

As administrators address the manner in which HIV-infected and AIDS-diagnosed inmates and/or employees should be supervised, they must consider current legal and liability guidelines on the federal, state, and local level as well as management issues pertaining to, at a minimum:

- HIV testing, counseling;
- Training, education, and equipment;
- Inmate housing and work assignments;
- Confidentiality of medical information;
- Discrimination;
- CPR and other first aid;

- Food and laundry services;
- Sanitation;
- Visiting rights of inmates with HIV disease.

INMATE POLICIES

HIV Testing Counseling

Management decisions regarding housing and work assignments often depend on the inmate's health. Therefore, for several years, there has been considerable debate over whether inmates should be tested for HIV disease, and if so, under what conditions (Hammett, 1989). A few administrators have favored mass screening, or the screening of all inmates upon intake; however, the National Commission on Correctional Health Care has adopted a policy that opposes mass screening for inmates (NCCHC, 1988); and the National Sheriffs' Association also recommends that mass screening be avoided for the following reasons:

- Staff and inmate training in the use of universal precautions generally eliminates the need to know exactly who may or may not be infected:
- The Fourth Amendment's protection against unreasonable search and seizure applies to testing; thus, in general, inmates cannot be forced to take an HIV antibody blood test;
- Mass testing that yields negative results can result in a false sense of security on the part of inmates who have engaged in high-risk behavior;
- Test results may be inconclusive; "false negative" results are occasionally seen in persons who are actually infected but who have not yet developed antibodies to HIV, making retesting necessary every three months for as long as one year; further, inmates who seroconvert while incarcerated may raise liability issues for the facility;
- Mass screening may identify large numbers of seropositive inmates, resulting in: (1) overwhelming demands for medications, particularly AZT, that have proven effective in early stages of HIV infection; (2) problems involving protecting the confidentiality of large volumes of medical information and preventing discrimination; and (3) problems related to inmate housing;
- In the absence of a cure or vaccine, testing alone will not necessarily control behavior and prevent the spread of HIV infection; testing is but one phase of an overall prevention plan that includes counseling, behavioral change, education, partner notification, and care.

Focused Screening. For the above reasons, most jails today adhere to a policy of focused, rather than mass screening for HIV disease. Focused screening is the voluntary testing of inmates who are symptomatic of HIV disease or who have engaged in activities that place them at high risk for infection, as previously discussed. In addition, focused screening may be utilized for any of the following reasons:

- The inmate has been involved in an incident in which transmission may have occurred;
- The inmate requests testing;
- Testing may be utilized as part of anonymous epidemiological studies (Hammett, 1989).

In general, focused screening is more practical than mass screening and may provide valuable

information about an inmate's medical needs as well as the risk of transmission to other persons.

HIV-Related Counseling. All policies addressing HIV testing should include requirements for appropriate pre- and post-test counseling. Inmates for whom testing is recommended should be counseled by designated medical professionals to ensure their understanding of the implications of both positive and negative test results as well as the need for behavior modification to avoid possible HIV transmission to others.

Education

As soon as possible after intake, it is recommended that all inmates receive information on the cause, means of transmission, and means to prevent transmission of HIV disease. A formal, written policy should detail the procedures to be used in educating inmates.

Education for at-risk persons, such as many members of the inmate population, is a critical step to halting the spread of HIV disease. It is recommended that training be implemented through on-staff or outside medical professionals, utilizing such methods as discussions combined with language-appropriate videotapes and/or reading materials. A number of excellent training videotapes are now available for inmates, in both English and Spanish. Chapter XII provides further discussion on training topics and methods for inmate education.

In addition to serving as an effective tool for preventing HIV transmission within the facility, appropriate education can provide liability protection for the administrator. It is recommended that, following appropriate training, inmates at risk for or known to have HIV disease sign a document stating they have been informed of and understand the means of transmitting and of preventing HIV infection. The document should also be signed by a medical staff member and kept in the inmates' medical file. As these inmates are released, medical personnel should hold formal exit interviews with them, during which it should again be documented that the inmates understand the means of transmitting HIV infection and the practices that prevent transmission.

Condom Distribution

As a proactive measure to impede the spread of HIV infection, a number of correctional administrators across the nation have incorporated a carefully controlled condom distribution policy, coupled with counseling and education in safe sexual practices. As of this writing, the correctional systems distributing condoms to inmates are New York City, the Vermont state system, San Francisco County, and Philadelphia. (In the latter facility, each inmate receives three condoms upon intake as part of an AIDS information package.) In addition, the Mississippi state system makes condoms available for sale in institutional canteens (Hammett, 1989).

The pros and cons of condom distribution in correctional facilities have been debated for several years, with San Francisco, California, Sheriff Michael Hennessey among those currently favoring such a policy. According to Sheriff Hennessey, county jails present a prime opportunity to educate a large population of persons at risk of HIV infection. He stated:

> "The incidence of AIDS is increasing among prisoners, as well as in the general population. According to the National Institute of Justice's 1988 *Update: AIDS in Correctional Facilities,* the total number of AIDS cases in city/county jail systems increased 350 percent from 1983 to 1988. AIDS is now the leading cause of inmate deaths in some correctional systems.
>
> "Most county jail prisoners are persons who have engaged in high-risk activities. By making condoms available as part of an educational program, prisoners can learn how to use them correctly and are more likely to incorporate them into their sexual practices when they return to the community.
>
> "By advocating the use of condoms in jails, I am *not* condoning sex in jail. According to California

> state law and our policy, sexual activity is prohibited in the jail. Our deputies are instructed to arrest and book any inmates caught having sex. However, ***we must face reality.*** As much as we try to prevent it, sex does occur in jail, most of it consensual. Human beings are sexual creatures. Whether one is incarcerated for a day, a month, or a year, sexual urges exist; and we must take the necessary public health measures to protect inmates and the community. Education and prevention practices are the only effective protection we can offer" (National Sheriffs' Association, 1989-1990).

Sheriff Hennessey recommended that condoms not be distributed randomly. He reported that, in his department, each condom recipient is counseled by health educators and also reminded that sexual relations while incarcerated is a felony and a violation of jail rules and regulations.

Numerous corrections officials have also spoken out against condom distribution. Dr. John Clark, chief physician for the Los Angeles County Sheriffs Department, contended:

> "The issuance of condoms delivers a 'mixed message' to inmates, who become confused about what appears to be condonement of sex, when they have been told that sexual activity in the correctional facility is a felony. Condoms can be used as receptacles for contraband, including illegal drugs; they can easily be inserted internally or swallowed and brought into jails by new bookings and/or transferees--a major concern in large urban jails, with their constant movement and housing changes.
>
> "Few persons are incarcerated long enough that meeting sexual needs is a high priority. Further, with overcrowding, there is little opportunity for intimate activity; the sex that does occur is gang rape, where condoms are not likely to be used anyway. In the few jurisdictions that are distributing condoms, controls are either too strict to result in reduced HIV transmission or so lax that the potential for misuse as contraband is exacerbated.
>
> "Most instances of HIV transmission behind bars are actually related to IV drug use; 'needle works' are more likely to be shared among inmate users than among users in the free community. For the facility that distributes condoms, the question might arise concerning a possible obligation to protect IV drug users by giving them bleach and needles, lest the facility be guilty of 'deliberate indifference' to the highest risk group behind bars" (National Sheriffs' Association, 1989-1990).

Condom Distribution Prior to Conjugal Visits, Release. In addition to those agencies already cited, several other agencies issue condoms, along with appropriate educational counseling, to inmates prior to conjugal visits and/or release into the community. For inmates with HIV disease, the receipt of condoms at such times, along with appropriate counseling, greatly decreases the potential for infecting sexual partners.

Most administrators recognize the issue of condom distribution as an extremely controversial one, with potentially serious administrative and political ramifications. Prior to making a decision regarding this question, administrators should educate themselves and evaluate the potential impact of condom distribution within the framework of ***their particular facilities.***

Appendix C contains a sample condom distribution policy from the Vermont Department of Corrections. Administrators seeking further, specific guidelines or information are urged to contact those facilities that are currently making condoms available.

Housing

One of the most important decisions facing administrators concerns the housing of inmates with HIV disease. In the past few years, the pros and cons of segregating such inmates in the correctional facility have been widely discussed. However, in 1988, the National Commission on Correctional Health Care adopted a policy that opposes special housing for HIV positive inmates who are ***asymptomatic.*** According to the Commission:

> "Since the AIDS virus is not airborne and is not spread by casual contact, HIV-positive inmates can be maintained in the general population in whatever housing is appropriate for their age, custody class, etc. Patients diagnosed with AIDS may require isolation for their well-being, as determined by the treating physician" (National Commission on Correctional Health Care, 1988).

Protection from Opportunistic Infections. Although infected persons cannot transmit HIV disease to others through casual contact, even those who are asymptomatic have greatly suppressed immune systems that make them susceptible to infections that may not affect a healthy person. Therefore, since the administrator is responsible for protecting the health and well-being of every inmate, the asymptomatic person with HIV infection may require separation from other inmates or staff members who have colds or other mild viral or bacterial infections.

Medical Segregation for symptomatic Inmates. Persons in later stages of HIV disease; i.e., suffering from one or more opportunistic infections and diagnosed with AIDS, should, where staffing and housing are available, normally be housed in medical units or hospitals, as recommended by the physician, rather than in general population housing. Medical segregation facilitates closer observation by medical staff than would general population housing and greatly decreases the chance for unrecognized development of deadly opportunistic infections.

During medical segregation within the correctional facility, care must be taken to ensure that inmates: (1) retain their legal rights; (2) receive proper medical treatment; (3) do not develop a sense of isolation; and (4) are not unduly restricted in their activities.

Protection from Threats, Intimidation, Violence. The HIV-infected person housed within the general population may be the target of other inmates' threats, intimidation, or violence and may require evaluation for housing in protective custody. The administrator should require that correctional officers be particularly alert to and report any signs of aggression toward inmates suspected of or known to be infected.

Statutes Authorizing Quarantine. Some states have enacted statutes that authorize the quarantine or isolation of "recalcitrant" individuals who know that they are HIV-infected and yet continue to engage in activities that transmit the virus.

Work Assignments

Work assignments need to be governed only by the degree to which the HIV-infected inmate's illness has progressed. For example, an asymptomatic person should be able to perform normal assignments; while a person whose strength has decreased should not be expected to do heavy or strenuous work and should be given only light work assignments *at the physician's discretion.*

Persons known to be HIV-infected who are working in certain areas, such as food service, may be a source of concern; however, the virus is not known to be transmitted through food, so there is no risk to inmates or staff being served. Therefore, CDC specifically advises against requiring food service workers to be screened for the HIV antibody. However, to avoid alarm and possible disruption, the administrator may wish to confine infected inmates to light work assignments away from the kitchen or serving area.

Confidentiality of Medical Information

Confidentiality protections provide safeguards against discrimination and are necessary to encourage offenders to come forward for voluntary counseling, testing, and treatment--the first steps to halting the AIDS epidemic. It is critical that administrators understand the need to protect the confidentiality of inmate medical information and that staff training address this issue. (See Chapter IV for policy guidelines.)

An issue of concern to administrators has been whether to relay inmates' HIV-positive status to inmates' spouses or sexual partners prior to furloughs and conjugal visits, as well as prior to release. The

relaying of an inmate's HIV status to the inmate's spouse or sexual partner may be contingent upon the laws of the jurisdiction. Of the state confidentiality statutes that have been enacted at this writing, most allow disclosures deemed necessary to protect the public health. Further, courts are finding in favor of disclosure under extremely limited circumstances; e.g., in the case of an inmate who has made it clear that he or she has no intention of preventing an exchange of body fluid or of disclosing seropositive status to spouse or sexual partner, medical personnel would be expected to discuss the inmate's condition with the sexual partner.

Discrimination

The most important protection for persons with HIV disease is the protection against discrimination. Within the correctional facility, discrimination can be a direct result of failure to maintain the confidentiality of inmate medical information.

HIV policies addressing discrimination should delineate sanctions for officers discriminating or allowing discrimination against inmates who are HIV infected. (See Chapter IV for a complete discussion on anti-discrimination laws applying to HIV disease.)

Sanitation

Personal toilet articles that can become contaminated with blood, such as razors or toothbrushes, should be distributed to ***each inmate*** to discourage the sharing of such items. The maintenance of good personal hygiene is necessary for ***all*** inmates, and particularly so for those with HIV infection. All inmates should bathe regularly and wash hands before preparing food and after using bathroom facilities or having contact with their own body fluids (semen, mucous, blood).

In addition, the highest environmental and food service sanitation standards must be followed to prevent the growth of fungi and bacteria that can cause illness in both normal persons and those with suppressed immune systems. Food service personnel should be closely monitored to ensure that they follow strict rules of personal health and hygiene and food preparation practices as well as cleaning procedures that prevent contamination.

Food Service. Because HIV infection is not known to be transmitted through food, no special provisions for food service and no special handling of utensils used in meal preparation or cleanup are needed for persons with HIV disease. To prevent the spread of any infections throughout the inmate population, dishes and utensils used by all inmates should be washed in sufficiently hot water to destroy all bacteria and viruses. [1]

Cautions Concerning Problem-Causing Food. Certain foods--particularly unpasteurized milk and milk products--should not be served to HIV-infected persons. Milk products have been associated with salmonella infections, which are not well tolerated by persons with HIV disease. In addition, organically grown food (composted with human or animal feces) should be cooked or peeled before eating; organically grown food that cannot be cooked or peeled should be avoided.

Laundry Service

Special laundry precautions are necessary only for those HIV-infected inmates who have draining wounds or are unable to control excretions. Laundry from such persons should be placed in specially labeled plastic bags and disposed of or laundered according to the facility's policies for items contaminated with hepatitis B virus.

---

[1] For detailed food service sanitation procedures, see: Ayres, M.B. ***Food Service in Jails.*** Alexandria, VA: The National Sheriffs' Association, 1988.

No special precautions are needed for the laundry of HIV-infected inmates who do not have the above symptoms. Normal laundry procedures involving hot water, detergent, and the heat settings in automatic clothes dryers will kill the HIV virus. In addition, household bleach should be used for the laundry of all inmates to prevent the spread of any infectious diseases.

Visiting Rights

Inmates with HIV disease should have the same visiting rights as other inmates. To prohibit any type of visit could result in legal action against the institution for discrimination and/or infringement of inmates' rights. If institutional regulations permit conjugal visits, such visits should not be prohibited for persons with HIV disease. Therefore, the administrator should ensure that all inmates have received AIDS education upon intake, and that those at high risk for or diagnosed with HIV disease have received additional counseling to ensure their understanding of the importance of both partner notification and of preventing transmission to sexual partners.

Further, as previously discussed, the **administrator should consider the advisability of distributing condoms to inmates prior to conjugal visits.**

EMPLOYEE POLICIES

In addition to developing and enforcing HIV-related policies for inmate supervision, administrators must develop a clear perception of their responsibilities regarding the very real probability of future infection ***among their own employees.*** Experience has shown that agencies lacking understanding and ***explicitly defined guidelines*** for the management of employees with HIV disease are the ones most likely to experience disruptive incidents when a staff member is suspected of or known to be infected.

On the other hand, those agencies that have established proactive, written policies that clearly define employee responsibilities greatly minimize confusion and misunderstanding when an inmate or fellow employee is found to be HIV-infected.

A number of policy issues pertaining to inmates must also be addressed for employees. For example, employees should have specific HIV-related policies on ***confidentiality, discrimination, testing,*** and ***training*** and ***equipment.***

Confidentiality

Recognizing the need for heightened confidentiality protections in cases of HIV, the majority of states have now enacted ordinances that apply to employee medical information (Gostin, 1989). Employees' rights to confidentiality of medical information also stem from evolving case law as well as from the Federal Privacy Act of 1974, which protects the privacy of medical records held by federal agencies.

A person's HIV antibody test result is extremely personal, and disclosure of it could well lead to embarrassment and discrimination. Therefore, employers who obtain and disclose this information may be risking liability in a number of areas, including invasion of privacy based on inappropriate publication of test results, failure to maintain the security of records, and intentional infliction of emotional distress if a person were subjected to harassment or ridicule by supervisors or coworkers (Rothstein, 1987). In Massachusetts, a trial court has recognized a tort action for invasion of privacy under a state privacy statute on behalf of an employee with AIDS whose supervisor failed to keep confidential the nature of the employee's medical condition (Leonard, 1987).

Discrimination

The importance of anti-discrimination laws for employees with HIV disease--particularly Section 504 of the Federal Rehabilitation Act of 1973--cannot be overemphasized. To write effective employee policies prohibiting discrimination, the administrator should be familiar with the provisions of Section 504.

For example, this law prohibits the isolation of persons with HIV disease from the normal work

environment; and employers may ***not*** arbitrarily reassign infected employees simply because coworkers fear contagion. Therefore, employees who are concerned about contracting HIV infection through casual contact with a coworker must be educated to understand that the kind of non-sexual person-to-person contact that occurs in the workplace does not pose a risk of transmission; and that they are expected to continue working with infected persons, ***treating them fairly and humanely.*** Policies should ensure that harassment and discrimination ***do not occur*** in the workplace, and that "well" employees are encouraged to show sensitivity and understanding to infected persons who urgently need social, financial, and emotional support.

Testing

CDC does not recommend HIV antibody testing as a condition of initial or continued employment for any occupation. Further, many states have passed laws that specifically regulate the conditions under which people may be tested.

CDC does recommend that testing be offered to employees following any incident involving possible transmission (although appropriate precautions make it unlikely that such incidents will occur). Specific procedures should be established for the reporting and followup of any such incidents and should clearly delineate staff responsibilities with regard to these procedures and the circumstances under which workman's compensation claims may be filed. (See Figure 5.1, "Checklist of Procedures for Officers who Sustain Accidental Exposure to Infectious Diseases.")

Training and Equipment

Written policies should clearly establish a plan for educating employees. Training--particularly in specific procedures to prevent HIV transmission during the performance of duties--has greatly reduced the incidence of officers' refusal to work among persons suspected or known to be infected. In addition to reducing fears, training is critical to ensure that all staff understand the agency's policies and procedures, including exactly what is expected of them regardless of an inmate's or another employee's HIV status.

Today, all correctional personnel--administrators, supervisors, and officers--require information on: (1) the causes, symptoms and means of transmitting HIV, (2) the methods of preventing transmission, including the use of appropriate, readily available equipment and of universal precautions; and (3) the importance of protecting the privacy of inmate **and** employee medical information and of preventing discrimination against both inmates and coworkers, The need for ongoing training for both administrators and officers is crucial, especially as court decisions continue to define the legal responsibilities of all who work within the criminal justice system.

CPR and Other First Aid

As discussed in previous chapters, all law enforcement and correctional officers must provide CPR or other medical assistance to all persons in need, regardless of health status. (See Chapter VI for a complete discussion on CPR and other emergency medical assistance.) Policies addressing these issues must:

- Clearly specify what action is expected of each officer, and under what circumstances;
- Ensure that pocket masks or other resuscitation devices as well as protective gloves are carried on the person of or easily accessible to every officer;
- Ensure that additional equipment that may be needed for universal precautions is readily available to every officer, and that every officer is thoroughly trained in the use of all equipment issued;
- Ensure that every officer understands his or her obligation to perform CPR or other emergency medical assistance with or *without* a resuscitation device.

CHAPTER X

GUIDELINES FOR MEDICAL AND MENTAL HEALTH PERSONNEL

Health care is one the primary responsibilities of correctional administrators. Whether services are provided by full-time correctional health care staff or by contract medical professionals and facilities, the treatment of the HIV-infected inmate is of utmost importance. Additionally, medical staff must be aware of and practice the proper infection control procedures for their own as well as the inmate/patient's protection.

GUIDELINES FOR THE EVALUATION OF IMMUNE DEFICIENCY

The standards for medical and health care services for adult local detention facilities call for health appraisals for each inmate within 14 days after arrival at the facility (American Correctional Association, 1988). Health history and vital signs should be collected by health trained or qualified health care personnel and all other data should be collected only by qualified health care personnel. The health appraisal includes:

- Review of the receiving screening data;
- Collection of additional data to complete the medical, dental, psychiatric, and immunization histories;
- Laboratory and/or diagnostic testing to detect communicable diseases, including venereal disease and TB;
- Recording of height, weight, pulse, blood pressure, and temperature;
- Completion of a medical examination with comments about mental and dental status;
- A physician's review of medical examination results and tests and identification of problems;
- Initiation of therapy when appropriate (ACA, 1981).

Since many diseases cause varying degrees of immune deficiency, the identification of immune deficiency alone is not diagnostic for HIV disease. Deficiencies may be due to causes as simple as viral illness. The evaluation of an inmate who is symptomatic and at risk for HIV disease should include a complete history and physical and appropriate laboratory tests. The history should include a review of symptoms; past medical history, including sexual orientation, IV drug use, transfusions, and previous sexually transmitted diseases; and other pertinent factors. Figure 10.1 is a diagnostic checklist for AIDS.

GUIDELINES FOR THE PREVENTION OF HIV AND HBV FOR HEALTH CARE WORKERS

CDC has developed infection control guidelines for all health care personnel, including laboratory and dental workers. These guidelines detail the precautions that are to be taken by all persons who come in contact with potentially infectious materials during patient medical treatment. The guidelines include a discussion on disposal of used syringes and contaminated materials and should be strictly followed by all health care personnel. Administrators should keep abreast of CDC infection control guidelines and updates.'

[1] For the complete CDC guidelines for the prevention of HIV and HBV transmission in health care settings, see: CDC, MMKR, Vol. 37, No. 24, 1988.

Figure 10.1

ACQUIRED IMMUNE DEFICIENCY SYNDROME DIAGNOSTIC CHECKLIST

SYMPTOMS

GENERAL

Fatigue	YES	NO
Fever of Unknown Origin	YES	NO
Night Sweats	YES	NO
Enlarged Lymph Nodes in the Neck, Armpits or Groin	YES	NO
Unexplained Weight Loss	YES	NO

RESPIRATORY

Persistent Dry Cough	YES	NO
Shortness of Breath not Related to Smoking	YES	NO
Difficulty Breathing	YES	NO

GASTROINTESTINAL

Oral Thrush	YES	NO
Abdominal Cramping	YES	NO
Bloating	YES	NO
Gas	YES	NO
Diarrhea: More Than 1 Month	YES	NO

DERMATOLOGICAL

Herpes Simplex	YES	NO
Herpes Zoster	YES	NO
Suspicious Lesions on the Skin, Mucous Membranes and Lymph Nodes	YES	NO

NEUROLOGICAL

Headache	YES	NO
Disorientation, Confusion	YES	NO
Loss of Memory	YES	NO
Dizziness	YES	NO
Seizure Disorder	YES	NO
Dementia	YES	NO

PAST HISTORY

Sexual Orientation (Heterosexual, Bisexual, Homosexual)		
Years Active _____		
IV Drug Use	YES	NO
Tobacco	YES	NO
Recreational Drugs	YES	NO
If "Yes," Type_____		

Blood Transfusion History	YES	NO
If "Yes," Date of Last Transfusion_____		
Hemophilia	YES	NO
Previous Sexually Transmitted Diseases	YES	NO
Gonorrhea (Date)_____		
Syphilis (Date)_____		
Condyloma Acuminata (Date)_____		
Intestinal Parasite (Date)_____		
Hepatitis (Type/Status)_____		
Oral Candida	YES	NO
Medications (Type and Dosage)	YES	NO
_____		
_____		
_____		
Allergies	YES	NO
_____		
_____		

PHYSICAL EXAM

Gross Adenopathy	YES	NO
Fever	YES	NO
Malnourished Appearance	YES	NO
Oral Thrush	YES	NO
Papillomavirus	YES	NO
Lymphadenopathy	YES	NO
Dry Cough Induced with Deep Inspiration	YES	NO
Hepatomegaly (Enlarged Liver)	YES	NO
Splenomegaly (Enlarged Spleen)	YES	NO
Abdominal Masses	YES	NO
Abdominal Tenderness	YES	NO
Rectal Lesions	YES	NO
Rectal Ulcers	YES	NO
Condyloma (Wartlike Growths)	YES	NO
Edema	YES	NO
Characteristics of Kaposi's Sarcoma (Penny-sized Purplish Lesions Appearing on the Skin, Mucous Membranes, and Lymph Nodes)	YES	NO
Seborrheic Dermatitis (Dry or Moist Greasy Scales and Yellowish Crusts)	YES	NO
Shingles (Herpes Zoster-Small Red Flat Areas of Discoloration)	YES	NO
Tinea (Skin Diseases Characterized By Itching, Scaling, Sometimes Painful Lesions)	YES	NO

Molluscum (Skin Disease with Soft Rounded Masses) YES NO

OPPORTUNISTIC INFECTIONS

Cryptosporidium Diarrhea	YES	NO
Toxoplasmosis	YES	NO
Esophageal Candidiases	YES	NO
Cryptococcal Meningitis	YES	NO
Ctyptococcal Fungemia	YES	NO
Disseminated Cytomegalovirus	YES	NO
Progressive Mucosal Herpes Simplex	YES	NO
Progressive Multifocal Leukoencephalopathy	YES	NO
Disseminated Mycobacterium Avium-intracellulare	YES	NO

LABORATORY

TEST: CBC--Complete Blood Count with Differential

SIGNIFICANT FINDINGS/(NORMAL RANGES): Decreased WBC (4,500-11,5OO/mm3), Decreased RBC (Females: 4.2-5.4 million/mm3; males: 4.6-6.2); **Hemoglobin/Hematocrit Indices** (HGB: Female: 12-16g/lOOml; Male: 13-18g/l00ml; HCT: Female: 37-48 percent; Male: 45-52 percent)

TEST: Platelet Count

SIGNIFICANT FINDINGS/(NORMAL RANGES): **Decreased Platelet Count** (150,000-350,000/mm3)

TEST: ESR--Erythrocyte Sedimentation Rate

SIGNIFICANT FINDINGS/(NORMAL RANGES): **Increased Sedimentation Rate** (Male: 1-13mm/hr.; Female: 1-20mm/hr.)

TEST: SMAC-12--Sequential Multiple Analysis Computer

SIGNIFICANT FINDINGS/(NORMAL RANGES): **Increased LDH** (60-120u per ml); Increased ALK **Phosphates (13-39** IU); **Increased Transaminase; Increased Serum Globulins** (2.3-3.5g/100ml); Increased **Serum Cholesterol** (120-255mg/dl); Decreased **Iron** (50-150mg/dl)

TEST: Amylase

SIGNIFICANT FINDINGS/(NORMAL RANGES): Decreased Amylase (4-25U/ml)
TEST: VDRL

SIGNIFICANT FINDINGS/(NORMAL RANGES): **Positive VDRL**

TEST: Hepatitis Profile: HBsAG, HBsAB, HAIM

SIGNIFICANT FINDINGS/(NORMAL RANGES): **Positive HBsAG, Positive HBsAB, Positive HAIM**

TEST: Herpes Simplex Virus/ Cytomegalovirus

SIGNIFICANT FINDINGS/(NORMAL RANGES): **Positive Culture, Increased Titers**

TEST: Chest X-Ray

SIGNIFICANT FINDINGS/(NORMAL RANGES): Diffused Interstitial, Infiltrates

---

PSYCHOLOGICAL ISSUES AND HIV INFECTION

A diagnosis of AIDS or HIV infection may result in some psychological stress for infected persons and their families. In its late stages, the disease causes extremely debilitating symptoms, making a previously young and vigorous person very ill in a relatively short period of time. Even at the initial infection stage, changes in the infected person's lifestyle may be necessary immediately, thus causing a great deal of stress.

Therefore, mental health and other support services are essential components of a comprehensive health care delivery system. Given the complexities of the problems accompanying a diagnosis of HIV disease, a multidisciplinary team approach to psychological services may be an effective method of meeting the infected inmate's needs.

stages of Intervention

Infected persons and their families have varied counseling needs throughout the course of HIV disease; and there are several stages of intervention, from pre-test/post-test counseling to the termination of treatment. Therefore, at a minimum, mental health professionals should be prepared to address: (1) pre-test and post-test counseling issues; (2) reactions to catastrophic illness; (3) quality-of-life issues; (4) sexuality and transmission risks; (5) drug abuse and transmission risks, (6) cultural and personal values; (7) support systems; (8) infection control; and (9) community medical and mental health resources.

The counseling goals should be to assist the individual to: (1) understand and implement behavioral changes necessary as a result of HIV infection, including needlesharing and sexual practices; (2) focus on quality-of-life issues, including taking control of his or her treatment; (3) identify existing support systems and build new ones; and (4) deal with the multiple effects of the disease and identify effective coping strategies.

Pre-Test Counseling. Perhaps some of the most critical counseling tasks are those that address the decision to undergo HIV testing. During pre-test counseling, counselors should:

- Explain what the test does and does not measure (i.e., that while it will detect antibodies to HIV disease, it is not a test for AIDS); how the test is performed; and the likelihood of false-positive and false-negative results;
- Explain "informed consent" and the confidentiality protections regarding test results, including any state laws requiring the reporting of HIV status to public health authorities;
- Ensure that written consent is obtained before the test is conducted (Appendix D is a sample consent form);
- Allow for questions about the test as well as about AIDS and risks for HIV transmission;
- Support the inmate's decision to consent to or defer testing; if the decision is made to take the test, the person should be told that he or she must return for post-test counseling.

Post-Test Counseling. Post-test counseling should always be done in person and should include a comprehensive discussion on the modes of HIV transmission, risk reduction behaviors, and recommendations for future medical and mental health followup. As in pre-test counseling, post-test counseling should begin with the counselor introducing or reintroducing himself or herself. The purpose of the meeting should then be explained, and confidentiality issues should be reviewed briefly.

Providing Negative Test Results. Where the HIV-antibody test is negative, the inmate should be given the results immediately at the start of the counseling session. According to the AIDS Health Project of the University of California at San Francisco, the revelation of the test result is best presented "in a straightforward manner, with direct eye contact and without undue expression of concern." The counselor should then caution that, despite the negative test result, risks still remain since HIV antibodies may not yet have developed at the time of the test.

Emphasizing Risk-Reduction Behavior in HIV-Negative Persons. The inmate's return appointment to obtain test results is an opportunity for the counselor to reemphasize the importance of avoiding high-risk behavior, despite the negative test result. The inmate should be advised against donating blood, plasma, tissue, or sperm if he or she has used IV drugs.

Concluding Part-Test Counseling for HIV-Negative Persons. The final segment of the post-test counseling for HIV-negative inmates should be devoted to answering any questions, providing written handout material, and discussing retesting if the person has had a high-risk exposure within the past three months.

Providing Positive Test Results. The counselor who must inform an inmate of a positive test is presenting extremely stressful news. Such news requires the counselor's skill and specific attention to his or her own demeanor in helping the inmate to process this devastating information.

When informing the inmate of a positive test, the same procedure should be followed as when giving negative results: the counselor should introduce (or reintroduce) himself or herself, define the purpose of the session, and give the test result. Once the positive results are given, he or she should resist the urge to fill the silence. The counselor should assess the person's verbal and nonverbal cues and then judge when to discuss the results.

Individuals will react to the news of a positive test in a variety of ways; e.g., shock, disbelief, inability to speak, anger, sadness, fear, relief, or resignation. The inmate's response will direct the remainder of the session, and the counselor who can employ active listening may be most helpful. The inmate needs to be able to process the information, and the counselor's ability to convey understanding and to allow freedom of expression will facilitate this process.

The inmate will need help in understanding what the results mean. It should be reemphasized that a seropositive test does not diagnose AIDS; it detects antibodies to HIV. It does mean the individual is infected and can transmit the virus to a sex or needlesharing partner; a woman can pass the virus to her child during pregnancy or birth and possibly through her breast milk.

Providing Resources, Referrals. A counselor who must tell an inmate of a positive test should have all the necessary resources available. Inmates with positive tests need assistance in developing a health plan that focuses on staying as healthy as possible to reduce the possibility of developing AIDS. Inmates should understand that AIDS develops when the virus multiplies sufficiently to overwhelm the body's defense, or immune system. Inmates also need to learn strategies for coping with the interpersonal implications of the positive test result.

The inmate with a positive test result should be referred to the medical unit for evaluation, particularly for the presence of TB, HBV, and other infections.

Addressing Risk-Reduction for HIV-Positive Inmates. The post-test counseling session for the HIV-positive inmate should focus on risk-reducing behavior. Depending on how much information the inmate can assimilate at this time, the counselor should present information on the importance of avoiding IV drugs

and needlesharing, as well as on abstaining from sex or using a condom to avoid passing or receiving body fluids. The inmate should be advised strongly against donating blood, plasma, body organs, tissue, or sperm. Women should be advised against becoming pregnant, and men should be advised against causing pregnancy. If appropriate, the inmate should be referred to a drug treatment program.

Informing Partners, Family of Positive Test Results. The inmate should be assisted in developing a plan for managing the test information and for determining who should be informed and how. The counselor should be aware of the profound impact a positive test result will have on the inmate and should assess the inmate's ability to notify sex and needlesharing partners as well as "significant others." The counselor's role should be to focus solely on providing emotional support while discussing methods for informing these persons. Role-playing a potentially difficult situation may be effective.

Concluding Post-Test Counseling of HIV-Positive Inmates. The inmate who receives a positive test result needs both time and emotional support; the counselor should recognize that the test result is just a first step in a very long process. Life changes may be indicated, and individuals need a framework from which to facilitate these changes. Education, support, and access to resources are some of the basics a counselor can provide to inmates.

Counseling Guidelines After Diagnosis and Treatment. While the time of diagnosis is a particularly stressful period for HIV-infected persons, it may be a time that is often neglected by mental health professionals (Grossman, 1984). At this stage, persons may: (1) attempt to deny the potential fatality of the disease; (2) have enormous difficulty admitting the high-risk behaviors that exposed them to infection; and (3) be unable to cope with the fear and rejection expressed by their families and friends (Christ, 1986; Coppola and Zabarsky, 1983).

As the disease progresses, the physical symptoms of AIDS, such as progressive dementia, severe weight loss, weakness and fatigue, blurred vision or blindness, and multiple infections also have psychological effects on the infected person. Further, some of the specific treatments currently available cause severe side effects, may require multiple hospital visits or painful tests and procedures, and are extremely expensive. Added to the stress of these problems is the fact that some treatments must be terminated because of their adverse effects; thus, the person is left with an increased fear of the disease's renewed progression (Christ, 1986).

Some research has indicated that a diagnosis of AIDS may be a significant risk factor for suicide. For example, a study conducted by the New York Department of Health reported that the risk of suicide in persons with AIDS is substantially higher than in the general population (Marzuk, et al., 1988). The study reported that men aged 20-59 years with a diagnosis of AIDS are approximately 36 times more likely to commit suicide than men in the general population. Further, the suicide is likely to occur within six months of diagnosis.

Finally, since persons with AIDS are often abandoned by family and friends and are thus relying on a network of social service providers to meet their needs, ongoing mental health and social services are essential. Such services should include: (1) support groups for infected persons, their sexual partners, and family members; (2) education; and (3) referral to community resources, drug and alcohol treatment programs, cancer counseling, and the Social Security Administration.

Agencies should establish policies and guidelines that specifically address the psychological and social needs of HIV-infected inmates. Figure 10.2 provides sample assessment and treatment guidelines for mental health service providers working with HIV-infected persons.

Figure 10.2

GUIDELINES FOR MENTAL HEALTH SERVICE PROVIDERS

Understand the Treatment Goal. The goal of counseling persons with AIDS differs markedly from traditional psychotherapeutic treatment objectives. Treatment often means just being with the person, listening to his or her needs, and providing empathetic support. The sharing of intense emotions helps to dilute the AIDS patient's feelings of isolation and grief. It is essential to allow the person to express fears about the disease and about dying and to recognize the stages of coping with a terminal illness that are exhibited. When working with a dying person, empathy is often the most effective tactic--where there exists an honest, direct counselor-patient relationship.

Be Aware of Control Issues. Persons with AIDS tend to become passive recipients of medical treatment dictated by physicians. Medical treatment may seem impersonal and frustrating and may lead to a sense of helplessness. AIDS patients should be encouraged to take as active a role in treatment as possible and should be encouraged to ask questions about their treatment.

Assist the Patient. Assistance in the form of helping AIDS patients to do things they can do for themselves is *not* assistance. "Overhelping" can lead a person to develop a sense of passivity, dependency, and helplessness and can reinforce a sense of imminent decline. Persons with AIDS should be encouraged to do as much as they can within the limitations imposed by their health.

Encourage the Patient to be Vocal and Expressive. Family and friends often try to avoid discussing the disease and possible death. They may tell the AIDS patient that he or she is morose, depressing, or engaging in negative thinking by initiating discussions about mortality. Mental health professionals should not assume that the AIDS patient does not wish to discuss the issues of death and dying; however, it is important to allow the person to lead in these topics.

Permit Denial. If the AIDS patient is obviously utilizing the defense mechanism of denial, the counselor should allow it, as long as medical care is not compromised as a result. The failure to accept one's prognosis is not usually damaging. Denial reduces stress, assists in coping, and helps maintain a positive quality of life.

Recognize Fear of Abandonment. Mental health professionals should recognize that the fear of abandonment may occupy a central position in the HIV-infected person's mind. Fear of death is usually greater when faced without family and friends.

Provide Reliable, Consistent and Continuous Support. The support offered by mental health professionals must be reliable, consistent, and continuous. Since therapy primarily involves the therapist's being available to the client, it is important that counselors make commitments to themselves and to their patients to be available. Patients should be advised far in advance of a counselor's plans to be out of town. Arrangements should be made for backups. Additionally, patient followup should be conducted regularly to ensure continuity of care after referral to other services.

Be Sensitive to the Patient's Social Unit. Patients do not live in vacuums. They are surrounded by friends and family members, and they can experience as much stress from these persons as they do from the disease itself. Counselors should obtain the patient's permission to consult with friends and family to make them aware of the infected person's support needs.

Allow Time for the Therapeutic Alliance to Develop. It takes time to establish trust and to cultivate an ongoing, accepting counselor-patient relationship.

Avoid Statistics. Statistics may not be helpful for persons with AIDS. Discussions of mortality rates can lead to pessimism, self-defeatism, and helplessness. Further, overall statistical data may not be relevant for individual cases.

Maintain Regular Contact with the Patient's Primary Physician if Possible. It is not unusual for patients to misconstrue doctors' statements. Anxiety often interferes with listening and comprehension. Therefore, it is important for counselors to consult with patients' doctors and hospitals; however, they must obtain *written permission from their patients to do so.*

Accept Being Used as a "Dartboard." Counselors should recognize their need for a "thick skin." Patients will find many reasons to become angry and often will direct this anger at whatever or whoever is present. Counselors should not personalize these attacks; rather, they should engage the patient in dialogue.

Be Alert to Suicidal Feelings. Counselors should be vigilant for suicidal feelings and behaviors that may present themselves in persons with AIDS. This may be particularly important in correctional facilities, where the inmate may become very depressed from the combination of incarceration and terminal illness.

Clearly, medical and mental health professionals must work as a team to provide the most comprehensive care to HIV-infected persons. Further, as treatment for HIV disease and theories of case management evolve, HIV-infected persons will need early and appropriate diagnosis, coupled with support, counseling, and compassion.

CHAPTER XI

GUIDELINES FOR COURT PERSONNEL

The methods of HIV transmission have been well documented and are limited to intimate sexual contact and direct contamination with infected blood or blood products.[1] Since these are not factors in courtroom situations, court personnel, including judges, attorneys, jurors and court officers need to use no special **precautions** when persons suspected of or known to be HIV-infected are brought before them. Court personnel need to understand that HIV-infected persons pose no risk to their health or safety.

INCIDENTS NOT SHOWN TO TRANSMIT HIV

All court personnel should be aware of medical research findings that clearly indicate that HIV is NOT airborne and is NOT spread by any of the following:

- Sneezing, coughing, or spitting;
- Handshakes or other nonsexual physical contacts;
- Contact with an infected person's tears, urine or perspiration;
- Using toilet seats, drinking fountains, bathtubs, showers, eating utensils, dishes, or linens used by infected persons;
- Eating food prepared or served by infected persons;
- Handling articles worn by infected persons;
- Being around an infected person, even on a daily basis, over a long period of time.

Therefore, HIV-infected persons who are not bleeding should not be restricted from using telephones, drinking fountains, rest rooms, or eating facilities during court recesses simply because of their illness.

RESPONSES TO PERSONS WHO ARE VIOLENT OR WHO REQUIRE CPR

Court personnel, like public safety or emergency response workers, may encounter individuals who are violent or who may require CPR. Thus, court officers should be trained to use universal blood precautions as outlined by CDC.[2]

Although saliva does not pose a risk for transmitting HIV, court officers should be trained to perform CPR with a one-way valve mask to prevent the transmission of airborne viruses and bacteria. It should be noted that an assaultive person who is spitting or throwing urine poses no threat of contamination since these fluids are not known to transmit HIV.

---

[1] Refer to Chapter III for a complete discussion of the methods of HIV transmission.

[2] For a complete discussion on universal precautions, see Chapter V and CDC, *MMWR,* Vol. 36, No. 2S, 1987.

HANDLING OF PHYSICAL EVIDENCE

During trial, clothing or other articles worn by the defendant may often be submitted as physical evidence to be examined by jurors. Attorneys and jurors may have concerns about handling such articles, particularly if they belong to an individual suspected of or known to have HIV infection. Such concerns are unnecessary, however, since the virus cannot be transmitted by handling contaminated clothing. Furthermore, general principles of good hygiene would dictate that any pieces of evidence which have been soiled by blood, body fluids or other hazardous materials will be properly packaged to ensure sanitary handling.

LEGAL REPRESENTATION FOR THE HIV-INFECTED PERSON

HIV-infected persons have a right to the same legal protections and representation as other individuals. Therefore, it is imperative that attorneys representing clients who may be HIV-infected understand that they are at no risk for infection through day-to-day contact with their clients. In response to the concerns of the legal community, the American Bar Association has published guidelines addressing the legal system's appropriate response to HIV infection (ABA, 1988).

CHAPTER XII

GUIDELINES FOR TRAINING STAFF AND INMATES

A recent National Institute of Justice survey of HIV-related issues facing correctional institutions noted the progress which has been made in the area of training and education for both staff and inmates (Hammett, 1989). However, while many correctional systems have developed comprehensive AIDS-related education programs, staff and inmate training must be a continuing process; those responsible for program development must keep abreast of innovative training methods and resources.

Correctional officers continue to have concerns about the risks of HIV and HBV infection from violent confrontations with inmates, from responding to suicide attempts where there may be a considerable amount of blood involved, from needlestick injuries, and from cleaning up blood and body fluid spills. Additionally, officers may still have fears and misconceptions regarding the risk for HIV and HBV infection when administering CPR.

To ensure that officers perform their duties effectively and without unnecessary fear, training programs must be implemented in a timely and systematic manner, comprehensively addressing: (1) how HIV and HBV are spread; (2) personal prevention practices; (3) universal precautions; (4) protective equipment; (5) specific workplace prevention practices, including the cleaning up of blood and body fluid spills; and (6) the management of exposures.

Additionally, managers should be educated about a range of issues addressing HIV disease, including policies affecting infected employees; housing policies for infected inmates; confidentiality protections; employee and inmate testing; and policies regarding condom distribution within the facility.

Training is particularly important for those jurisdictions lacking a great deal of experience with HIV-infected inmates. It is perhaps in these jurisdictions that fear is greatest and that education can have the most impact by allaying misconceptions before the first cases of HIV infection are identified.

STAFF TRAINING ISSUES

Staff training curricula should address general medical and legal issues related to HIV disease as well as specific procedures for correctional staff during all phases of their work. Thus, at a minimum, training programs for correctional staff should address the following:

- Epidemiology of HIV disease;
- Causes, symptoms and transmission of HIV disease;
- Legal and liability issues within correctional facilities;
- Universal blood precautions and infection control procedures;
- Initial response and arrest procedures;
- Intake/booking and classification procedures;
- Administrative and management issues;
- Mental health and counseling issues for HIV-infected inmates.

GUIDELINES FOR TRAINING AND EDUCATION OF CORRECTIONAL STAFF

As a first step in training staff, correctional administrators should establish training as a priority within the facility's policies. Administrators should then identify an individual within the facility to be responsible for all AIDS education activities, thus ensuring that educational materials will be continuously updated and that followup training will be conducted as necessary for both staff and inmates.

A training needs assessment survey is a helpful tool for evaluating the staffs training experience and needs surrounding HIV disease. These surveys vary from comprehensive departmental assessments to brief, issue-oriented assessments that focus on specialized topics of concern. Survey results may help trainers determine both long- and short-term staff training needs.

A less formal way to assess staff training needs is to design and conduct a pre-test of HIV-related issues. Pre-test results can identify specific knowledge gaps concerning HIV disease as well as staff responsibilities and departmental policies and procedures. The test may be administered again upon completion of training to gauge program effectiveness. Figure 12.1 is a sample pre-test/post-test.

Training Methods

A variety of training methods may be employed, including the following:

- Presentations by trained facility staff or professionals from the community with expertise in medical, legal, and correctional management issues;

  While the length of the training sessions may vary, adequate time must be allocated to ensure that all staff thoroughly understand the nature of HIV disease and their respective roles and responsibilities in responding to infected inmates;

- Sessions involving audiovisual materials and a trainer to facilitate group discussions;

- Dissemination of written materials that clearly and thoroughly describe guidelines and/or departmental policies and procedures;

- Dissemination of written materials that address general questions about HIV disease and its transmission.

Regardless of the presentation mode, training sessions must be responsive to the needs of all correctional staff and should be regularly updated.

Training Objectives

Training objectives should clearly describe what knowledge and skills staff should acquire as a result of the session. At the completion of the training, staff should be able to:

- Explain the difference between HIV seropositivity and a diagnosis for AIDS;

- Identify how HIV and HBV are and are not transmitted;

- Recognize who is at risk for infection;

- Identify personal behaviors and practices that protect persons from risk of HIV and HBV infection;

- Describe universal blood precautions;

- Describe the proper procedures for cleaning up blood and body fluid spills, patdowns and cell searches, CPR, and intake and classification of HIV-infected inmates;

- Identify local laws and departmental regulations addressing HIV disease.

Model Staff Training Curricula

Both CDC and the National Sheriffs' Association have developed model training programs for public safety officials (CDC, 1989, Laszlo, 1990). A model staff training curriculum, including both "core" and "elective" modules, is presented in Figure 12.2. Core modules are those which are fundamental to an understanding of: (1) how HIV and HBV are transmitted; (2) universal precautions; and (3) the legal/liability issues involved in managing both inmates and employees who may be infected. Elective modules address specialized issues for correctional facilities.

Throughout the development and implementation of this training program, trainers are encouraged to work with a multidisciplinary team of instructors, including medical and legal experts, infection control experts, correctional officials, and community service providers.

GUIDELINES FOR INMATE TRAINING

Timely, accurate inmate education is an essential component of any comprehensive effort to minimize the spread of infection within the correctional facility and to eliminate fear and misunderstanding.

Of primary concern to inmates are the causes, symptoms and methods of transmitting HIV as well as the ways to reduce or eliminate the risk for infection. Educational programs should focus on the following topics:

- Definition of HIV seropositivity and AIDS;

- Means of transmitting HIV and HBV, including high-risk practices;

- Contacts which do not transmit HIV and HBV,

- Causes and symptoms of HIV infection;

- Infection prevention while incarcerated;

- Infection prevention during conjugal visits and after release.

Program participation may be voluntary or mandatory, depending on departmental regulations regarding inmate education programs. However, ***it is strongly recommended that inmates receive AIDS-related education as soon as possible after intake.*** For inmates who will be released within a short time, prompt education is particularly important, as it may be the only opportunity the correctional system will have to impact infection prevention behavior.

Inmate education sessions should be clear, concise, practical, and in language understandable and culturally sensitive to the inmate population. Methods of preventing HIV transmission should be clearly and thoroughly explained.

Training Methods

A variety of methods may be used to educate inmates, including the following:

- Sessions led by staff or community outreach workers who are providing services to HIV-infected persons;

- Sessions involving audiovisual materials and a facilitator to answer questions and conduct group discussions;

- Audiovisual education followed by individual, private counseling sessions with medical or mental health staff regarding behaviors that may place the inmate at risk for HIV or HBV infection;

- Dissemination of written materials, including posters, brochures, comic books and pamphlets that specifically address inmates' concerns and questions about HIV disease. These materials should be designed with an understanding of the inmate's reading comprehension level and printed in the language best understood by the inmate (e.g., Spanish, French, Chinese, Braille). Many educational materials specifically targeted at the inmate population have been developed by national and local organizations. CDC, the National AIDS Information Clearinghouse, the National Sheriffs' Association, and the American Red Cross are but a few of the national organizations that have designed inmate educational materials. At the local level, the state AIDS Coordinators, the Departments of Public Health, and the local chapters of the American Red Cross provide education and training services that may be very effective for the correctional setting. Since information about HIV disease is continually expanding, trainers must be vigilant to new and appropriate sources of training and educational materials for both staff and inmates.

Training Objectives

At the completion of the education program, inmates should be able to:

- Differentiate between HIV seropositivity and a diagnosis of AIDS;

- List the ways HIV and HBV are transmitted;

- List the ways HIV and HBV are not transmitted;

- List behaviors and practices that reduce or eliminate the risk of infection;

- Name community medical and mental health resources that provide services for HIV-infected persons and their families.

Model Inmate Training Curricula

Model inmate training curricula are presented in Figure 12.3.

Figure 121

ACQUIRED IMMUNE DEFICIENCY SYNDROME PRE/POST TEST

1. A positive HIV antibody test means that the person (circle all correct responses):

   a. will, in all likelihood, develop AIDS.

   b. has developed antibodies to the HIV virus.

   c. needs to restrict his/her normal day-to-day contacts.

   d. has AIDS.

   e. may need to modify his/her sexual practices.

   f. has been exposed to the AIDS virus.

2. What evidence is required to make a diagnosis of a case of AIDS?

   _____

3. The HIV virus is easily killed by soap and water. True False

4. In its later stages, HIV can be spread by casual contact. True False

5. You cannot contract HIV infection by doing patdown searches. True False

6. HIV is transmitted through the following ways (circle all correct responses):

   a. sharing eating utensils.

   b. contaminated clotting factor used by hemophiliacs.

   c. mother to fetus.

   d. exchanging body fluids, such as blood or semen.

   e. sharing toothbrushes.

   f. sharing needles.

7. HIV-infected persons carry high concentrations of the virus in their saliva and tears. True False

8. There are no documented cases of HIV infection by giving CPR. True False

9. Latex gloves are an effective barrier against HIV or HBV. True False

10. Correctional facilities may refuse to hire officers whom they know to be HIV infected. True False

11. A bleach solution (1:100) is adequate to kill the viruses that cause AIDS and hepatitis B on equipment and environmental surfaces. True False

12. The most effective way for HIV or HBV to be transmitted in an occupational setting is through a needlestick. True False

Figure 122

TRAINING MODULES FOR CORRECTIONAL STAFF

CORE MODULES

Module 1: Introduction and Overview of Program

Module 2: The Medical Issues: Causes, Symptoms and Transmission of HIV and HBV

Module 3: The Legal Issues: Employment, Discrimination, Confidentiality, Housing and Testing

Module 4: Universal Blood Precautions: Preventing the Transmission of HIV and HBV

Module 5: State Laws and Departmental Regulations

ELECTIVE MODULES

Module 1: Intake and Classification of HIV-infected Inmates

Module 2: Guidelines for Medical and Mental Health Staff within Correctional Facilities

Module 3: Policy Issues for Correctional Administrators

Module 4: Guidelines for Court Personnel

Figure 123

TRAINING MODULES FOR INMATES

The following modules are recommended for inmate education programs.

Module 1: Introduction and Purpose of Training

Module 2: Causes, Symptoms and Methods of HIV and HBV Transmission

Module 3: Guidelines for Preventing Infection

Module 4: Community Medical and Mental Health Resources

GLOSSARY

ACUTE (disease) - A disease of short duration, sometimes severe, and usually with an abrupt onset (as opposed to chronic disease).

AIDS (acquired immune deficiency syndrome) - An acquired illness of the immune system which reduces the body's ability to fight special types of infection and cancer. The human immunodeficiency virus (HIV) is thought to be the cause of this illness, which is transmitted through intimate sexual contact, in particular, anal and vaginal intercourse, direct exposure to infected blood or blood products, and from an infected woman to her fetus or infant. The data on oral sexual transmission are unclear. Once the immune system is impaired, persons who are diagnosed as having AIDS may easily develop one or more specific opportunistic infections or rare cancers which become life-threatening. Of persons officially diagnosed as having AIDS for three or more years, over 80 percent have died.

A person must have specific diseases to be diagnosed officially as having AIDS and to be reported to the Centers for Disease Control. These diseases, defined separately in the following section, generally include unusual forms of bacterial, fungal, and viral infections, as well as rare cancers.

AIDS DEMENTIA - A degenerative disorder of the brain and central nervous system caused by infection with HIV that leads to progressive deterioration of mental and neurological functions. AIDS dementia is reported to occur in approximately 70 percent of AIDS patients. Symptoms include memory loss; mood shifts; depression; difficulty in concentrating; and motor impairment; including difficulty walking and weakness in arms and legs.

AMNIOTIC FLUID - The watery fluid that surrounds the fetus or unborn child in the uterus.

ANTIBODY - Special protein developed by the body's immune system in response to exposure to specific foreign agents. **A** given antibody exactly matches a specific agent that causes an infection, much like a key matches a lock; the antibody then helps to destroy the infectious agent.

ANTIBODY POSITIVE - A term used to describe the result of a test or series of tests that detect the presence of antibodies in blood. Positive results mean that antibodies are present.

ANTIGEN - A substance, such as HIV, that is foreign to a person's body. An antigen causes the immune system to form antibodies to fight the antigen.

ANTIVIRAL DRUG - A drug that can interfere with the life cycle of a virus.

ARC (AIDS Related Complex) - Some HIV-infected people may go for a long period without developing the specific, life-threatening conditions that identify AIDS. However, these people may develop other illnesses and symptoms indicative of impaired immune responses; i.e., weight loss, chronic fatigue, lethargy, swollen glands, persistent diarrhea, low-grade fevers, and oral thrush. Such persons are said to have ARC. Currently, it is believed that a person may continue to have ARC without progressing to AIDS for an indefinite number of years.

ASYMPTOMATIC - Without subjective or objective signs of illness. People who are infected with the AIDS virus (HIV), as evidenced by the presence of HIV antibodies, may show no symptoms of disease. Currently, scientists believe that 10-40 percent of persons who are infected with the HIV will develop AIDS within 5 years; approximately 25 percent may develop lesser forms of the disease; the remaining persons may remain asymptomatic for longer, possibly indefinite periods.

ASYMPTOMATIC HIV SEROPOSITIVE - The condition of testing positive for HIV antibody without showing any symptoms of disease. A person who is HIV-positive, even without symptoms, is capable of transmitting the virus to others.

AZT - The first FDA-approved drug used to treat AIDS.

BLOOD/BODY FLUID PRECAUTIONS - Special medical procedures to prevent exposure to infected blood or body fluids. Appropriate infection control procedures include the use of protective gloves; gowns, if it is likely that clothing would be soiled by infected blood or body fluids; and masks, if there is a chance of splattering blood.

BLOOD/BRAIN BARRIER - A natural defense mechanism that protects the brain by keeping certain drugs and other chemicals or toxins that may be present in the body from reaching the brain.

BODY FLUIDS - Fluids that the body makes; i.e., semen, blood, vaginal secretions, and breast milk.

CARRIER - A person who is apparently healthy but is infected with some disease-causing organism (such as HIV or HBV) that can be transmitted to another person.

CENTERS FOR DISEASE CONTROL (CDC) - Federal health agency that is a branch of the U.S. Department of Health and Human Services. The CDC provides national health and safety guidelines and statistical data on AIDS and other diseases.

CHRONIC ***(disease)*** - Lasting a long time, or recurring often.

CONTACT TRACING - When public officials: (1) actively seek the names or trace the identity of persons who have come in contact with or have been exposed to a disease; and (2) actively notify these contacts concerning their possible exposure to the disease. Contact tracing is most commonly associated with certain contagious, highly infectious diseases, such as syphilis, HIV, or other sexually transmissible diseases.

CONTAGIOUS DISEASE - An illness caused by a specific infectious agent (i.e., a virus, bacteria, fungus) that is transmitted, directly or indirectly, from an infected person to a susceptible host.

CONTROLLED CLINICAL TRIAL - A clinical study in which two or more therapies are compared, and the decision as to which patient receives which therapy is often determined by chance. Some of these studies involve a "placebo," usually a pill that looks like the drug being studied but does not contain any active ingredients. Such research is referred to as a "blind study"; i.e., the patient does not know which treatment he is receiving. "Double blind" studies refer to trials in which neither doctor nor patient know which drug the patient is receiving.

CYTOMEGALOVIRUS - (CMV) A viral infection that may occur without any symptoms or result in mild flu-like symptoms. Severe CMV infections can result in hepatitis, mononucleosis, or pneumonia. CMV is "shed" in body fluids (urine, semen, sputum and saliva). In the presence of immune deficiency, such as AIDS, it can also affect other internal organs and vision, sometimes leading to blindness.

DECONTAMINATION - Removing disease-causing agents, thus making the environment or specific object safe to handle.

DIAGNOSIS - Identifying a disease by its signs, symptoms, course, and laboratory findings.

ELISA Test (Enzyme Linked Immunoabsorbent Assay) - A simple, rapid, sensitive blood test that measures

antibodies to HIV proteins. The ELISA test was licensed by the Food and Drug Administration in 1985 to screen blood supplies only. As a blood screening test, the ELISA is highly sensitive and produces a small number of "false positive" and "false negative" test results. Because false positives are produced, and the virus has a long incubation period, ELISAs are usually repeated if the first test is positive. If the patient tests positive a second time, then a more specific test, the Western Blot, is performed to confirm the results.

ENDEMIC - The constant presence of a disease or infectious agent, like a virus, within a geographic area or defined population. For example, HIV infection is estimated to be present in a large percentage of certain well-defined groups and is now considered to be endemic in that population.

EPIDEMIC - When an illness or disease occurs in a region, population or community clearly in excess of what is expected.

EPIDEMIOLOGY - The study of the incidence, distribution, and control of a disease in a population.

ETIOLOGY - The causes or origins of disease.

EXPOSURE - The act or condition of coming in contact with, but not necessarily being infected by, a disease-causing agent.

FALSE NEGATIVE - Incorrect test result indicating that no antibodies are present when they are.

FALSE POSITIVE - Incorrect test result indicating that antibodies are present when they are not.

HBIG - Hepatitis B immune globulin, which is a preparation that provides some temporary protection following exposure to HBV if given within 7 days after exposure.

HELPER/SUPPRESSOR T-CELLS - White blood cells that are part of the immune system.

HEPATITIS B (HBV) - A viral infection that affects the liver. The effects of the disease on the liver can range from mild, even inapparent, to severe or fatal.

HIGH-RISK BEHAVIOR - A term that describes certain activities that increase the risk of transmitting HIV or HBV. These include anal intercourse, vaginal intercourse without a condom, oral-anal contact, semen in the mouth, sharing intravenous needles.

HIV - (human immunodeficiency virus) the virus that causes AIDS. This specific AIDS retrovirus has been identified as destroying the body's immune system, making it susceptible to life-threatening, opportunistic infections or rare cancers. The HIV is believed to be a relatively new virus. It is particularly resistant to treatment, as the HIV genetic material is incorporated into the healthy genetic material of the blood cells and is reproduced. Because the HIV genetic material is reproduced, individuals who are infected with the virus remain carriers for the rest of their lives. The virus has a long incubation period; thus, it may be a long time between the point when a person is infected and when the antibodies can be detected (anywhere from two weeks to six months). It may also take up to five years or more before the disease becomes apparent and is diagnosed.

HIV-II - A retrovirus identified by the Pasteur Institute in Paris that has currently been isolated among West Africans and a small number of AIDS patients in France, West Germany and Great Britain. The virus is capable of causing clinical symptoms that are similar to those found in patients with AIDS and related disorders. In spite of this, HIV remains the main cause of concern for public officials and the general public.

HIV ANTIBODY POSITIVE - A test result indicating that HIV antibodies are found.

HIV ANTIBODY SCREENING TEST - A blood test that reveals the presence of antibodies to HIV.

HIV ANTIGEN POSITIVE - The result of antigen testing where it has been found that HIV is present. Antigen testing can be useful in predicting the progression of HIV infection and monitoring treatment.

HIV DISEASE - The term to describe the spectrum of HIV infection, chronologically described as a progression from asymptomatic seropositive to AIDS.

IMMUNE STATUS - The state of the body's immune system. Factors affecting immune status include heredity, age, diet, and physical and mental health.

IMMUNE SYSTEM - A complex network of organs and cells that allows the body to defend itself against infections and substances which are foreign to the body.

IMMUNOSUPPRESSED - A condition or state of the body in which the immune system does not work normally.

INCIDENCE - The number of new cases of a disease over a specified period of time.

INCUBATION PERIOD - The time period between infection and appearance of disease symptoms or clinical signs. Based on current data, the incubation period for the AIDS virus is estimated to range up to five or ten years. (See also latency period.)

INFECTION - A condition or state of the body in which a disease-causing agent has entered it.

INFECTIOUS DISEASE - An illness that results from the entry, development or multiplication of a disease-causing organism. Not all infectious diseases are highly contagious or easily communicable to other people. Although HIV is highly infectious, it is not easily or casually transmitted.

INFORMED CONSENT - When it is documented that a patient has been counseled by trained counselors about the positive as well as negative implications of undergoing a procedure and the patient agrees, in writing or verbally, to undergo that procedure.

INTRAVENOUS (IV) DRUGS - Drugs injected by needle directly into a vein.

LATENCY PERIOD - The time period between infection and appearance of disease symptoms or clinical signs. Based on current data, the latency period for the AIDS virus is estimated to range up to five or ten years. (See also incubation period.)

MMWR - (Morbidity and Mortality Weekly Report) a CDC weekly publication that gives information on current trends in the nation's health.

MUCOUS MEMBRANE - A moist layer of tissue that lines the mouth, eyes, nostrils, vagina, anus, or urethra.

MUTATION - A change in the genetic component of a human cell (i.e., DNA or RNA) that can cause the cell not to produce proteins or can change the proteins that are made.

NON-INTACT SKIN - Skin that is chapped, abraded, weeping, or that has rashes or eruptions.

OPPORTUNISTIC INFECTION - A type of infection that is usually warded off by a healthy immune

system. If the immune system is not strong and effective, this type of infection "takes the opportunity" to harm the body.

PATHOGEN - A disease-causing substance.

PEDIATRIC AIDS - Clinical AIDS in children under 13. Because more common or even rare congenital infections and congenital immune-related diseases must be eliminated as a cause of illness, a working definition of pediatric AIDS is open to more interpretation.

PERCUTANEOUSLY - Entering the body through the skin, for example, by needlestick or on broken skin.

PERICARDIAL FLUID - A clear fluid contained in the thin. membranous sac that surrounds the heart.

PERINATAL - Happening just before, during, or immediately after birth.

PERITONEAL FLUID - Fluid contained in the membrane lining of the abdominal cavity.

PERSONS WITH AIDS (PWA) - A preferred term for a person diagnosed with AIDS.

PLEURAL FLUID - Fluid contained in the membrane that covers the lung and lines the chest cavity.

PNEUMOCYSTIS CARINII PNEUMONIA (PCP) - A lung infection that has been common among people infected with HIV or diagnosed with AIDS.

PREDICTIVE VALUE - The likelihood that an individual with positive test results actually has the disease (i.e., is a true positive), or that one with a negative test does not have the disease (i.e., is a true negative). The predictive value of a positive test is equal to the number of true positive individuals divided by the number of all positives identified. Because the HIV antibody tests were designed to be highly sensitive and accurately identify as many true positives as possible, they have a very high predictive value, especially when used in high-risk populations, where the number of diseased people is high. The predictive value of positive test results generally decreases when performed in low-risk populations, where there are few diseased persons.

PREVALENCE - The number of people in a given population who have a disease, usually measured at a specific point in time.

RETROVIRUS - A special group of viruses that are proven to cause a variety of diseases in animals. A special type retrovirus, the human immunodeficiency virus (HIV), is believed to be the virus which causes AIDS.

REVERSE TRANSCRIPTASE - The enzyme unique to retroviruses that allows them to copy RNA to DNA and replicate themselves in the genetic material of the cell.

RISK FACTORS - Any personal characteristic or behavior that increases the likelihood that a person will be affected by a given condition. The risk factors that are believed to increase the chances of transmitting HIV infection include engaging in intimate sexual contact (in particular, vaginal or anal intercourse) without a condom, sharing IV needles, and other activities which involve the exchange of infected body fluids. Co-factors are additional characteristics or other conditions that work with other risk factors to increase the chances of getting a disease. For instance, having a diagnosed sexually transmissible disease or already weakened immune system are believed to be co-factors or increase the chances of being infected with HIV or progressing to ARC or AIDS.

SAFE SEX - Sexual practices that involve no exchange of blood, semen, or vaginal secretions.

SCREENING - The process of identifying undetected disease by using tests, examinations or other procedures. These are usually simple, quick procedures that can be applied to large numbers of people. The tests are used to separate apparently well individuals who probably have a disease from those who probably do not. A screening test is not designed to diagnose a disease. It is important for persons testing positive on a screening procedure to be diagnosed and receive appropriate treatment, if necessary. Generally, screening tests are directed towards or used in populations considered to be at high risk of contracting a disease.

SENSITIVITY - The ability of a screening test to identify individuals with a disease or condition; i.e., to identify "true positives." Most HIV antibody tests are highly sensitive, with the sensitivity of currently licensed tests averaging 99 percent or greater under optimal laboratory conditions. However, the sensitivity of the tests, or their ability to identify true positives, may vary according to the manufacturer of the test kit used, the prevalence of HIV infection in the test population, the quality assurance standards employed by the testing laboratory, the interpretation of the test results, and the standardization of values to determine the presence of HIV antibodies.

SEROCONVERT - When the status of a person's blood changes from being seronegative to seropositive. Because it may take from two weeks to six months for HIV antibodies to appear, and thus for a person to seroconvert, it may be necessary to retest high-risk patients who originally test negative after this period of time.

SEROLOGIC TEST - Any of a number of tests that are performed on blood. Usually refers to a test that measures antibodies to a virus.

SERONEGATIVE - The status of a person's blood when it is tested and the results cannot confirm that HIV antibodies are present. Generally, a person is considered to be seronegative if: (1) the initial ELISA is negative; (2) the initial ELISA is positive and the repeat ELISA is negative; or (3) both ELISAs are positive and the Western Blot is negative.

SEROPOSITIVE - A condition in which antibodies to a disease-causing agent are found in the blood, a positive reaction to a blood test. The presence of antibodies indicates that a person has been exposed to the agent.

SEROPREVALENCE - The relative frequency or number of individuals in a given population or community whose blood tests positive for an infection, in this case for HIV infection.

SIGNIFICANT EXPOSURE TO HIV INFECTION - A person is believed to be at particularly high risk of contracting HIV infection if he or she:

- Is or was a sexual partner of an HIV-infected male;
- Has shared needles with an HIV-infected drug user;
- Was injected with or has broken or abraded skin exposed to substantial amounts of blood or body fluid from HIV-infected persons;
- Has received blood, semen or body organs donated by an HIV-infected patient;
- Is a child born to an HIV-infected mother.

Vaginal intercourse allows for male-to-female transmission, but less frequently than does anal intercourse. Female-to-male transmission via vaginal intercourse is believed to be a less-frequent means of transmitting the infection. Persons who have non-sexual contacts with HIV-infected individuals via other means, such as through sharing residential or workplace facilities or even through casual kissing are not at high risk for infection. Therefore, these persons are not considered to have had significant exposure to HIV infection.

SPECIFICITY - The ability of a screening test to identify correctly people who do not have a specific disease or condition. To increase the chances that true negatives are identified using HIV antibody tests, a series of three tests are usually given. An individual must test positive on all three to be found positive. The specificity of currently licensed ELISA tests is 99 percent if repeat tests are completed.

STERILIZATION - Destruction of all microbial life by means of steam, gas, or liquid agents.

SUBCUTANEOUS - Beneath or introduced beneath the skin (for example, subcutaneous injections).

SURVEILLANCE - Surveillance of disease involves collecting, analyzing and interpreting public health data. This is done systematically and on an ongoing basis to study how disease occurs and spreads through the population. The data may also be used to help design programs to help prevent and control the spread of disease.

SYNDROME - A collection of signs and symptoms that occur together.

TESTING - Using tests on an individual, case-by-case basis to screen for or to confirm the presence of disease.

T-LYMPHOCYTE (T CELL) - A type of white blood cell that is essential to the body's immune system in its fight against infection. T cells help regulate the production of substances called antibodies. T4 lymphocytes are a special subset of T cells. T4 cells start the body's immune response and help the body protect itself against viruses, parasites, tumors, and fungi. The HIV virus interferes with the function of the T4 cells.

TRANSMISSION - The way in which a disease can be transferred from one person to another or the way in which a person is exposed to the disease. HIV may be transmitted in three main ways:

- ***Through intimate, unprotected sexual contact:*** male to male anal sexual intercourse is believed to be the most efficient means of transmitting HIV. Male-to-female transmission occurs, but less frequently. Female-to male sexual contact is currently believed to be a less frequent means of transmitting the infection.

- ***Through percutaneous exposure:*** through injections with contaminated or unsterilized needles. This primarily occurs with drug users who share needles when injecting drugs. Injection with contaminated blood products through blood transfusions received before 1985 was also a route of transmission.

- ***Through perinatal transmission:*** transfer of HIV from the mother to the infant: (1) through the placenta before the infant is born; (2) during the birth process itself; or (3) soon after birth through breast milk. Studies are still being conducted to see which mode of transmission occurs most frequently. Such information will help physicians decide the best way to care for pregnant women and new mothers and their infants who may be at risk of HIV infection. It is currently estimated that the chance that an infected mother will pass the virus to her child is 30 to 50 percent and believed to be higher if the mother is or becomes seriously ill during her pregnancy.

TRUE NEGATIVE - When test results from a healthy, non-diseased individual fail to show the presence

of a disease or condition. Commonly, to be considered a "true negative" for HIV infection, a person tests negative on one of two ELISAs or tests negative on the confirmatory Western Blot test.

TRUE POSITIVE - When test results from a diseased individual show the presence of that disease or condition. Commonly, to be considered a "true positive" for HIV infection, a person with HIV antibodies must have two positive ELISA tests confirmed by a positive Western Blot test.

TUBERCULOCIDAL - Capable of killing a moderately resistant bacterium, called mycobacterium tuberculosis var. bovi. This organism is one used in laboratory tests to classily disinfectant chemicals according to their power.

UNIVERSAL BLOOD PRECAUTIONS - Special procedures to avoid exposure to bloodborne diseases, such as HIV and HBV, by treating all blood and certain other body fluids as if they are infected. Universal precautions apply to blood and other body fluids containing visible blood, as well as to semen and vaginal secretions.

VACCINE - A drug made from non-living or modified virus, bacteria, etc., primarily to prevent certain infectious diseases. Vaccines stimulate the body's defense mechanisms, helping it to develop an immunity to the disease without actually causing the disease itself.

VIRUS - A microorganism that causes infectious diseases. It can reproduce only in living cells, which it invades and then destroys as it multiples.

WESTERN BLOT - A highly sensitive blood test that is able to identify and measure most, if not all, of the HIV antibodies in a blood sample. This test, which is more expensive than the ELISA, uses viral proteins separated by size that attach to the HIV antibodies in the patient's serum. It is used to confirm previously positive ELISAs; when patients test positive on the Western Blot, it is assumed that they have HIV antibodies. However, there is no guarantee that the virus can actually be isolated from the blood and, therefore, it is not always clear how infectious an antibody positive patient actually is or if he or she will progress to ARC or AIDS. In addition, laboratories using different chemical compounds or less stringent criteria when performing the Western Blot may produce more false-positive results.

WINDOW PERIOD - The time it takes the immune system to develop antibodies to the virus after exposure to it.

AIDS RESOURCE DIRECTORY:

NATIONAL ORGANIZATIONS

American Association of Physicians
for Human Rights
P.O. Box 14366
San Francisco, CA 94114

American Bar Association
AIDS Project
1800 M Street, N.W.
Washington, DC 20006

American Council of Life Insurance
1001 Pennsylvania Avenue, N.W.
Washington, DC 20006

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611

The American Foundation for AIDS Research
40 West 57th Street
New York, NY 10019

The American Hospital Association Advisory
Committee on Infections in Hospitals
840 N. Lake Shore Drive
Chicago, IL 61611

American Public Health Association
1015 15th Street, N.W.
Washington, DC 20005

American Red Cross
AIDS Education Office
1730 D Street, N.W.
Washington, DC 20006

American Social Health Association
100 Capitol Drive, Suite 200
Durham, NC 27713

Gay Men's Health Crisis
P.O. Box 274
132 West 24th Street
New York, NY 10011

The Hastings Center Project on AIDS
255 Elm Road
Briarcliff Manor, NY 10510

Health Insurance Association of America
1025 Connecticut Avenue, N.W., Suite 1200
Washington, DC 20036

Hispanic AIDS Forum
c/o APRED
835 Broadway, Suite 2007
New York, NY 10003

Mothers of AIDS Patients
c/o Barbara Peabody
3403 E Street
San Diego, CA 92102

National Academy of Sciences
Institute of Medicine
2101 Constitution Avenue, N.W.
Washington, DC 20418

National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850

National AIDS Network
1012 14th Street, NW, Suite 601
Washington, DC 20005

National Association of People with AIDS
1012 14th Street, NW, Suite 601
Washington, DC 20005

National Association of Public Hospitals
AIDS Committee
1001 Pennsylvania Avenue, N.W., Suite 635
Washington, DC 20004

National Coalition of Gay/STD Services
P.O. Box 239
Milwaukee, WI 53201

National Council of Churches AIDS Task Force
475 Riverside Drive, Room 350
New York, NY 10115

National Council of Churches
Minority Task Force on AIDS
92 St. Nicholas Avenue
New York, NY 10025

National Council of State Legislatures
1050 17th Street, Suite 2100
Denver, CO 80265

National Funeral Directors' Association
1121 West Oklahoma Avenue
Milwaukee, WI 43227

National Gay Rights Advocates
540 Castro Street
San Francisco, CA 94114

National Gay Task Force
1517 U Street, N.W.
Washington, DC 20009

National Governors' Association
444 North Capitol Street
Washington, DC 20001

National Hemophilia Foundation
104 East 23rd Street, Suite 506
New York, NY 10012

National Institute of Allergy
and Infectious Disease
Office of Communications
Building 31, Room 7A32
9000 Rockville Pike
Bethesda, MD 20892

National Institute of Justice
AIDS Clearinghouse
Box 6000
Rockville, MD 20850

National Jewish AIDS Project
2025 Eye Street, N.W., Suite 721
Washington, DC 20006

National Lawyers' Guild AIDS Task Force
853 Broadway, Suite 1705
New York, NY 10003

National Leadership Coalition
1150 17th Street, N.W., Suite 202
Washington, DC 20036

National Lesbian and Gay Health Foundation
P.O. Box 65472
Washington, DC 20035

National Research Council
Committee on AIDS Research
and the Behavioral and Social Sciences
National Academy of Sciences and Engineering
21011 Constitution Avenue, N.W.
Washington, DC 20418

National Sheriffs' Association
Research and Development Division
1450 Duke Street
Alexandria. VA 22314

Planned Parenthood Federation
Presidential Commission on the Human
Immunodeficiency Virus Epidemic
655 15th Street, N.W., Suite 901
Washington, DC 20005

U.S. Conference of Mayors
AIDS Information Exchange
1620 Eye Street, N.W.
Washington, DC 20006

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control
1600 Clifton Road, N.E.
Atlanta, GA 30333

U.S. Public Health Services
Hubert Humphrey Bldg., Room 721-H
200 Independence Ave., S.W.
Washington, DC 20201

Whitman-Walker Clinic AIDS Project
1407 S Street, N.W.
Washington, DC 20009

BIBLIOGRAPHY

Allen, Harry E., and Simonsen, Clifford E. ***Corrections in America: An Introduction*** (5th ed.). New York: Macmillan Publishing Co. 1989.

Altman, D.E. ***AIDS in the Mind of America.*** New York: Doubleday. 1986.

American Bar Association. ***AIDS: The Legal Issues.*** Discussion draft of the American Bar Association AIDS Coordinating Committee. Washington, DC: American Bar Association, 1988.

American Correctional Association. ***Standards for Adult Local Detention Facilities*** (2nd ed.). College Park, MD: 1981.

Barre'-Sinoussi, F., et al. "Isolation of a T-Lymphotropic Retrovirus from a Patient at Risk for AIDS." ***Science.*** May 1983.

Burgess, A.W., and Grant, C.A. ***Guidelines for professionals who counsel victims of sexual assault about HIV infection.*** Rockville, MD: National Institute of Mental Health. 1988.

Burgess, AW., and Holmstrom, L.L. ***Rape: Crisis and Recovery.*** Bowie, MD: Robert J. Brady and Co. 1984.

Camus, A. ***The Plague.*** (Translated from the French by Stuart Gilbert.) New York: Alfred A. Knopf, Inc., 1948.

Centers for Disease Control (CDC). "Update on Kaposi's Sarcoma and Opportunistic Infections in Previously Healthy Persons--United States." ***Morbidity and Mortality Weekly Report (MMWR),*** Vol. 31. Atlanta: U.S. Department of Health and Human Services, Public Health Service. June 11, 1982.

CDC. ***Recommendations and Guidelines Concerning AIDS Published in the MMWR - November 1982 through November 1986.*** September 1986.

CDC. "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome." ***MMWR,*** Vol. 36, No. 1s. August 14, 1987.

CDC. "Recommendations for Prevention of HIV Transmission in Health-Care Settings." ***MMWR*** (Supplement), Vol. 36, No. 2S, August 1987.

CDC. "Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge." ***MMWR*** (Supplement), Vol. 36, No. S-6. December 18, 1987.

CDC. "Partner Notification for Preventing HIV Infection in Colorado, Idaho, South Carolina, and Virginia." ***MMWR,*** Vol. 37. July 1, 1988.

CDC. "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings." ***MMWR,*** Vol. 37, No. 24, 1988.

CDC. "Prevention and Control of Tuberculosis in Correctional Institutions. Recommendations of the Advisory Committee for the Elimination of Tuberculosis." ***MMWR,*** Vol. 38, No. 18. May 12, 1989.

CDC. "Interpretation and Use of the Western Blot Assay for Serodiagnosis of Human Immunodeficiency Virus Type 1 Infections." ***MMWR,*** Vol. 38, No. S-7. July 21, 1989.

CDC. ***HIV/AIDS Surveillance Report.*** July 1990.

CDC and the National Institute for Occupational Safety and Health (NIOSH). ***Guidelines for Prevention of Transmission of HIV and HBV to Health Care and Public Safety Workers.*** Atlanta: U.S. Department of Health and Human Services, Public Health Service. February 1989.

Chamberland, M.E., and Dondero, J.I. "Heterosexually acquired infection with human immunodeficiency virus." ***Annals of Internal Medicine,*** Vol. 107. 1987.

Christ, G.H., et al. "Psychological Issues in AIDS." ***Psychiatric Annals,*** Vol. 16, No. 3. 1986.

Clavel, F., et al. "Isolation of a New Human Retrovirus from West African Patients with AIDS." ***Science.*** July 1986.

Clavel, F.; Mansinho, K.; Chamaret, S., et al. "Human Immunodeficiency Virus Type II Infection Associated with AIDS in West Africa." ***The New England Journal of Medicine,*** Vol. 316, No. 19. May 7, 1987.

Clear, Todd, and O'Leary, Vincent. ***Controlling the Offender in the Community.*** Lexington, MA: Lexington Books. 1983.

Coppola, V., and Zabarsky M. "Coming Out of the Closet." ***Newsweek.*** August 8, 1983.

Curran, J.W.; Morgan, W.M.; Hardy AM., et al. "The Epidemiology of AIDS: Current Status and Future Prospects." ***Science,*** Vol. 229. September 27, 1985.

Curran, J.W., et al. "Acquired Immunodeficiency Syndrome Associated with Transfusions." New ***England Journal of Medicine,*** Vol. 310. 1984.

de Clerq, E. "Chemotherapeutic approaches to the treatment of AIDS." ***Journal of Medical Chemistry,*** Vol. 29, 1986.

Des Jarlais, D., et al. "Intravenous drug use and the heterosexual transmission of the human immunodeficiency virus." ***New York State Journal of Medicine,*** Vol. 87. May 1987.

Des Jarlais, D., and Freidman, S. "AIDS Among Intravenous Drug Users: Current Research in Epidemiology, Natural History and Prevention Strategies." Paper presented at the AIDS Epidemiology Workshop, National Academy of Sciences--Institute of Medicine, Washington, DC, March 6, 1986.

Des Jarlais, D., and Friedman, S. "HIV Infection Among Intravenous Drug Users: Epidemiology and Risk Reduction." ***AIDS:*** An International Bi-monthly Journal, Vol. 1. 1987.

Des Jarlais, D., and Hunt, D.C. "AIDS and Intravenous Drug Use." ***AIDS Bulletin.*** Washington, DC: National Institute of Justice. 1988.

Duffee, David E., ***Corrections Practice and Policy.*** New York: Random House, Inc. 1989.

Essex, M., and Kanki, P. "The Origins of the AIDS Virus." ***Scientific American.*** October 1988.

Friedland, G. "Lack of Transmission of HTLV-lll/LAV Infection to Household Contacts of Patients with

AIDS or AIDS-Related Complex with Oral Candidias." ***New England Journal of Medicine,*** Vol. 314. 1986.

Friedland, G., et al. "Intravenous Drug Abusers and Acquired Immunodeficiency Syndrome: Demographic Drug Use and Needle-Sharing Patterns." ***Archives of Internal Medicine,*** Vol. 245. 1985.

Gallo, R.C., and Montagnier, L. "AIDS in 1988." ***Scientific American.*** October 1988.

George Washington University, AIDS Policy Center. ***Intergovernmental AIDS Reports,*** Vol. 2, No. 5. Washington, DC: 1989.

Gostin, L. "Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States." ***JAMA.*** March 17, 1989.

Gostin, L., and Curran, W.J. "AIDS Screening, Confidentiality, and the Duty to Warn." ***American Journal of Public Health,*** Vol. 77, No. 3. March 1987.

Gostin, L., and Curran, W.J. "Legal Control Measures for AIDS: Reporting Requirements, Surveillance, Quarantine, and Regulation of Public Meeting Places." ***American Journal of Public Health,*** Vol. 77, No. 2. February 1987.

Gostin, L., and Zeigler, L. "A Review of AIDS-related Legislative and Regulatory Policy in the United States. ***Law, Medicine and Health Care,*** Vol. 15. 1987.

Gottlieb, et al. "Pneumocystis carinii pneumonia and mucosal candidiasis in previously healthy homosexual men." ***The New England Journal of Medicine,*** Volume 305. 1981.

Griggs, J., ed. ***AIDS: Public Policy Dimensions.*** New York: United Hospital Fund. 1987.

Grossman, R.J., "Psychosocial Support in AIDS: A Practitioner's View." In ***AIDS.*** Ed. A Friedman, New York: Masson, Inc. 1984.

Hammett, T.M., et al. ***1988 Update: AIDS in Correctional Facilities.*** Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. 1989.

Hammett, Theodore M. "HIV Antibody Testing: Procedures, Interpretation, and Reliability of Results." ***National Institute of Justice AIDS Bulletin.*** October 1988.

Haseltime, W.A., and Wong-Staal, F. "The Molecular Biology of the AIDS Virus." ***Scientific American.*** October 1988.

Heyward, W.L., and Curran, J.W. "The Epidemiology of AIDS in the U.S." ***Scientific American.*** October 1988.

Kanki, P., et al. "Isolation of T-Lymphotropic Retrovirus Related to HTLV-III/LAV from Wild Caught African Green Monkeys." ***Science. Nov.*** 1985.

Klein, J.A. ***AIDS: An Employer's Guidebook.*** Washington, DC: U.S. Chamber of Commerce. 1989.

Krim, M. "The Human Immunodeficiency Virus." in Griggs, J. ***AIDS: Public Policy Dimensions. New*** York: United Hospital Fund, 1987.

Laszlo, AT., and Ayres, M.B. ***AIDS: Improving the Response of the Correctional System.*** Alexandria, Virginia: National Sheriffs' Association. 1986.

Laszlo, AT. "HIV Infection, Illegal Drug Use and High-Risk Youth." Paper presented at National Conference on Crimes Against Children. Washington, DC: U.S. Department of Justice. February 1989.

Leonard, Arthur S. "AIDS in the Workplace." In ***AIDS*** and ***the Law.*** Ed. Harlon L. Dalton, Scott Burris, and the Yale AIDS Law Project. New Haven, CT: Yale University Press. 1987.

Lifson, AR. "Do Alternate Modes of Transmission of HIV Exist?" ***Journal of the American Medical Association,*** Vol 259, No. 9. March 4, 1988.

MacDonald, Malcolm. "An Official Statement of the American Probation and Parole Association to the President's Commission on Human Immunodeficiency Virus Epidemic: AIDS Issues in Probation and Parole." ***Perspectives.*** Summer 1988.

Mann, J.M., et al. "Surveillance for AIDS in a Central African City." ***JAMA,*** Vol. 255. 1986.

Marzuk, P.M., et al. "Increased Suicide in Persons with AIDS." ***JAMA,*** Vol. 259, No. 9. March 4, 1988.

Masur, H., et al. "An outbreak of community-acquired pneumocystis carinii pneumonia." ***New England Journal of Medicine,*** Vol. 305. 1984.

Matthews, Thomas J., and Bolognesi, Dani P. "AIDS Vaccines." ***Scientific American.*** October 1988.

National Commission on Correctional Health Care. "Commission Adopts AIDS Policy." ***CorrectCare,*** Vol. 2, Issue 1. January 1988.

National Institute for Occupational Safety and Health, (NIOSH.) ***A Curriculum Guide for Public Safety and Emergency Response Workers.*** Atlanta: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control. February 1989.

National Sheriffs' Association. "Condoms In Jails: ***Yes. No." The National Sheriff,*** Vol. 41, No. 6. December 1989-January 1990.

Nichols, S.E., and Ostrow, D.G., eds. ***Psychiatric Implications of Acquired Immune Deficiency Syndrome.*** Washington, DC: American Psychiatric Press. 1984.

Peterman, T.A., et al. "Risk of HIV transmission from heterosexual adults with transfusion-associated infections." ***JAMA.*** 1988.

Presidential Commission on the HIV Epidemic. Washington, DC: U.S. Government Printing Office Press. 1988.

Ressler, R.J., et al. ***Sexual Homicide: Patterns and Motives.*** Lexington, MA: Lexington Books. 1988.

Robbins, R.K "Synthetic Anti-viral Agents." ***Chemistry and Engineering.*** January 27, 1986.

Rogers, M.F. "AIDS in Children: A Review of the Clinical, Epidemiological and Public Health Aspects." In Kenneth J. Bart. ***Current Issues in Pediatrics.*** Atlanta: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control. 1985.

Rothstein, Mark A. "Screening Workers for AIDS." In ***AIDS and the Law.*** Ed. Harlon L. Dalton, Scott Burris, and the Yale AIDS Law Project. New Haven, CT: Yale University Press. 1987.

Rowe, Mona and Ryan, Caitlin. ***A Governor's Policy Guide on AIDS.*** Washington, DC: The National Governors' Association. 1989.

Sande, M.A. "Transmission of AIDS: The Case Against Casual Contagion." ***The New England Journal of Medicine,*** Vol. 314, No. 6. February 6, 1986.

Scott, G.B., et al. "Mothers of Infants with AIDS." ***Journal of the American Medical Association,*** Vol. 253. 1985.

Singleton, J.A., et al. ***HIV Seroprevalence Among Prisoners Entering the California Correctional System.*** Sacramento, CA, Department of Health Services. 1989.

Small, C.B. "Community Acquired Opportunistic Infections and Defective Cellular Immunity Among Heterosexual Drug Users and Homosexual Men." ***American Journal of Medicine,*** Vol. 74. 1983.

Takas, Marianne, and Hammett, Theodore M. "Legal Issues Affecting Offenders and Staff." ***AIDS Bulletin.*** National Institute of Justice. May 1989.

Truman, B.I., et al. "HIV Seroprevalence and Risk Factors Among Prison Inmates Entering New York State Prisons." Paper presented at 4th International AIDS Conference, Stockholm, June 1988.

U.S. Department of Health and Human Services. ***Study of Runaways and Youth.*** Washington, DC. 1986.

U.S. Department of Justice. ***AIDS in the Workplace: The Manager's Role and Responsibility.*** Washington, DC: U.S. Government Printing Office. 1988.

Wish, E.D., et al. "Lost Opportunity to Combat AIDS: Drug Abuse in the Criminal Justice System." Paper presented at the National Institute on Drug Abuse Technical Review Session on AIDS and Intravenous Drug Use. July 1, 1988.

Wish, E.D., and Johnson, B.D. "The Impact of Substance Abuse on Criminal Careers." ***Criminal Careers and Career Criminals.*** Washington, DC: National Academy Press. 1986.

World Health Communications, Inc. ***Management of HIV Treatment Team Workshop Handbook. New*** York: World Health Communications, Inc. 1988.

ADDITIONAL READING

Acquired Immune Deficiency Syndrome: A Demographic Profile of New York State Inmate Mortalities 1981- 1985. New York State Commission of Correction. March 1986.

Acquired Immune Deficiency syndrome in California: A Prescription for Meeting the Needs of 1990. California Department of Health Services. Sacramento, CA: March 1986.

AIDS: The American Medical Association's Monographs on AIDS. AMA Chicago: April 1987.

"The AIDS Crisis in New York: A Legislative Perspective and Agenda for Study." Prepared by the staff of the New York State Senate Majority Task Force on AIDS. June 1987.

AIDS: Diagnosis of a Dawning Crisis. (A report of the Health Care Task Force of the Midwestern Legislative Conference of the Council of State Governments.) Prepared by Philip Schutte and Chris Ertel. May 1987.

"Aids: The Emerging Ethical Dilemmas." ***Hastings Center Report*** (Special Supplement). Vol. 15, No. 4. August 1985.

"The AIDS Epidemic and Business: A Frightening Disease Poses Delicate Questions for Employers." ***Business Week,*** No. 2991. March 23, 1987.

"AIDS in the Heartland: The Legislative Response." (A Review and Summary of 1987 State AIDS Legislation in the Midwest.) A report of the Health Care Task Force of the Midwestern Legislative Conference of the Council of State Governments. Prepared by Philip Schutte, August 1987.

"AIDS and HTLV-III Infection." ***Prevention Notes.*** (Newsletter on state preventive health services of the Association of State and Territorial Health Officials.) Issue 20. January-February 1987.

"AIDS and HIV Infection - Part 2". ***Prevention Notes.*** (Newsletter on state preventive health services of the Association of State and Territorial Health Officials.) Issue 21. March-April 1987.

AIDS Legal Guide. Lambda Legal Defense and Education Fund, Inc. New York: 1984.

"AIDS and People of Color: The Discriminatory Impact." Report prepared by the AIDS Discrimination Unit of the New York City Commission on Human Rights. November 13, 1986.

"AIDS Prevention: Views on the Administration's Budget Proposals." (Briefing Report to the Chairman, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. Senate.) General Accounting Office. Washington, DC: August 1987.

"AIDS: The Public Context of an Epidemic." ***The Milbank Quarterly*** (Supplement l), Vol. 64. 1986.

"AIDS: Public Health and Civil Liberties." ***Hastings Center Report*** (Special Supplement), Vol. 16, No. 6. December 1986.

AIDS and the Schools. (A Position Statement from the NASW Commission on Education.) National Association of Social Workers, Inc. Silver Springs, MD: August 1987.

Altman, D.E. Testimony provided before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives, March 5, 1986.

Arno, P.S. "AIDS: A Balancing Act of Resources." ***Business and Health,*** Vol. 4, NO. 2. December 1986.

Arno, P.S. "The Non-Profit Sector's Response to the AIDS Epidemic: Community-Based Services in San Francisco." ***American Journal of Public Health,*** Vol. 76, No. 11. November 1986.

Arno, P.S., and Hughes, R.G. "Local Policy Responses to the AIDS Epidemic: New York and San Francisco." ***New York State Journal of Medicine,*** Vol. 87, No. 5. May 1987.

Barnes, D.M. "AIDS: Statistics But Few Answers." ***Science,*** Vol. 236. June 12, 1987.

Barnes, D.M. "Brain Damage by AIDS Under Active Study." ***Science,*** Vol. 235. March 27, 1987.

Barnes, D.M. Broad Issues Debated at AIDS Vaccine Workshop." ***Science,*** Vol. 236. April 17, 1987.

Barnes, D.M. "Keeping the AIDS Virus Out of the Blood Supply. ***Science,*** Vol. 233. August 1, 1986.

Beneson, ***AS.,*** ed. ***Control of Communicable Diseases in Man*** (14th ed.). Washington, DC: The American Public Health Association, 1985.

Berrill, K. Testimony on anti-gay violence provided before the Sub-committee on Criminal Justice of the Committee on Judiciary, U.S. House of Representatives, October 7, 1986.

Binder, R.L. "AIDS Antibody Tests on Inpatient Psychiatric Units." ***American Journal of Psychiatry,*** Vol. 144, No. 2. February 1987.

Boland, M., and Rizzi, D. ***The Child with AIDS (Human Immunodeficiency Syndrome: A Guide for the Family).*** Newark, NJ: United Hospital Medical Center, Children's Hospital of New Jersey. 1986.

Brakel, S.J.; Parry, J.; and Weiner, B.A. ***The Mentally Disabled and the Law*** (3rd ed.). Chicago: American Bar Foundation, 1985.

Brandt, A.M. ***No Magic Bullet: A Social History of Venereal Disease in the United States since 1880. New*** York: Oxford University Press, 1985.

Branson, B.M. ***AIDS and the Nursing Home Patient.*** Prepared for American Health Care Association and the National Foundation for Long Term Health Care by the Health Education Resource Organization, October 1985.

Carbine, M.E., and Lee, P. ***AIDS in the*** 90s. Washington, DC: National Aids Network, 1988.

Carlson, G.A., and McClellan, T.A. "The Voluntary Acceptance of HIV Antibody Screening by Intravenous Drug Users." ***Public Health Reports,*** Vol. 102, No. 4. July-August 1987.

Centers for Disease Control (CDC). "Antibody to Human Immunodeficiency Virus in Female Prostitutes." ***Morbidity and Mortality Weekly Report*** (MMWR), Vol. 36. Atlanta: U.S. Department of Health and Human Services, Public Health Service, March 27, 1987.

CDC. "The History of Patient Interviewing and Sex Partner Referral in the Control of Sexually Transmitted Diseases." Paper prepared by CDC, April 1987.

CDC. ***Recommended Additional Guidelines for HIV Antibody Counseling and Testing in the Prevention of HIV Infection and AIDS.*** April 30, 1987.

CDC. "Increases in Primary and Secondary Syphilis - United States." ***MMWR,*** Vol. 36, No. 25. July 3, 1987.

CDC. "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS." ***MMWR,*** Vol. 36, No. 31. August 14, 1987.

Chachkes, E. "The Social Health Care of Children and Women with AIDS." In ***Responding to the Challenge of AIDS: Psychosocial Initiatives.*** Washington, DC: The National Association of Social Workers, 1987.

Chaisson, R.E.; Moss, AR.; Onishi, R., et al. "Human Immunodeficiency Virus Infection in Heterosexual IV Drug Users in San Francisco." ***American Journal of Public Health,*** Vol. 77, No. 2. February 1987.

Clinton, J.J. Testimony provided before the Committee on Labor and Human Resources, U.S. Senate, April 16, 1986.

Cole, H.M., and Lundberg, G.D., eds. ***Journal of the American Medical Association - AIDS From the Beginning.*** Chicago: American Medical Association, 1986.

Collier, AC.; Barnes, R.C.; and Handsfield, H.H. "Prevalence of Antibody to LAV/HTLV-III among Homosexual Men in Seattle." ***American Journal of Public Health,*** Vol. 76, No. 5. May 1986.

"Consensus Conference: The Impact of Routine HTLV-III Antibody Testing of Blood and Plasma Donors on Public Health." ***JAMA,*** Vol. 256, No. 13. October 3, 1986.

Conte, J.E., Jr. "Infection with Human Immunodeficiency Virus in the Hospital." ***Annuls of Internal Medicine,*** Vol. 105, No. 5. November 1986.

"Coolfont Report: A Public Health Service Plan for Prevention and Control of AIDS and the AIDS Virus.' ***Public Health Reports,*** Vol. 101, No. 4. July-August 1986.

The Council on Scientific Affairs of the American Medical Association. "Autologous Blood Transfusions." ***JAMA,*** Vol. 256, No. 17. November 7, 1986.

Curran, J., et al. ***AIDS: Legal and Regulatory Policy.*** Cambridge, MA: Harvard School of Public Health, 1986.

Curran, W.; Gostin, L; and Clark, M. ***Acquired Immunodeficiency Syndrome: Legal and Regulatory Policy.*** Springfield, VA: National Technical Information Service, July 1986.

Darrow, W.W.; Echenberg, D.F.; Jaffe, H.W., et al. "Risk Factors for Human Immunodeficiency Virus (HIV) Infections in Homosexual Men." ***American Journal of Public Health,*** Vol. 77, No. 4. April 1987.

DeClemente, R.J.; Zorn, J.; and Temoshok, L. "Adolescents and AIDS: A Survey of Knowledge, Attitudes, and Beliefs About AIDS in San Francisco." ***American Journal of Public Health,*** Vol. 76, No. 12. December 1986.

Dennings, J. Testimony provided before the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, March 4, 1987.

Dowdle, W. "The Search for an AIDS Vaccine." ***Public Health Reports,*** Vol. 101, No. 3. May-June 1986.

Drotman, P.D. "Now is the Time to Prevent AIDS." (Editorial) ***American Journal of Public Health,*** Vol. 77, No. 2. February 1987.

Dunne, R.D. Testimony provided before the Subcommittee on Human Resources and Intergovernmental Relations of the Committee on Governmental Operations, U.S. House of Representatives, March 16, 1987.

Faulstick, M.E. "Psychiatric Aspects of AIDS." ***American Journal of Psychiatly,*** Vol. 144, No. 5. May 1987.

Feuer, D. "AIDS at Work: Fighting the Fear." ***Training.*** June 1987.

Field, MA., et al. "AIDS and the Criminal Law." ***Law and Medical Health Care,*** Vol. 15. 1987.

Fineberg, H.B. Testimony provided before the Committee on Labor and Human Resources, U.S. Senate, April 16, 1986.

Fischi, M.A.; Dickinson, G.M.; Scott, G.B., et al. "Acquired Immunodefiency Syndrome in Low-Incidence Areas." ***JAMA,*** Vol. 258, No. 6. August 14, 1987.

Francis, D.P., and Chin, J. "The Prevention of Acquired Immunodefiency Syndrome in the United States." *JAMA,* Vol. 257, No. 10. March 13, 1987.

Franke, K. M. "AIDS as a Physical Handicap Under State Law." AIDS and Employment Project, San Francisco: May 18, 1987.

Gallo, R.C. "The First Human Retrovirus." (Part I of a two-part article on the human retroviruses.) ***Scientific American,*** Vol. 255, No. 6. December 1986.

Gallo, R.C. "The AIDS Virus." (Part II of a two-part article on the human retroviruses.) ***Scientific American,*** Vol. 256, No. 1. January 1987.

Gartner, S.; Markovits, P.; Markovitz, D.M., et al. "Virus Isolation from the Identification of HTLV-III/LAV-Producing Cells in Brain Tissue from a Patient with AIDS." ***JAMA,*** Vol. 256, No. 17. November 7, 1986.

Gebbie, J. Testimony provided before the Subcommittee on Human Resources and Intergovernmental Relations of the Committee on Government Operations, U.S. House of Representatives, March 16, 1987.

Gellman, R.M. "Prescribing Privacy: the Uncertain Role of the Physician in the Protection of Patient Privacy." ***North Carolina Law Review,*** Vol. 62, No. 2. 1983-1984.

Gerald, G. Testimony provided before the Subcommittee on Human Resources and Intergovernmental Relations of the Committee on Government Operations, U.S. House of Representatives, March 16, 1987.

Gerber, P.C. "AIDS: How Great is the Risk for Physicians?" ***Physician's Management,*** Vol. 26, NO. 7. July 1986.

Gerberding, J.L., and the University of California at San Francisco Task Force on AIDS. "Recommended Infection-Control Policies for Patients with Human Immunodeficiency Virus Infection - An Update."

The New England Journal of Medicine, Vol. 315, No. 24. December 11, 1986.

Gooding, D.E. Testimony provided before the NAIC 1986 Western Zone Meeting - AIDS Panel Presentation, San Francisco, CA, March 11, 1986.

Greene, R.R. "Case Management: Helping the Homeless and Persons with AIDS and Their Families." (Concept Paper.) National Association of Social Workers, Inc. Silver Spring, MD: 1987.

Halper, H.R. "AIDS Court Case Raises Many Serious Right of Privacy Questions." ***Business and Health,*** Vol. 3. No. 6. May 1986.

Hardy, AM. "Planning for the Health Care Needs of Patients with AIDS." ***JAMA,*** Vol. 256, No. 22. December 12, 1986.

Hardy, AM.; Stracher, E. Thomas; Morgan, W.M., et al. "Review of Death Certificates to Assess Adequacy of AIDS Case Reporting." ***Public Health Reports,*** Vol. 102, No. 4. July-August 1987.

Haugen, R.K., and Hill, G.E. "A Large-Scale Autologous Blood Program in a Community Hospital." ***JAMA,*** Vol. 257, No. 9. March 6, 1987.

Henderson, D.K., et al. "Risk of Nosocomial Infection with Human T-Cell Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in a Large Cohort of Intensively Exposed Health Care Workers." ***Annuls of Internal Medicine,*** Vol. 104, No. 5. May 1986.

Hill, I.T. "Broadening Medicaid Coverage of Pregnant Women and Children: State Policy Response." Health Policy Studies of the Center for Policy Research at the National Governor's Association, Washington, DC. February 1987.

Holland, E.J., and Wing, D.L. "AIDS and Hospitals--The Emerging Legal Issues." ***Hospital Law Manual.*** (Special Supplement.) March 1986.

Horsburgh, C.R., Jr.; Douglas, J.E.; and LaForce, F. Marc. "Preventive Strategies in Sexually Transmitted Diseases for the Primary Care Physician." ***JAMA,*** Vol. 258, No. 6. August 14, 1987.

Hunter, N.D. "AIDS Prevention and Civil Liberties: The False Promise of Proposals for Mandatory Testing." The American Civil Liberties Union Foundation. New York: 1987.

"Information on AIDS for the Practicing Physician." Prepared in 2 volumes by the American Medical Association, with funding from the Pharmaceutical Manufacturers' Association, Pharmaceutical Manufacturers' Association Foundation, and the National Council on Drugs, Inc. 1987.

The Institute of Medicine of the National Academy of Sciences. ***Confronting AIDS: Directions for Public Health, Health Care, and Research.*** Washington, DC: The National Academy Press, 1986.

Jason, J.; Holman R.C.; Dixon, G., et al. "Effects of Exposure to Factor Concentrates Containing Donations from Identified AIDS Patients." ***JAMA,*** Vol. 256, No. 13. October 3, 1986.

Jenness, D. "Scientists' Roles in AIDS Control." (Editorial.) ***Science,*** Vol. 233, No. 4766. August 22, 1986.

Johns, D.R.; Tierney, M.; and Felsenstein, D. "Alteration in the Natural History of Neosyphilis by Concurrent Infection with the HIV." ***The New England Journal of Medicine,*** Vol. 316, No. 25. June 18, 1987.

Jonsen, AR.; Cooke, M.; and Koenig, B.A. "AIDS and Ethics." ***Issues in Science and Technology,*** Vol. 2, No. 2. Winter 1986.

Joseph, S.C. Testimony provided before the Subcommittee on Human Resources and Intergovernmental Relations of the Committee on Government Operations, U.S. House of Representatives, March 16, 1987.

"Justice Department's AIDS Memo Reviewed." ***Mental and Physical Disability Law Reporter,*** Vol. 10, No. 4. July-August 1986.

Kaplan, L.D.; Wofsy, C.B.; and Volberding, PA. "Treatment of Patients with Acquired Immunodeficiency Syndrome and Associated Manifestations." ***JAMA,*** Vol. 257, No. 10. March 13, 1987.

Keeling, Richard P., ed. ***AIDS on the College Campus: ACHA Special Report.*** Produced by the Task Force on AIDS of the American College Health Association, 1986.

Kelly, J.k; St. Lawrence, J.S.; Smith, S., Jr., et al. "Stigmatization of AIDS Patients by Physicians." ***American Journal of Public Health,*** Vol. 77, No. 7. July 1987.

"Key Epidemiologic Questions About AIDS and Infections with HTLV-III/LAV." (Developed by the Epidemiology and Prevention Workgroup of the Public Health Service Executive Task Force on AIDS.) ***Public Health Reports,*** Vol. 101, No. 3. May-June 1986.

Kitch, E.W. "The Vaccine Dilemma." ***Issues in Science and Technology,*** Vol. 2, No. 2. Winter 1986.

Kizer, K.W.; Rodriguez, J.; and McHollard, G.F. ***An Updated Quantitative Analysis of AIDS in California.*** California Department of Health Services, Sacramento, CA: April 1987.

Kleiman, M.A.F., and Mockleer, R.W. "AIDS, the Criminal Justice System, and Civil Liberties." ***Governance Harvard Journal of Public Policy,*** Summer-Fall 1987.

Kolata, G. "Imminent Marketing of AZT Raises Problems." ***Science,*** Vol. 235, No. 4795. March 20, 1987.

Kolata, G. "Mathematical Model Predicts AIDS Spread." ***Science,*** Vol. 235, No. 4795. March 20, 1987.

Koop, C.E. "Surgeon General's Report on Acquired Immune Deficiency Syndrome." ***JAMA,*** Vol. 256, No. 20. November 28, 1986.

Koop, C.E. "Surgeon General's Report on Acquired Immune Deficiency Syndrome." (Editorial.) ***Public Health Reports,*** Vol. 102, No. 1. January-February 1987.

Koshland, D.E., Jr. "Epidemics and Civil Rights." ***Science,*** Vol. 235, No. 4790. February 13, 1987.

Kosterlitz, J. "Educating About AIDS." ***National Journal,*** August 30, 1986. No. 35.

Kristal, A.R. "The Impact of the Acquired Immunodeficiency Syndrome on Patterns in New York City." ***JAMA*** Vol. 255, No. 17. May 2, 1987.

Kuhls, T.L.; Viker, S.; Parris, N.B., et al. "Occupational Risk of HIV, HBV and HSV-2 Infections in Health Care Personnel Caring for AIDS Patients." ***American Journal of Public Health,*** Vol. 77, No. 10. October 1987.

Lautzenheiser, B. Testimony provided before the Committee on Labor and Human Resources, U.S. Senate, April 16, 1986.

Lawlor, HA. "Providers Cautiously Implement AIDS Programs." ***Today's Nursing Home,*** Vol. 7, No. 11. November 1986.

Lederman, M.M. "Transmission of the Acquired Immunodeficiency Syndrome Through Heterosexual Activity." (Editorial.) ***Annals of Internal Medicine,*** Vol. 104, No. 1. January 1986.

Lee, P.R. "AIDS: Allocating Resources for Research and Patient Care." ***Issues in Science and Technology,*** Vol. 2, No. 2. Winter 1986.

Leishman, K. "AIDS and Insects." ***The Atlantic Monthly,*** Vol. 260, No. 3. September 1987.

Leishman, K. "Heterosexuals and AIDS." ***The Atlantic Monthly,*** Vol. 259, No. 2. February 1987.

Leukefeld, C., and Fimbres, M., eds. ***Responding to AIDS: Psychosocial Initiatives.*** National Association of Social Workers, Washington, DC: 1987.

Levi, J. Testimony provided before the Committee on Labor and Human Resources, U.S. Senate, April 16, 1986.

"Local School Districts Active in AIDS Education." ***AIDS Information Exchange,*** Vol. 4, No. 1. January 1987.

Martin, Lisa. "Home Care for Children with AIDS." ***Caring,*** December 1986.

Marx, J.L. "Probing the AIDS Virus and Its Relatives." ***Science,*** Vol. 236, No. 4808. June 19, 1987.

Mason, J.O. "Statement on the Development of Guidelines for the Prevention of AIDS Transmission in the Workplace." ***Public Health Reports,*** Vol. 101, No. 1. January-February 1986.

Matthews, G.W., and Newlund, V.S. "The Initial Impact of AIDS on Public Health Law in the United States - 1986." ***JAMA,*** Vol. 257, No. 3. January 16, 1987.

Mays, V.M., and Cochran, S.D. "Acquired Immune Deficiency Syndrome and Black Americans: Special Psychological Issues." ***Public Health Reports,*** Vol. 102, No. 2. March-April 1987.

McAuliffe, W.E. "Intravenous Drug Use and the Spread of AIDS." ***Governance - Harvard Journal of Public Policy,*** Summer-Fall 1987.

McLaughlin, N. "AIDS: Healthcare's Deadly Challenge." ***Modem Healthcare,*** Vol. 16, No. 25. December 5, 1986.

McNeill, W.H. ***Plagues and Peoples.*** Garden City, NY: Anchor Books, a Division of Anchor Press/Doubleday, 1976.

Mills, M.; Wofsy, C.B.; and Mills, J. "The Acquired Immunodeficiency Syndrome: Infection Control and Public Health Law." ***The New England Journal of Medicine,*** Vol. 314, No. 14. April 3, 1986.

Morgan, W.M., and Curran, J.W. "Acquired Immunodeficiency Syndrome: Current and Future Trends."

Public Health Reports, Vol. 101, No. 5. September-October 1986.

Morin, S.F., and Batchelor, W.F. "Responding to the Psychological Crisis of AIDS." ***Public Health Reports,*** Vol. 99, No. 1. January-February 1984.

National Governors' Association. "Policy Position on AIDS." National Governors' Association, Washington, DC: July 28, 1987.

National Institutes of Health. "The Impact of Routine HTLV-III Antibody Testing of Blood and Plasma Donors on Public Health." (Consensus Conference Statement.) ***JAMA,*** Vol. 256, No. 13. October 3, 1986.

National Institute of Mental Health. ***Coping with AIDS: Psychological and Social Considerations in Helping People with HTLB-III Infection.*** Washington, DC: U.S. Government Printing Office, 1986.

"The Nature and Extent of Collaboration Among Public and Private Organizations Responding to AIDS in Nine Cities." (Draft.) Prepared for the Centers for Disease Control of the Public Health Services, 1984.

Office of Technology Assessment. "Do Insects Transmit AIDS?" (A Staff Paper in OTA's Series on AIDS-Related Issues.) Prepared by Lawrence Miike. Washington, DC: U.S. Government Printing Office, September 1987.

Office of Technology Assessment. ***Review of the Public Health Service's Response to AIDS: A Technical Memorandum.*** Washington, DC: 1985.

Oppenheimer, G.M., and Padgug, R.A. "AIDS: The Risks to Insurers, the Threat to Equity." ***Hastings Center Report,*** Vol. 16, No.5. October 1986.

Osborn, J.E. "The AIDS Epidemic: An Overview of the Science." ***Issues in Science and Technology,*** Vol. 2, No. 2. Winter 1986.

Osborn, J.E. "The AIDS Epidemic: Multidisciplinary Trouble." ***The New England Journal of Medicine,*** Vol. 314, No. 12. March 20, 1986.

Padian, N.; Marquis, L.; Francis, D., et al. "Male-to-Female Transmission of Human Immunodeficiency Virus. ***JAMA,*** Vol. 258, No. 6. August 14, 1987.

Parry, J. "AIDS as a Handicapping Condition." ***Mental and Physical Disability Law Reporter,*** Vol. 9, No. 6., November-December 1985; Vol. 10, No. 1, January-February 1986.

Parry, J. "AIDS as a Handicapping Condition." (Editorial.) ***Mental and Physical Disability Law Reporter,*** Vol. 10. No. 2. March-April 1986.

"Psychosocial and Special Aspects of the Acquired Immune Deficiency Syndrome: Early Findings of Research Sponsored by the National Institute of Mental Health." Prepared by NIMH, Rockville, MD: April 15, 1986.

Public Health Foundation. ***Guide to Public Health Practice: State Health Agency Programmatic Response to HTLV-III Infection.*** Recommendations from a Consensus Conference convened by the Association of State and Territorial Health Officials, Washington, DC, June 1986.

Public Health Service. ***Information/Education Plan to Prevent and Control AIDS in the United States.*** Developed by the Public Health Service of the Department of Health and Human Services, Washington, DC, March 1987.

"Public Health Service Plan for the Prevention and Control of Acquired Immune Deficiency Syndrome (AIDS)." ***Public Health Reports,*** Vol. 100, No. 5. September-October 1985.

Ranki, A, et al. "Long latency precedes overt seroconversion in sexually transmitted HIV infection." ***Lancer.*** Vol, 2, No. 8559. 1987.

Report #2 of the Governor's Task Force on AIDS. Florida Department of Health and Rehabilitative Services, Tallahassee, FL, December 1986.

Report of the Presidential Commission on the HIV Epidemic. Washington, D.C.: U.S. Government Printing Office Press, 1988.

Robert-Guroff, M.; Weiss, S.H.; Giron, J.S., et al. "Prevalence of Antibodies to HTLV-I -11, and -111 in Intravenous Drug Abusers from an AIDS Endemic Region." JAMA, Vol. 255. No. 22. June 13, 1986.

Rogers, M.F., and Williams, W.W. "AIDS in Blacks and Hispanics: Implications for Prevention." Issues ***in Science and Technology,*** Vol. 3, No. 3. Spring 1987.

Roper, W. Testimony provided before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives, March 10, 1987.

Rosen, M. Testimony provided before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives, March 5, 1986.

Rosenberg, M.J. Testimony provided before the Subcommittee on Human Resources and Intergovernmental Relations of the Committee on Government Operations, U.S. House of Representatives, March 16, 1987.

Rovner, J. "Special Report: AIDS." ***Congressional Quarterly Weekly Report,*** Vol. 45, No. 7. February 14, 1987.

Runcke, B. "Federal Government Intensifies Its Efforts in the Mental Health Aspects of AIDS." ***Hospital and Community Psychiatry,*** Vol. 37, No. 3. March 1986.

Ryan, C. "AIDS in the Workplace: How to Reach Out to Those Among Us." ***Public Welfare,*** Summer 1986.

Ryan, C., and Pohl, M. ***Protocol for AIDS Education and Risk Reduction Counseling in Chemical Dependency Treatment Settings.*** Waltham, MA: ARC Research Foundation, March 1987.

Scitovsky, A.A., Testimony provided before the Committee on Labor and Human Resources, U.S. Senate, April 16, 1986.

Scitovsky, A.A.; Cline, M.; and. Lee, P.R. "Medical Care Costs of Patients with AIDS in San Francisco." JAMA, Vol. 256, No. 22. December 12, 1986.

Scitovsky, AA., and Rice, D.P. "Estimates of the Direct and Indirect Costs of Acquired Immunodeficiency Syndrome in the United States, 1985, 1986, and 1991." ***Public Health Reports,*** Vol. 102, No. 1. January-February 1987.

Seage, G.R.; Landers, S.; Barry, M.A., et al. "Medical Care Costs of AIDS in Massachusetts." JAMA, Vol. 256, No. 22. December 12, 1986.

Smith, N. Testimony provided before the Committee on Labor and Human Resources, U.S. Senate, April 16, 1986.

Steinback, S.E. "AIDS on Campus: Emerging Issues for College and University Administrators." Prepared by the Division of Governmental Relations of the American Council on Education, Washington, DC, November 1985.

Stein, R.E. ***The Settlement of AIDS Disputes: A Report for the National Center for Health Services Research,*** Washington, DC: Environmental Mediation International, September 1986.

Steinbrook, R., et al. "Preferences of Homosexual Men with AIDS for Life-Sustaining Treatment." ***The New England Journal of Medicine,*** Vol. 314, No. 7. February 13, 1986.

Stickler, KB. "Florida Commission Rules AIDS is a Handicap." ***Health Law Vigil,*** Vol. 9, No. 2. January 31, 1986.

Stickler, K-B. "Rehabilitation Act's Protection of AIDS Victims Restricted." ***Health Law Vigil,*** Vol. 9, No. 14. July 18, 1986.

Stromberg, C.D. "AIDS Poses Significant Legal Considerations for the Work Place." ***Business and Health,*** Vol. 3, No. 3. January/February 1986.

Stroud, F. Testimony provided before the Subcommittee on Human Resources and Intergovernmental Relations of the Committee on Government Operations, U.S. House of Representatives, March 16, 1987.

Tramont, E.C. "Syphilis in the AIDS Era." ***The New England Journal of Medicine,*** Vol. 316, No. 25. June 18, 1987.

Weiss, S.H.; Saxinger, C.; Rechtman, D., et al. "HTLV-III Infection Among Health Care Workers: Association with Needle-Stick Injuries." JAMA, Vol. 254, No. 15. October 18, 1985.

Werta, D.C.; Sorenson, J.R.; Liebling, L., et al. "Knowledge and Attitudes of AIDS Health Care Providers Before and After Education Programs." ***Public Health Reports,*** Vol. 102., No. 3. May-June 1987.

West, K.H. ***Infectious Disease Handbook for Emergency Cure Personnel.*** Philadelphia: J.B. Lippincott Co. 1987.

Winkelstein, W., Jr.; Lyman, D.M.; Padian, N.S., et al. "Sexual Practices and Risk of Infection by the AIDS-Associated Retrovirus: The San Francisco Men's Health Study." ***JAMA,*** Vol. 257, No. 2. January 9, 1987.

Winkelstein, W., Jr.; Samuel, M.; Padian, N.S., et al. "The San Francisco Men's Health Study: Reduction in Human Immunodeficiency Virus Transmission Among Homosexual/ Bisexual Men, 1982-1986." ***American Journal of Public Health,*** Vol. 77, No. 6. June 1987.

"Women and AIDS - A Report by the New York City Commission on Human Rights AIDS Discrimination Unit." Report summarizing complaints received between June 1983 and December 1986.

Worth, D., and Lorimer, D. "Women and AIDS in New York City." Paper prepared for the Lower East Side AIDS Task Force, June 1986.

Worth, D., and Rodriguez, R. "Latina Women and AIDS." SICCUS Report, New York: January-February 1987.

Wykoff, R.F., et al. "Contact Tracing to Identify HIV infection in a Rural Community." ***JAMA.*** Vol. 259, 1988.

Yankauer, Al. "The Persistence of Public Health Problems: SF, STD, and AIDS." (Editorial.) ***American Journal of Public Health,*** Vol. 76, No. 5. May 1986.

Yarchoan, R., and Broder, S. "Development of Antiretroviral Therapy for the Acquired Immunodefiency Syndrome and Related Disorders." ***The New England Journal of Medicine,*** Vol. 316, No. 9. February ***26,*** 1987.

Zinsser, H. ***Ruts, Lice and History: The Biography of a Bacillus.*** Boston: Little, Brown and Co. 1934.

APPENDICES

Current Trends

Prevention and Control of Tuberculosis in Correctional Institutions: Recommendations of the Advisory Committee for the Elimination of Tuberculosis

These recommendations are designed to assist federal, state, and local correctional officials in controlling tuberculosis (TB) among inmates and staff of correctional facilities (e.g., prisons, jails, juvenile detention centers). This document addresses issues unique to correctional institutions; more general information about TB is available in the official American Thoracic Society (ATS/CDC) statements referenced in this document.

BACKGROUND

TB remains a problem in correctional institutions (1-8) where the environment is often conducive to airborne transmission of infection among inmates, staff, and visitors. In a survey of TB cases reported during 1984 and 1985 by 29 state health departments, the risk for TB among inmates of correctional institutions was more than three times higher than that for nonincarcerated adults aged 15-64 years (CDC, unpublished data). Since 1985, 11 known TB outbreaks have been recognized in prisons in eight states (CDC, unpublished data). In addition, in some large correctional systems, the incidence of TB has increased dramatically. Among inmates of the New York State system TB incidence increased from an annual average of 15.4/100,000 person-years served during 1976-1978 to 105.5/100,000 in 1986 (1). In New Jersey during 1987, the incidence of TB among state inmates was 109.9/100,000--a rate 11 times that of the general population in New Jersey that year (New Jersey State Department of Health, unpublished data). In a survey of California Department of Corrections facilities, the TB rate among inmates during 1987 was 80.3/100,000--a rate nearly six times that of California's general population for that year (California Department of Health Services, unpublished data).

Increasing prevalence of human immunodeficiency virus (HIV) infection among prisoners in a growing number of geographic areas heightens the need for TB control among inmates (9.10). According to a National Institute of Justice (NIJ) survey, as of October 1988, a cumulative total of 3,136 confirmed AIDS cases had been reported among U.S. inmates since 1981--2,047 cases by 44 of 51 state and federal systems, and 1,089 cases by 26 responding city and county jail systems. These reported AIDS cases represent a 60% increase since a similar survey was conducted in 1987. The risk for AIDS among prisoners has been reported as markedly higher than that of the total U.S. population (9). During 1988, the incidence for AIDS in the U.S. population was 13.7/100,000 (11). During the same year, the aggregate incidence rate for state/federal correctional systems was 75 cases/l00,000. Rates for individual systems ranged from 0 to 536. Although more than half of the states have incidence rates 125, 8 state systems have rates 1100. The aggregate rate for 26 responding city/county jail systems was 183/100,000. However, rates in city/county jails were described by NIJ as "extremely suspect" due to rapid turnover of population (9).)

HIV infection in persons with latent tuberculous infection appears to create a very high risk for development of TB (12.13.14). One review of AIDS cases among inmates in selected New York correctional facilities found TB in 22 (6.9%) of 319 persons with AIDS (2).

Transmission of TB in correctional facilities presents a health problem for the institutions and may also be a problem for the community into which inmates are released. Because the median age of inmates on release is relatively young--27 years (15) --the total lifetime risk for TB in persons infected during incarceration is considerable. Many potentially infected persons are released to the community: each year, more than 8 million inmates are discharged from local jails (16) and more than 200,000, from state and federal prisons (17).

GENERAL GUIDELINE

Control of TB and other communicable diseases is essential in correctional health care. Each correctional institution should designate an appropriately trained official responsible for operating a TB prevention and control program in the institution. A multi-institutional system should have a qualified official and unit to oversee TB control activities throughout the system. These responsibilities should be specified in the official's job performance plan and should include surveillance, containment, and assessment.

Surveillance refers to identification and reporting of all cases in the system or institution and identification of all inmates and staff who are infected (i.e., those with positive skin tests). New cases and newly infected persons must be quickly identified and appropriate therapy begun.

Containment is ensuring that transmission of tuberculous infection does not occur. Appropriate diagnostic, treatment, prevention, and laboratory services must be available. Environmental factors conducive to the spread of TB, such as poor ventilation, should be corrected. Prison officials must ensure that persons undergoing treatment or preventive therapy be carefully monitored for compliance and drug toxicity and complete an appropriate course of treatment.

Assessment refers to prison officials' responsibility for knowing whether the surveillance and containment activities are being effectively carried out.

Surveillance

Diagnosis. The intracutaneous Mantoux tuberculin test (not multiple puncture tests) should be used to identify persons infected with tubercle bacilli. Generally, for correctional institution staff and inmates, a tuberculin skin test reaction >=10 mm induration is considered positive. However, a reaction of >=5nun is considered positive in persons who have had close recent contact with an infectious case and in persons who have an abnormal chest radiograph consistent with tuberculosis (18). In addition, infected persons who are immunosuppressed for any reason may show little or no reaction to the tuberculin test (19). Therefore, a tuberculin skin test reaction in a person known to be infected with HIV should be considered positive if induration is >5 mm (20).

Skin testing of inmates and staff should be carried out at entry or on employment (21). Each skin test should be administered and read by appropriately trained personnel and recorded in mm induration in the personal medical record. All inmates and staff should participate, except those providing documentation of a previous positive reaction to the tuberculin test.

In jails with a rapid turnover of inmates, authorities may decide not to tuberculin test new detainees who are unlikely to remain in the system or in that facility for >7 days. However, provision must be made for appropriate diagnostic measures (e.g., sputum smear and culture and/or chest radiograph) for all persons who are symptomatic (18,20). (See Containment, below.)

In most correctional institutions, skin-test-negative inmates and employees having contact with inmates should have repeat skin tests at least annually. If data from previous screening and TB casefinding are available, the frequency for repeat skin testing should be determined based on the need for timely surveillance information. Observed risk of new tuberculous infection is the most useful evaluation criteria to consider. In institutions with a historically low risk of tuberculous infection (e.g.,<0.5% of persons with skin-test conversions annually), an increase in AIDS cases or TB cases should be viewed as indicating a need for more frequent skin testing and intensified TB casefinding activities.

Persons with positive skin test reactions and all persons with symptoms suggesting TB (e.g., cough, anorexia, weight loss, fever) should receive a chest radiograph within 72 hours. Correctional health-care personnel should be aware of the often atypical signs and symptoms of TB in persons with HIV infection (20). Inmates with abnormal chest radiographs and/or physical symptoms compatible with TB should also have sputum smear and culture examinations. Sputum should be submitted for smear and culture examination from persons with pneumonia or bronchitis symptoms that fail to abate promptly after initiation of antibiotic treatment. Three specimens should be collected, preferably once daily on 3 consecutive days. In the absence of spontaneous production of sputum, aerosol induction in a properly ventilated area should be used to obtain specimens.

Tuberculin skin test anergy may be a relatively late development in the progression from HIV infection to AIDS (22); consequently, inmates with known or suspected HIV infection (including those with nonreactive tuberculin tests) should receive a chest radiograph as part of initial screening, regardless of tuberculin skin test status.

Case Reporting. Whenever TB is suspected or confirmed among inmates or staff, this information should be immediately entered into the TB control records at the institution and at the headquarters level, if in a multi-institutional system. The local or state health department should also be notified, as required by state and local laws or regulations.

Contact Investigation. Because TB is transmitted by the airborne route, persons at highest risk for acquiring infection are "close contacts" (e.g., persons who sleep, live, work, or otherwise share air with an infectious person through a common ventilation system. When a person with suspected or confirmed TB appears to be infectious (e.g., has pulmonary involvement on chest radiograph with cough and/or positive sputum smear), close contacts must be skin tested unless they have a documented history of a positive tuberculin test (21). Close contacts with a positive tuberculin reaction or a history of a previous positive test and symptomatic persons, regardless of skin test results, should receive immediate chest radiographs to detect evidence of pulmonary TB.

Depending on the ventilation in an institution, close contacts could include all cellmates, all inmates and staff on a tier, or all inmates and staff in a building. Health department staff should be consulted to determine who should be tested. When tuberculin converters are found among the close contacts, other persons with less contact may need to be examined. Every effort should be made by medical and nonmedical staff to ensure the confidentiality of persons with TB.

Close contacts with positive tuberculin reactions, but without TB, should be given at least 6 months' preventive therapy (see Preventive Therapy, below), unless medically contraindicated (21). Close contacts who do not have a positive tuberculin reaction and who are asymptomatic should have a repeat tuberculin test 10-12 weeks after contact has ended.

Contacts with known or suspected HIV infection should be considered for a 12-month course of preventive therapy, regardless of skin test results, if evidence indicates that the source patient was infectious.

A patient with clinical TB may have negative sputum smears or cultures, especially if recently infected. Close contacts of such persons should also be examined to detect a source case and other newly infected inmates or staff.

Containment

Isolation. Persons with suspected or confirmed TB who have pulmonary involvement on chest radiograph, cough, and/or a positive sputum smear should be immediately placed in respiratory isolation (e.g., housed in an area with separate ventilation to the outside, negative air pressure in relation to adjacent areas, and at least four to six room air exchanges per hour). It may be necessary to move a patient to another facility or hospital with a respiratory isolation facility.

Respiratory isolation should continue until patients are on appropriate therapy and at least three consecutive daily negative sputum smears indicate respiratory precautions may be removed. No masks or special precautions are needed for handling patients' dishes, books, laundry, bedding, or other personal items.

Inadequate or interrupted treatment for TB can lead to drug-resistant TB and transmission of infection. After effective medications have begun, it is of utmost importance to keep the patient on medication until completion of therapy, unless signs or symptoms of an adverse reaction appear. Arrangements must be made with the health department for continued medication and follow-up before an inmate with TB is released. Similar arrangements should be made before the release of inmates on preventive therapy.

Because crowding and poor ventilation are conducive to transmission of TB, improvements in housing conditions can help prevent outbreaks. Installing ultraviolet lights may be helpful in prisons where transmission of tuberculous infection has been a problem (23). Although the effectiveness of ultraviolet lights in decreasing TB transmission in such settings has not been confirmed by epidemiologic studies, ultraviolet lights have been used to reduce transmission of TB in hospitals and shelters for the homeless (24.25). When ultraviolet lights are used, proper installation and maintenance is essential (23).

ATS/CDC recommendations should be followed in the treatment and management of persons with confirmed or suspected TB (20.26). Each dose of medication should be administered by a designated ancillary medical staff person who watches the inmate swallow the pills. The medication may be given twice weekly (with appropriate change in dosage) after 1-2 months of daily medication (26). To ensure continuing compliance, if a patient is to be discharged before completion of therapy, the health department should be notified before the inmates is released.

Persons with positive smears or cultures at the beginning of therapy should be monitored by repeat sputum examinations for treatment response until they become smear-negative. Treatment failure is usually due to patient noncompliance with therapy but may be due to the presence of drug-resistant organisms.

All patients must be monitored by trained personnel for signs and symptoms of adverse reactions during chemotherapy (20.26). Expert medical consultation regarding monitoring and/or treatment of patients with complications (e.g., AIDS, drug resistance, adverse reactions, pregnancy, nonpulmonary TB) should be sought when necessary. Special emphasis should be placed on close supervision and care of TB patients infected with drug-resistant organisms.

Inmates with TB should be routinely offered testing with appropriate counseling for HIV infection. The presence of HIV infection necessitates longer treatment for TB and continued close observation for adverse drug reactions, treatment failure, and relapse (20).

Preventive Therapy

All inmates and staff with positive tuberculin reactions who have not previously completed an adequate course of preventive therapy should be considered for preventive therapy unless there are medical contraindications (20.26). Eligible inmates include those who will be incarcerated long enough to complete at least 1 month of continuous therapy; provisions should be made before release for the health department to oversee completion of at least 6 months of appropriate therapy (unless HIV infected; see below).

HIV-antibody testing should be offered to all known tuberculin-positive inmates. Tuberculin-positive persons with concurrent HIV infection appear to be at very high risk for TB and have highest priority for preventive therapy, regardless of age. Efforts should be made to encourage persons with known or suspected HIV infection to complete 12 months of therapy.

Each dose of preventive therapy should be administered by a designated ancillary medical staff person who watches the patient swallow the pills. Since daily supervised therapy is often not feasible, twice-weekly supervised therapy is a satisfactory alternative.

Most experts believe twice-weekly intermittent preventive therapy (using isoniazid [INH] 900 mg) is effective, although it has not been studied in controlled clinical trials. Medication should not be given to an inmate without direct observation of drug ingestion.

All persons on preventive therapy must be monitored by trained personnel for signs and symptoms of adverse reactions during the entire treatment period (26). Some prison inmates will have underlying liver disease related to previous alcohol or narcotic abuse (27-79). Although chronic liver disease is not a contraindication to INH preventive therapy, such patients should be carefully monitored (26).

Persons for whom TB preventive therapy is recommended but who refuse or are unable to complete a recommended course should be counselled to seek prompt medical attention if they develop signs or symptoms compatible with TB. Routine periodic chest radiographs are generally not useful for detecting disease in the absence of symptoms; chest radiographs should be reserved for persons with symptoms, especially a persistent cough.

ASSESSMENT

Frequent transfer of inmates is unavoidable. Thus, a record system for tracking and assessing the status of persons with TB and tuberculous infection in the prison facilities is essential. This record system must be maintained with the latest information on the location, treatment status, and degree of infectiousness of these persons. Prompt action must be taken to assure reinstitution of drug therapy should treatment lapse for any reason.

The record system should also provide data needed to assess the overall effectiveness of TB control efforts, and the following information should be reviewed at least every 6 months:

1. Tuberculous infection prevalence and tuberculin conversion rates for inmates and staff within each institution;
2. Case numbers and case rates;
3. Percentage of TB patients recommended for therapy who complete the prescribed 6-month course of directly observed therapy in 6-9 months (goal is >=95%);
4. Percentage of patients with culture-positive sputum whose sputum converts to culture negative within 3 months of starting treatment (goal is >=90%);
5. Percentage of persons placed on INH preventive therapy who complete at least 6 months of directly observed therapy (goal is >=90%).

In multi-institutional systems, this data should be compiled for individual institutions and for the system as a whole, with results provided to corrections and health department officials.

ROLE OF THE HEALTH DEPARTMENT

Health departments should assist correctional institutions in developing and updating policies, procedures, and record systems for TB control. The health department should also provide access to expert TB medical consultation. A specific health department contact person should be designated to provide epidemiologic and management assistance to correctional facilities, and this responsibility should be an element in the designated person's job performance plan. This responsibility may require considerable initial onsite consultation and subsequent semiannual evaluation for correctional institutions.

Health department staff should assist in developing programs to train correctional institution staff (e.g., to perform, read, and record tuberculin skin tests; identify signs and symptoms of TB; initiate and observe therapy; monitor for side effects; collect diagnostic specimens; educate inmates; maintain record systems). Health or corrections departments may wish to grant certification to correctional staff completing this training.

Health departments should also provide consultation for contact examinations within correctional institutions and assure appropriate examinations for nonincarcerated contacts of persons with TB identified in these institutions.

In addition, health departments should cooperate with correctional staff in arranging continuing treatment for inmates released while receiving TB treatment or preventive therapy.

Health departments have a responsibility to maintain a TB registry with updated medical information on all current TB cases within its jurisdiction, including those in correctional institutions. Records should be assessed quarterly, and necessary revisions in policies or procedures should be recommended. In addition, the health department should periodically assess the impact of correctional institution-acquired TB and tuberculous infection on the community as a whole.

Because TB and HIV infection overlap, health department officials also should assist correctional institutions in developing and implementing HIV prevention programs. Such programs include strategies to identify persons practicing high-risk behaviors, counsel those infected with HIV, and reduce high-risk behaviors among all inmates.

As circumstances change, these recommendations will be periodically revised. They are not intended to discourage new and innovative approaches for dealing with TB prevention and control in prisoners. Nothing in these recommendations should be interpreted as encouraging discrimination against persons with AIDS, HIV infection, and/or TB. The recommendations should be used instead to enhance the quality of medical care for persons in correctional institutions.

References

1. Braun MM, Truman BI, Maguire B, DiFerdinando GT, Wormser G, Broaddus R, Morse DL. Increasing incidence of tuberculosis in a prison inmate population: association with HIV infection. JAMA 1989;261:393-7.
2. Snider DE, Hutton MD. Tuberculosis in correctional institutions (editorial). JAMA 1989;261:436-7.
3. Braun MM, Truman BI, Morse DL, Maguire B, Broaddus R. Tuberculosis and the acquired immunodeficiency syndrome in prisoners. JAMA 1987;257:1471-2.
4. Weiss R. TB troubles: tuberculosis is on the rise again. Science News 1988;133:92-3.
5. Stead, WW. Control of tuberculosis in institutions. Chest 1979;76(suppl):797-800.
6. Stead WW. Undetected tuberculosis in prison: source of infection for community at large. JAMA 14;8;240:2544-7.
7. King L. Geis G. Tuberculosis transmission in a large urban jail. JAMA 1977;237:791-2.
8. Abeies H, Feibes H, Mandel E, Girard JA. The large city prison--a reservoir of tuberculosis. JAMA 197O;101:706-9.
9. Hammett TM. 1988 Update: AIDS in correctional facilities. National Institute of Justice, US Department of Justice, 1989 (pre-publication COPY).
10. CDC. Acquired immune deficiency syndrome in correctional facilities: a report; of the National Institute of Justice and the American Correctional Association. MMWR 1986;35:195-9.
11. CDC. Update: acquired immunodeficiency syndrome-United States, 1981-1988. MMWR 1989;38:229-36.
12. CDC. Tuberculosis and AIDS--Connecticut. MMWR 1987;36:133-5.
13. Pitchenik AE, Burr J, Suarez M, Fertel D, Gonzalez G., Maos C. Human T-cell lymphotropic virus-III (HTLV-III) seropositivity and related disease among 71 consecutive patients in whom tuberculosis was diagnosed: a prospective study. Am Rev Respir Dis 1987;135:875-9.
14. Selwyn PA, Hartel D, Lewis VA, Schoenbaum GE, Vermund SH, Klein RS, Walker HT, Friedland GH. A prospective study of the risk of tuberculosis among intervenous drug users with human immunodeficiency virus infection. N Engl J Med 1989;320:545-50.
15. Bureau of Justice Statistics. US Department of Justice. Prison admissions and releases, 1982. Bureau of Justice Statistics Special Report July 1985; NCJ-97995.
16. Bureau of Justice Statistics, US Department of Justice. Jail inmates 1986. Bureau of Justice Statistics Bulletin. October 1987; NCJ-107123.
17. Bureau of Justice Statistics, US Department of Justice. Correctional populations in the United States, 1985. Dee 1987; NCJ-103957.
18. American Thoracic Society, CDC. Diagnostic standards and classification of tuberculosis and other mycobacterial diseases. Am Rev Respir Dis 1981;123:343-51. (Currently under revision).
19. American Thoracic Society, CDC. The tuberculin skin test. Am Rev Resp Dis 1981;124:356-63.
20. CDC. Tuberculosis and human immunodeficiency virus infection: Recommendations of the Advisory Committee for the Elimination of Tuberculosis. MMWR 1989:38:236-50.
21. American Thoracic Society, CDC. Control of tuberculosis. Am Rev Respir 1983;128:336-42.

22. Chaisson RE, Benkert C, Schecter GF, Hopewell PC. HIV infection in patients with tuberculosis [Abstract]. University of California and Department of Public Health, San Francisco, Ca. Fourth International AIDS Conference, Stockholm, Sweden, June 1988.
23. Riley, RL, Nardell EA. Clearing the air: The theory and practice of U.V. air disinfection. Am Rev Resp Dis (Submitted for publication).
24. CDC. Guidelines for prevention of TB transmission in hospitals. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, 1982; DHHS publication no. (CDC)82-8371.
25. CDC. Tuberculosis control among homeless populations. MMWR 1987;36:257-60.
26. American Thoracic Society, CDC. Treatment of tuberculosis and tuberculosis infection in adults and children. Am Rev Respir Dis 1986;134:355-63.
27. Boyer TD. Alcoholic liver disease. In: Wyngaarden JB, Smith LH, eds. Cecil textbook of medicine. Philadelphia: WB Saunders Co. 1982:799-800.
28. Kreek MJ. Medical complications in methadone patients. Ann NY Acad Sci 1987;311:110-34.
29. Cherubin CE, Kane S, Weinberger DR, Wolfe E, McGinn T. Persistence of transaminase abnormalities in former drug addicts. Ann Intern Med 1972;76:385-9.

Source: Centers for Disease Control. MMWR, Vol. 38, No. 18, May 12, 1989

APPENDIX B

SAMPLE INFECTIOUS DISEASE CONTROL POLICY
SAN FRANCISCO COUNTY, CALIFORNIA

PURPOSE:

The purpose of this policy is to provide officers with the necessary information to increase their safety on the job. This policy was written in accordance with the universal precautions for preventing the spread of infectious disease in the workplace, developed by the Centers for Disease Control. The procedures and guidelines in this policy should be followed when handling all prisoners or other persons in any facility, section, or other area of the department.

DEFINITIONS:

INFECTIOUS DISEASE: Any of a number of diseases identified in the California Health and Safety Code as a communicable reportable disease, including, but not limited to hepatitis B, tuberculosis, AIDS, etc.

POCKET MASK: A plastic face mask with a one-way valve used to administer cardiopulmonary resuscitation (CPR).

GLOVES: Surgical-type latex or nylon disposable gloves.

BODY FLUIDS: Any fluids secreted by the body, including, but not limited to blood, semen, saliva, urine, feces, etc.

EXPOSURE Direct contact with body fluids on open cuts, breaks in skin, or mucous membranes, such as the mouth or eyes.

POLICY STATEMENT

It shall be the policy of the San Francisco Sheriffs Department to provide training and equipment, as necessary, to ensure the safety of its officers, as it pertains to the prevention of exposure to infectious diseases, while working in all areas of the department. The San Francisco Sheriffs Department and its personnel shall adhere to all federal and state laws and local ordinances, legal opinions, and civil service regulations pertaining to infectious diseases.

1. ***GENERAL PROCEDURES***

A. GENERAL GUIDELINES:

1. All personnel should wear disposable gloves when they anticipate handling persons, equipment or materials contaminated with blood or other body fluids.

2. All personnel should use a pocket mask when administering CPR.

3. All contaminated materials except sharp objects should be disposed of in a clearly marked bag identified as a contaminated material bag.

4. Whether wearing disposable gloves or not, personnel who come into contact with blood or

other body fluids should wash their hands with warm water and soap as soon as possible following the contact.

5. Any open cuts or breaks in skin should be covered with a bandage and kept dry. If the protective covering gets wet, a new covering should be put on.

6. All personnel should handle any sharp object with extreme caution.

7. All sharp items should be placed in puncture-resistant containers clearly marked as containing sharp objects.

8. No department personnel shall refuse to provide emergency medical care or CPR to any person or prisoner, whether pocket masks or gloves or available or not.

B. EQUIPMENT ITEMS:

1. The department will provide the following equipment items to all personnel:

   a. Pocket mask with one-way valve and carrying case.

   b. Disposable latex or nylon gloves and glove pouches.

2. The department will provide the following equipment items in the facilities and sections:

   a. Disposable plastic bags clearly marked as containers for contaminated materials.

   b. Puncture resistant containers for securing sharp objects.

   c. Disposable paper towels and cleaning supplies.

   d. Gowns and surgical face masks, when necessary.

C. DISPOSABLE GLOW:

1. Department personnel are responsible for having disposable gloves on their persons while on duty.

2. Disposable gloves should be worn by personnel if they have uncovered open wounds or breaks in the skin on their hands.

3. Disposable gloves should be worn when handling persons who are bleeding or have open wounds or lesions.

4. Disposable gloves should be worn when handling clothing, bedding, or other material contaminated by blood or other body fluids.

5. Disposable gloves should be worn when handling equipment items contaminated by blood or other body fluids.

6. Disposable gloves should be worn by personnel in any situation where they may be exposed to blood or other body fluids.

7. Disposable gloves should be worn once and discarded. If the gloves have been contaminated by blood or other body fluids, they should be placed in a disposable bag that is clearly marked for contaminated items.

8. When removing disposable gloves, there should be no contact with the mouth. The gloves should be pulled off inside out to prevent any contaminated fluid from having contact with the skin.

9. Personnel should wash their hands as soon as possible after removing the disposable gloves.

10. Disposable gloves should never be worn for extended periods of time. Personnel should use a pair of gloves when warranted by the situation and then discard the gloves.

11. Replacement disposable gloves should be readily available and easily accessible at the work location.

12. Personnel shall not refuse to provide emergency care or any service to the prisoner or any other person, whether disposable gloves are available or not.

D. POCKET MASKS:

1. Department personnel are responsible for having their pocket masks on their persons while on duty.

2. Pocket masks should be worn by when personnel are administering CPR.

3. Pocket masks should be cleaned thoroughly after each use with soap and water or alcohol (either way is sufficient to decontaminate the mask). Pocket masks should be dried thoroughly before being returned to the carrying case.

4. No department personnel shall refuse to provide CPR to a prisoner or any other person, whether the pocket mask is available or not.

E. OTHER PROTECTIVE ITEMS:

1. Disposable surgical type face masks should be worn when there is a potential for the splattering of blood or other body fluids.

2. Disposable or laundered gowns should be worn when there is a potential for the splattering of blood or other body fluids.

F. SEARCHES:

1. General Guidelines:

   a. Personnel should never put their hands blindly into purses, bags, pockets, or any item that is not a clear container.

   b. Personnel should always empty out the contents of purses, bags, or any items that are not in clear containers prior to searching.

2. Cell Searches:

   a. Personnel should exercise extreme care while conducting cell searches, never placing their hands into an area they cannot visually inspect. Flashlights and mirrors should be used to assist in visual inspection.

   b. Personnel should exercise extreme care when searching any clothing or bedding items in the cell. Clothing and bedding items should be shaken gently, not patted or groped, to reduce the potential for being stuck by hidden sharp objects.

   c. Personnel should wear disposable gloves while conducting cell searches.

3. Body Searches:

   a. Disposable gloves should be worn while conducting a body search because the searching officer may come into contact with blood or other body fluids.

   b. Extreme caution should be exercised by the officer when searching the person's clothing to reduce the likelihood of being stuck by a hidden sharp object.

4. Patdown Searches:

   a. Prior to conducting the search, the officer should ask persons being searched if they have any sharp objects on themselves or their clothing. If yes, the searching officer should instruct the person to remove the sharp objects from their persons or clothing.

   b. The person being searched should then be instructed to remove all remaining items from the pockets.

   c. To provide safety for the searching officer, the person being searched should be directed to use the left hand to remove items from the right pockets and the right hand to remove items from the left pockets.

   d. Before conducting a patdown search, the searching officer should visually inspect the person to be searched for any noticeable bumps in their clothing that would indicate a hidden object.

   e. While conducting a patdown search, the searching officer should avoid rapidly sweeping movements with the hands down the arms, legs and torso of the person being searched.

   f. The searching officer should carefully pat areas before using the groping search technique to reduce the likelihood of being stuck by a hidden sharp object.

   g. Extreme caution should always be exercised by the searching officer while conducting any search to reduce the likelihood of being stuck by a hidden sharp object.

5. Clothing Searches:

   a. Extreme caution should be exercised when searching clothing to reduce the

potential for being stuck by hidden sharp objects.

b. As much as possible, clothing should be removed from the person prior to the search.

c. Disposable gloves should be worn by personnel if they may come into contact with blood or other body fluids.

G. SHARP OBJECTS:

1. Personnel should handle all sharp objects with extreme caution, and all sharp objects should be assumed to be infectious.

2. Needles should never be bent, broken or otherwise tampered with by department personnel.

3. Sharp objects should be placed in a puncture-resistant container clearly marked as containing sharp objects.

4. If puncture-resistant containers are not available, personnel should carefully wrap the sharp object in paper or cloth, place it in an envelope or bag, and clearly mark the envelope or bag as containing sharp objects.

IL CLEAN UP PROCEDURES

A. CLOTHING:

1. Uniform clothing and any other clothing that becomes contaminated with blood or other body fluids should be removed as soon as possible.

2. Heavily contaminated clothing should be put in a disposable bag for taking home.

3. Normal washing using regular detergents in a washing machine will decontaminate clothing.

4. Normal dry cleaning will decontaminate those uniform items that **must** be dry cleaned.

5. As an added precaution, heavily soiled clothing items should be washed separately from other wash items.

B. EQUIPMENT:

1. Equipment items that are contaminated with blood or other body fluids should be thoroughly cleaned after use.

2. A solution of 1 part household bleach to 100 parts water is sufficient to decontaminate equipment items.

3. This solution needs to be made freshly every 24 hours. Mixed solutions of bleach and water lose their potency after 24 hours.

4. This solution will not damage equipment items such as weapons, handcuffs, keys, car seats, etc.

C. SPILLS:

1. A solution of 1 part bleach to 100 parts water is sufficient to clean up any spills of blood or other body fluids.

2. Disposable towels should be used as much as possible to clean up blood or other body fluids. Disposable towels should be discarded in a disposable bag that is clearly marked for contaminated items.

3. Mops should be thoroughly cleaned in the same solution (1:100 bleach to water) after being used.

4. Disinfectants used in regular jail cleaning are sufficient to decontaminate areas where spills occur, if the bleach and water solution is not available.

5. Disposable gloves should be worn when cleaning up any spills of body fluids. Gowns and face masks may also be appropriate, if there is a potential for the splattering of the body fluids.

6. Disposable gloves, gowns, and face masks, if appropriate, should be provided to inmate workers who are required to clean up any spills of body fluids.

III. REPORTING PROCEDURES

A. EMPLOYEE RESPONSIBILITY:

1. At any time during a work assignment, when an employee has direct contact with blood or other body fluids on open cuts, breaks in skin or in mucous membranes, or is stuck or cut by a sharp object or is unsure whether an occurrence constitutes the likelihood of such an exposure, the following steps should be taken:

   a. Cleanse the area thoroughly, as soon as possible, with warm water and soap for at least 30 seconds, then rinse with copious amounts of warm water. (If water is not readily available, an alcohol wipe is sufficient for initial cleansing of the area. Washing with warm water and soap should be done as soon as possible.)

   b. If the exposure includes extensive contamination of clothes, put on disposable gloves, remove soiled articles and rinse with soapy water.

   c. Remove gloves carefully and wash hands thoroughly with warm soapy water for at least 30 seconds.

   d. Redress with clean garments.

   e. Cover any open wounds with clean bandage.

   f. Fill out an exposure incident form.

   g. The exposure incident form shall be submitted to the facility watch commander, who, after reviewing the form, shall submit it to the facility commander; it will then be placed in the employees' facility file.

B. MEDICAL STAFF RESPONSIBILITY:

1. If an exposure to the employee was a result of providing emergency medical care or CPR, the facility commander shall submit the exposure incident form to the head nurse of the medical staff at the location where the incident occurred. If the incident occurred in other than a jail facility, but involved a prisoner, then the exposure incident form shall be submitted to the head nurse of the jail facility where the prisoner is housed.

2. Upon receiving an exposure incident form detailing a possible exposure while providing emergency medical care or CPR, the head nurse will promptly review the report to determine whether the exposure constitutes a risk of infectious disease transmission.

3. The head nurse will contact the employee involved, if necessary, to gather more information or to allay concern.

4. If the exposure is determined to be a possible means of transmission, the head nurse will determine if the prisoner involved has an infectious, reportable disease.

5. If the prisoner has an infectious, reportable disease, the public health officer shall be notified.

6. The public health officer is responsible for reporting back to the employee the type of infectious, reportable disease the employee was exposed to and for recommending appropriate treatment.

7. The identity of the individual who has an infectious and reportable disease shall be confidential. Every effort shall be made by all persons involved to protect the individual's right to confidentiality.

IV. *LEGAL. ISSUES*

A. CONFIDENTIALITY OF PRISONER MEDICAL RECORDS:

1. Pursuant to federal and state law, and in accordance with the legal opinion of the San Francisco City Attorney's Office, medical records of all persons are confidential. This confidentiality of medical records extends to all prisoners.

2. Jail medical staff are not permitted to release any information regarding the diagnosis of a prisoner's medical condition to a San Francisco Sheriffs Department employee, except as provided for in P C 7521 (b) and P C 7522 (a).

B. EMERGENCY MEDICAL CARE AND CPR:

1. Pursuant to the State Legislative Counsel's opinion and the opinion of the San Francisco City Attorney's Office, all department personnel are required to provide emergency medical care and administer CPR to any person in their care and custody, when they have been trained to do so.

2. An employees' refusal to provide emergency medical care or CPR may result in criminal negligence and the employee may be held civilly liable for any damage caused from the refusal to provide proper care.

EXPOSURE INCIDENT FORM

EMPLOYEE NAME: _____

DATE, TIME, LOCATION OF INCIDENT: _____

NAME OF OTHER INDIVIDUAL INVOLVED: _____

DETAILS OF INCIDENT: _____

_____

_____

WAS A DEPARTMENT INCIDENT REPORT WRITTEN? YES_____NO_____

REASON FOR CONCERN:

_____Contact with body fluids (please identify which fluid)

_____

_____Clothes soaked with blood or other body fluid (please identify which fluid)

_____

_____Stick by needle or other sharp object

WERE YOU WEARING PROTECTIVE EQUIPMENT (GLOVES, MASKS, ETC.)?

_____YES _____NO

IF YES, LIST WHAT TYPE WAS USED: _____

_____

IF NO, EXPLAIN WHY NOT: _____

_____

IF GLOVES WERE WORN, WERE THERE ANY RIPS OR TEARS?

_____YES _____NO

REVIEWED BY: _____ WATCH COMMANDER

_____ FACILITY COMMANDER

_____ JAIL MEDICAL STAFF

APPENDIX C

VERMONT DEPARTMENT OF CORRECTIONS

Condom Distribution Procedure

Introduction

Acquired Immune Deficiency Syndrome (AIDS) has emerged as a significant threat to the public health and welfare. As the numbers of HIV positives, persons with ARC, and persons with AIDS continue to multiply, correctional facility administrators are faced with the challenge of preventing the transmission of the AIDS virus within their institutions. Although there is little evidence that inmates constitute an epidemiological high-risk population, certain "high-risk" behaviors within correctional facilities are known to occur. Homosexual contact, including anal and oral intercourse, is among these behaviors.

The Vermont Department of Corrections does not condone sexual activity of any manner within its institutions, and specific disciplinary sanctions are imposed upon discovery of such conduct. Nonetheless, it is an acknowledged reality that this behavior exists. In light of the extreme potential consequences of viral transmission in this context, the Department endorses a comprehensive program of education, counseling, and prevention reflective of best medical practices to reduce the likelihood of exposure. In recognition of the fact that the vast majority of inmates will eventually be released into society, this program stresses counseling options and preventive practices similar to those available to the general public.

Accordingly, to ensure that correctional health care professionals are not constrained in their application of best public health practices, the DOC has implemented the following procedure for the distribution of condoms on a confidential basis.

Procedure

1. Upon admission to a correctional facility, inmates are given written information on the nature of the AIDS virus, its consequences and means of transmission.

2. Within thirty days of admission, sentenced offenders are given physical assessments by facility medical staff. High risk behaviors are reviewed at this time. Inmates are also advised that counseling from the medical staff, the Department of Health, or an AIDS prevention advocacy group is available.

3. At this time inmates are also advised that condoms are available from medical staff on a confidential basis if they choose to engage in sexual contact while incarcerated. They are also advised against sexual activity and cautioned of possible disciplinary and medical consequences.

4. Inmates shall also be offered counseling to deal with issues of sexuality, medical liabilities, and related concerns.

5. Condoms shall be issued one at a time.

6. Issuance of condoms is a preventive medical procedure. As such, it shall remain confidential.

7. Inmates eligible for recreational furloughs, extended furloughs, or parole may receive condoms on request.

APPENDIX D

HIV ANTIBODY TESTING
CONSENT FORM

NAME (PRINT) INMATE NUMBER DATE

CONSENT FORM FOR HIV ANTIBODY TEST

I, _____, do hereby state that I have received information from the _____ County Sheriffs Department concerning the disease AIDS. The information was written, oral, and shown to me on videotape.

WITNESS SIGNATURE

* * * * *

I, _____, do hereby state that I have spoken with the jail medical staff, _____, about the AIDS disease and the test for the AIDS antibody. I understand that the test is not 100 percent accurate. I further request and understand that I will receive counseling from the jail, social services, and/or medical staff regarding test results.

WITNESS SIGNATURE

* * * * *

I, _____, do hereby authorize the testing laboratory _____, to release the confidential results of my blood test for the AIDS antibody to the _____ County Sheriffs Department Medical Division, Counseling Coordinator, and the Superintendent.

WITNESS SIGNATURE

ABOUT THE AUTHORS

Anna T. Laszlo, former Director of the National Sheriffs' Association's (NSA's) Research and Development Division and NSA's AIDS Policy, Training, and Technical Assistance Project, is currently a Project Director at The Circle, Inc., McLean, Virginia.

Marilyn B. Ayres is Assistant Director of NSA's Research and Development Division and Public Information Coordinator of the AIDS Policy, Training, and Technical Assistance Project.

Michael R. Smith, J.D., who provided an overview on legal issues (Chapter IV), is a professor of Public Law and Government at the Institute of Government, University of North Carolina, Chapel Hill, North Carolina.

Appendix 7

The following are copies of media campaigns to which anecdotal evidence is showing to be effective in Northern Kentucky and Paducah.

Northern Kentucky Independent District Health Department
Message: HIV is alive and well. Are you?

Heartland CARES, Inc. (Paducah)
Message: Got AIDS? Don't know? Got 20 minutes? Get tested!

Appendix 8

Kentucky AIDS Drug Assistance Program
Hepatitis Medication Treatment
Annual Cost Estimates
August 24, 2007

Drug Product	340B Cost	Cost /dose	Cost /month	Generic
Peg Intron RediPen 80mcg/0.5ml	$195.49	$195.49	$781.96	Peg Interferon Alfa 2B
Peg Intron RediPen 120mcg/0.5ml	$206.03	$206.03	$824.12	Peg Interferon Alfa 2B
Peg Intron RediPen 150mcg/0.5ml	$217.41	$217.41	$869.64	Peg Interferon Alfa 2B
Pegasys 180mcg/0.5ml 4 dose kit	$824.59	$206.15	$824.59	Peg Interferon Alfa 2A
Ribavirin 200mg caps	$0.28	$0.28	$8.40	ribavirin
Intron A 3mmu/0.2ml 6 dose Pen	$112.93	$28.23	$225.86	Interferon Alfa 2b

Typically you would see a patient receiving 4 Peg Intron per month, 1 Pegasys KIT per month and 2 of the Intron

Pens/month.

Information provided by:

Lucy Wells

University of Kentucky

"Prisoner health is public health."

AB 1334
Inmate and Community Public Health and Safety Act

Paul Sánchez
Center for Health Justice
West Hollywood, California

CENTER FOR HEALTH JUSTICE
(formerly CorrectHELP)

Opening Thought

"Correctional inmates engage in drug--related and sexual risk behaviors, and the transmission of HIV, hepatitis, and sexually transmitted diseases occurs in correctional facilities… Whether infection was acquired within or outside correctional facilities, the prevalence of HIV and other infectious diseases is much higher among inmates than among those in the general community, and the burden of disease among inmates and releasees is disproportionately heavy. A comprehensive response is needed"

American Journal of Public Health. 2006;96:974–978.
doi:10.2105/AJPH.2005.066993

AB 1334

Inmate and Community Public Health and Safety Act

a common sense response

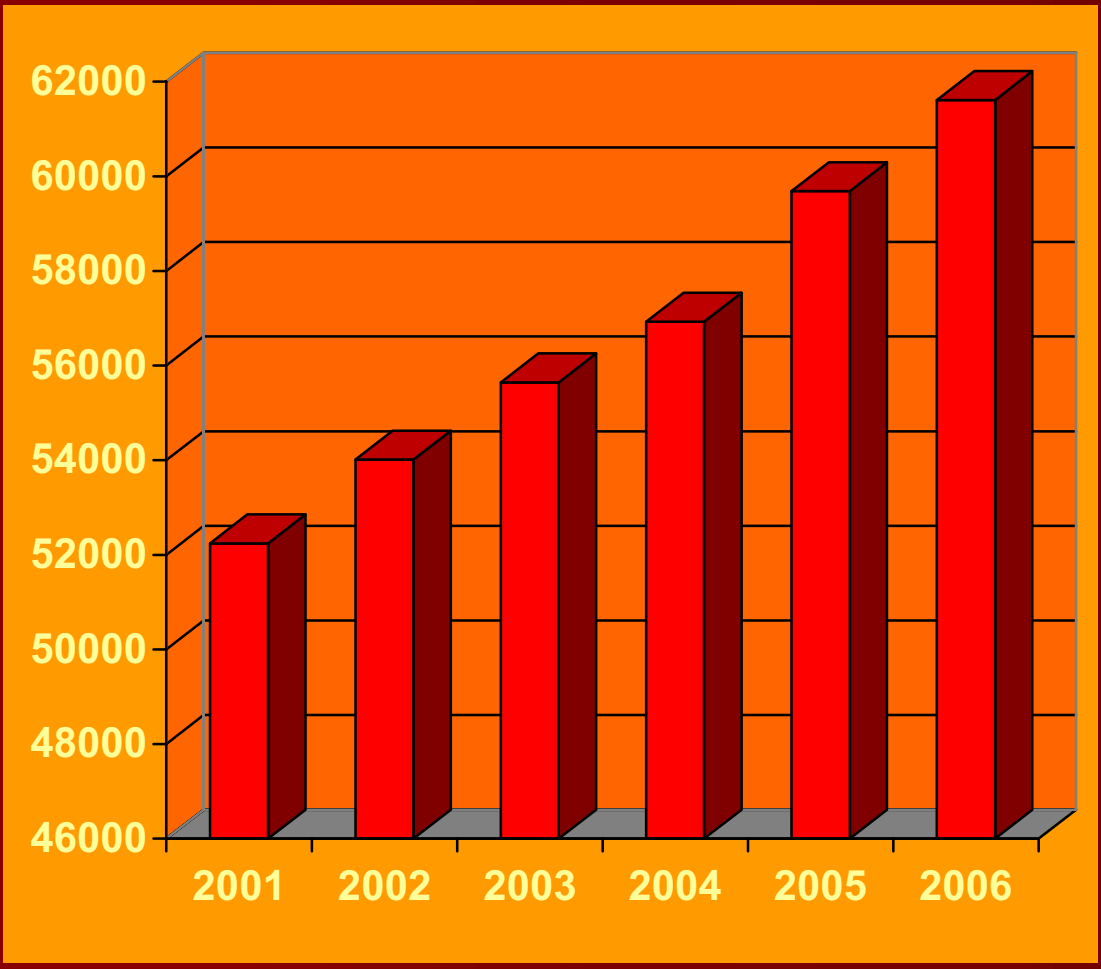
Statistics

Latinos & HIV

- 2004; Latino account for 20% of all new HIV diagnoses in US/year
- Of all ethnic groups: Latinos second highest rate of infection behind African Americans

Statistics (cont.)

Total Latinos Incarcerated



California Department of Corrections and Rehabilitation

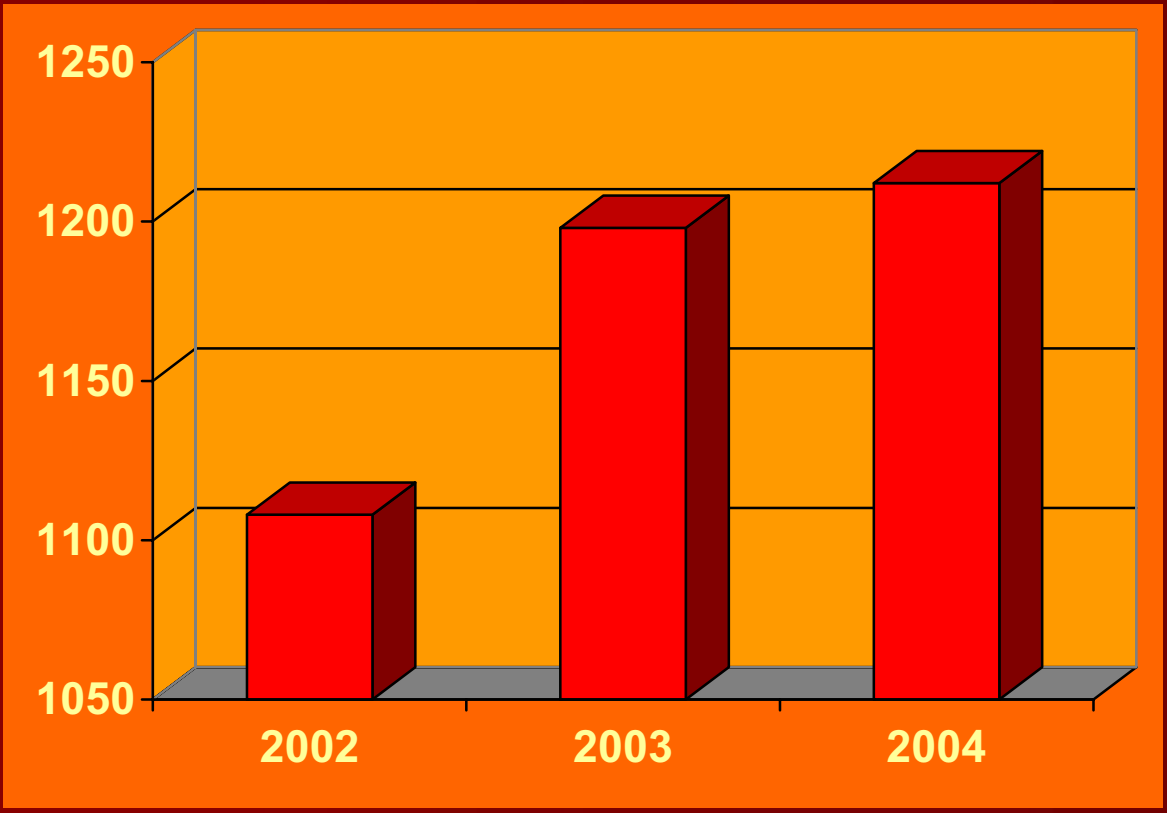
Statistics (Cont.)

Sex in Prisons

- Southeastern state prison survey: 44% of inmates admitted sexual contact w/ other inmates
- US Correctional Studies (1982 – 2002): 2% – 65% of inmates admitted to having sexual contact while incarcerated
- Occurs on continuum: consensual to violently coerced

Statistics (Cont.)

Incidence of Self-Identified HIV+ Inmates in CA



US Department of Justice -Bureau of Justice Statistics Bulletin, *HIV in Prisons, 2004.* November 2006

Statement of Need

- The prevalence of HIV among U.S. incarcerated populations is five to seven times that of the general U.S. population
- About 25% of people living with HIV in the U.S. have been incarcerated*
- Condoms are 98% effective at preventing the transmission of HIV
- In the United States, only two state prison systems and five local jail systems make condoms available to inmates (Mississippi, Vermont, Washington D.C., San Francisco, Los Angeles, New York, Philadelphia)

*Weinbaum CM, Sabin KM & Santibanez SS. AIDS 19 (3) (2006)

AB 1334

- Allows for any non profit or healthcare agency to distribute sexual barrier protection devices
- Distribution of these devices shall not be considered a crime nor deemed as encouraging sexual acts between inmates
- Possession of one of these devices shall not be used as evidence of illegal activity for purposes of administrative sanctions

Current Thinking Regarding Condoms in Prisons

- United Nations and the CDC support providing prisoners access to condoms
- Several state and local correctional facilities already distribute condoms to inmates
- Research shows that the few programs that do exist provide prisoners access to condoms without incident

Current Thinking Regarding Condoms in Prisons (Cont.)

- Correctional officers in facilities where condoms are available express support because it prevents HIV infection and makes their workplace safer

- Los Angeles and San Francisco Sheriff's Departments currently administering these programs have expressed openness to expanding the programs

Current Thinking Regarding Condoms in Prisons (Cont.)

- None of the correctional facilities that distribute condoms have retracted the distribution as a result of increased sexual activity, violence or illegal trafficking

- Public health advocates are calling for it and public opinion supports it

Cost Analysis

Based on a projected life expectancy of 24.2 years for HIV-positive people who receive optimal medical care, the "undiscounted" lifetime cost of medical care is $618,900

- According to the study:
- 73% of the cost is for antiretroviral drugs
- 13% is for inpatient care13% care
- 9% is for outpatient care9% care
- 5% is for other HIV-related laboratory expenses

Annual Cost: $25,200/inmate

Schackman et al.,Medical Care, November 2006

Cost Analysis (Cont.)

- As of 2004: 1212 HIV-positive inmates in California

  – 73% for the cost of antiretroviral drugs
  – $18,396.00 / 12 = $1533.00/month
  – $1533.00 x 1212 x 12 months= $22,295,952 (annually)
  – $1533.00 x 1212 x 21 months* = $39,017,916.00

- California tax payers reap substantial savings in health care cost when maintaining an inmate's HIV-negative status

*Median inmate prison term – *Solving California's Correctional Crisis*, Little Hoover Commission, January 2007

Cost Analysis (Cont.)

IN PREVENTING ONE NEW INFECTION

Annual Cost HIV+ Inmate (optimal care)	Cost per Condom (bulk rate)	Total # condoms that can be purchased & distributed
$25,200.00	0.65	38,769

Impact on Latino Community

- 37% of prison population is Latino
- AB 1334 will reduce the spread of HIV among Latino prison inmates by permitting non profit organizations and public health entities to distribute condoms in state correctional facilities

Impact on Latino Community (Cont.)

HIV & Latinos*

- prevalence in CA: 23% of all AIDS cases
- 2004; account for 20% of all new HIV diagnoses in US/year
- Of all ethnic groups: second highest rate of infection behind African Americans

AB 1334 will have an impact on reducing the transmission of HIV among the Latino general population

*Center for Disease Control; HIV/AIDS among Hispanics Fact Sheet

Research & Implementation Feasibility

- Center for Health Justice is partnered with distinguished researchers in the state on HIV and incarceration issues:
  - Dr. Nina Harawa of Charles R. Drew University in Southern California
  - Dr. Olga Grinstead of UCSF's Center for AIDS Prevention Studies (CAPS) in Northern California
- Researching best practices for condom distribution
- Currently evaluating access to condoms programs in Los Angeles and San Francisco

Summary

- Prevalence of HIV is much 5-7x higher among inmates than among those in the general population
- Allows for non profit organizations and public health entities to distribute condoms in state correctional facilities
- AB 1334 will reduce the spread of HIV among the Latino prison population
- AB 1334 will help reduce the spread of HIV among Latino general population
- The average cost for inmate's medication is $1533.00 per month (x 1212 x 12 = $22,295,952 annually)
- For 1212 HIV+ inmates' medications, averaging a 21--month incarceration term, California spends approximately $39,017,916.
- California tax payers will reap substantial saving in health care cost when maintaining an inmate's HIV--negative status as a result of AB 1334

Your support on this issue is gratefully appreciated.

"Prisoner health is public health."

Paul Sánchez
8235 Santa Monica Blvd. Suite 214
West Hollywood, Ca 90046
paul@healthjustice.net
(323) 822 822-3831

CENTER FOR HEALTH JUSTICE
(formerly CorrectHELP)

HIV Transmission and Prevention in Prisons

HIV InSite Knowledge Base Chapter
April 2006

Elizabeth Kantor, MD, University of California San Francisco

Introduction

Prisoners are at exceptional risk for infection with HIV because of the association of injection drug use with incarceration. Women prisoners who have practiced prostitution, which frequently is associated with injection drug use and contact with HIV-infected sex partners, are at additional risk for HIV infection. This chapter reviews the following issues involved with HIV infection in prisoners: epidemiology, prevalence, and transmission; the growing coincidence of tuberculosis and hepatitis C; institutional issues, including prison policies and practices, confidentiality, informed consent, and medical research; the extensive involvement of the legal system in the area of HIV in prisoners; and the role of educational programs in prevention efforts.

Epidemiology and Background

As of December 31, 2004, nearly 7 million people in the United States lived under the jurisdiction of the criminal justice system, and more than 2.2 million were in jail or prison. The United States imprisons its population at the highest known rate in the world, 724 per 100,000 persons in 2004. In 1998, 11.5 million people were released from jails and prisons into communities in the United States. These figures, which continue to increase, reflect the country's adherence to a formidable social policy of imprisonment and raise the public health issue of the huge impact that prisoners' health will have on the community at large. Prison populations have grown in recent decades primarily because incarceration has been the central tactic of the "war on drugs" in the United States. The millions of intermittently incarcerated people in America, many of whom are illicit drug users, have been among the most difficult people to reach with critical health information, management, and treatment. The National Commission on AIDS stated in its 1991 report: "By choosing mass imprisonment as the federal and state governments' response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection." Fifty-seven percent of federal prisoners were incarcerated for drug-related offenses in 2001.(1,2-4)

The AIDS prevalence in 2003 was more than 3 times higher in state and federal prisons (0.51%) than in the general U.S. population (0.15%).(3) Between 20% and 26% of people living with HIV/AIDS in the United States have spent time in the correctional system.(5) No precise count of HIV cases in prisoners is available, as brief incarceration, particularly in jails, limited access to health care, and lack of universal screening hinder the identification and diagnosis of inmates with HIV infection. Also, arrestees may choose not to declare their HIV status.

In 2003, a U.S. National Institute of Justice survey of the 50 state prison systems and the federal prison system reported 5,944 current AIDS cases.(3) New York, Texas, and Florida accounted for nearly half of the confirmed AIDS cases within the 50 state prison systems.

HIV seroprevalence reported by the 50 state prison systems was 1.9%, and 1.1% in the federal prisons, in 2003.(3) Jails in the south and northeast accounted for 80% of known HIV-infected inmates. Greatest seroprevalence was found in jails in the largest jurisdictions: the District of Columbia (7.6%), New York (4.3%), and Massachusetts (4.0%).

The 2002 Survey of Inmates in Local Jails was conducted by asking inmates for their HIV testing history and status. From a pool of 3,365 jails previously surveyed in 1999, a sample of 465 jails was selected in 2002. A total of 6,982 inmates in 420 jails agreed to participate, and the percentage of HIV-positive males in the local jail population in 2002 was determined to be 0.8-1.6%.(4)

Female inmates, accounting for 5-10% of the prison population, have had a higher HIV antibody seroprevalence than male prisoners (2.8% compared with 1.9%, respectively, in 2003). This discrepancy exists in most state prison systems, and cumulatively in each of the 4 regions identified by the U.S. Department of Justice: Northeast, Midwest, South, and West. More than 10% of all female inmates were known to be HIV positive in 2 states: New York and Maryland (14.6% and 11.1%, respectively). In all states, <10% of male inmates were reported to be HIV positive. Only New York reported >5% seroprevalence among male prisoners (7.4%).(3)

HIV seroprevalence in U.S. prison inmates parallels the uneven geographic distribution of HIV in injection drug users (IDUs) and regional patterns of incarceration and case finding. A comparison of prison AIDS cases with total U.S. AIDS cases in 1994-96 found that 61% of prisoners had injected drugs, compared with 27% of total cases.(6) A report from the state of New York on changing HIV seropositivity identified a decreasing incidence of HIV in newly admitted inmates between 1998 and 2003. Increasingly, persons of African American or Hispanic race, those >30 years of age, and men who have sex with men (MSM) have approached IDUs as predictor groups for seropositivity.(7)

The disproportionate burden of HIV infection among racial minorities is more pronounced in prison than in the community at large. A comparison of prison and total AIDS deaths found that African Americans comprise more than two thirds of prison cases, compared with 39% of total cases. A 2001 report from Maryland of 888 AIDS cases identified in the state's prisons noted that 91% were African American, compared with 75% statewide.(8)

Improved HIV identification and treatment in the late 1990s resulted in a precipitous drop in AIDS deaths among the incarcerated population as well as in the community at large. In 2003, a total of 268 state prisoners died of AIDS, down from 1,010 in 1995. The number 268 was determined by the use of 2 reporting systems, the National Prisoner Statistics and the additional Deaths in Custody Reporting Program, enacted in 2000. In 2001, the Bureau of Justice Statistics began collecting individualized details about deaths in state prisons, which corrected some previous underreporting of AIDS-related deaths. In 2002, the percentage of deaths due to AIDS in prisons was more than 2 times that of the U.S. general population.(3)

The state of New York has had the longest and the largest experience with HIV in its prison system, and the New York State Commission of Correction has published the most extensive reports on state prison cases of HIV infection beginning in the 1980s. As of the end of 2003, one fifth of all inmates in the United States known to be HIV infected were in New York prisons. New York had recorded 2,186 prison deaths from AIDS through September 1996. New York's early experience with huge numbers of prisoners with HIV offered a view into the future for other prison systems.(9,10) By 2003, however, HIV seroprevalence among inmates entering state prisons in New York had declined 75% for males and 40% for females.

Other nations began reporting AIDS cases in prisons several years after the United States. However, the rate of increase in such cases has been steep. Countries with particularly high seroprevalence identified among prisoners include Brazil (15% in 2001 [0.6% for the general community]), Côte d'Ivoire (27.5% in 2001 [10.8% for the general community]), South Africa (40% in 2003), Zambia (26.7%), Nigeria (9.0%), Honduras (6.8%), Russian Federation (3.1%), Netherlands (3.1%), France (4.1%), and Spain (16.4% in 2000).(11-16)

Survival Experience

AIDS deaths among prisoners have become less frequent. However, in the 1980s, the time from AIDS diagnosis until death was shortened to 42% (in 1986) and then 66% (in 1988) as long as that of matched New York City unincarcerated persons with AIDS. The survival time for female inmates in the state of New York was much worse than that for male inmates.(17) In addition, HIV-infected inmates with a first case of *Pneumocystis jiroveci* pneumonia (PCP) had a 22% mortality rate, compared with an 8% rate among patients with HIV and PCP in the community at large in 1989.(18) A remarkable statistic from New York in 1988 was that >25% diagnoses of AIDS, as defined by the U.S. Centers for Disease Control and Prevention (CDC), in prison settings were first made at autopsy.(19) In 1997, AIDS diagnoses of inmates in the state of New York were still often established only at autopsy, delaying statistical monitoring by at least 8 months, pending autopsy completion. Some diagnoses of tuberculosis (TB) in inmates were made only at autopsy. Although New York held one third of all prisoners in the United States known to be HIV positive, a 2001 report showed that the number of AIDS deaths in 1999 among prisoners in that state was 26, down from an annual peak of 258 in 1994, and the lowest it had been in 16 years. In 2003, when New York still reported the nation's highest HIV seroprevalence among its prisoners, the highest death rates from AIDS-related causes were reported in Delaware, Maryland, and Florida.(3) The availability of antiretroviral drugs for prisoners, increasing number of specialists in HIV care among prison medical staffs, and the lower rate of HIV seroprevalence among inmates are all believed to be factors contributing to the reduced frequency of AIDS-related deaths among prisoners.

A report from Spain describes a parallel improvement in case identification and survival. A review of the delay between time of discovery of HIV seropositivity and diagnosis of AIDS revealed that, in 1984, 100% of prisoners' HIV infections were diagnosed in the same month as AIDS, whereas in 2000 only 4% of HIV and AIDS diagnoses were made within a month of each other.(20)

HIV Transmission in Prisons

Numerous activities known to occur among prisoners pose a risk for HIV infection. studies have identified transmission of HIV in prison, based on serial serotesting for HIV antibody, some identifying seroconversion in inmates after more than 5 years of continuous incarceration.(21-24) Molecular analysis of 14 HIV-positive inmates in Glenochil Prison in Scotland in 1993 found sequencing similarities and clinical histories in 13 of the 14, indicating transmission occurred at the institution.(25)

Data gathered in the Georgia State Prisons from mandatory testing of all inmates at intake followed by inmate requested tests, or annual voluntary HIV serotesting which was offered between 2003-2005, identified 88 prisoners who seroconverted between 1992-2005 after one or more negative tests. Investigators analyzed data collected from cases and control subjects through computer assisted self interviews. Characteristics associated with prisoners' HIV seroconversion were male-male sex in prison, tattooing in prison, age >26 at interview, >5 years served of current prison sentence, black race, and a body mass index <25.4kg/m2 on entry into prison. This CDC report includes a wealth of information about the prisoners, reported risk activities, precautions practiced, and knowledge about and suggestions for prevention of transmission of HIV in prison.(26)

No confirmed cases of HIV infection among prison staff in the United States have been attributed to contact with inmates. There is a report from Australia of seroconversion of an officer who was injected by an HIV-infected inmate with a syringe full of the inmate's blood.(27)

Sexual activity among male inmates is not uncommon in prisons and jails. A Federal Bureau of Prisons study in 1982 reported that 30% of federal prison inmates engaged in homosexual activity while incarcerated.(28) In a 1984 study of Tennessee inmates, 17% reported homosexual activity in prison.(29) Former prisoners surveyed in New York reported use of makeshift devices for safer sex, such as fingers of latex gloves, when condoms were not available.(30)

The frequency of homosexual rape in jails and prisons is extremely difficult to estimate. The victim who reports rape in prison faces a probability of further suffering and worse injury. The Federal Bureau of Prisons study reported that 9-20% of federal inmates, especially new or homosexual inmates, were victims of rape.(28) The text of the Prison Rape Reduction Act of 2002 states that the best expert estimate of the percentage of individuals who are sexually attacked at least 1 time during their incarceration is a national median of 13.6%. (The act establishes standards for identifying, investigating, and eliminating prison rape in the United States.)

Other incidents of interpersonal violence (including fights involving lacerations, bites, and bleeding in 2 or more participants) present some risks for HIV transmission. Housing more than 1 inmate per cell, common now in crowded institutions, is a major contributing factor to incidents of violence and sexual assault.

British investigators interviewed 452 released prisoners about activities before, during, and after prison stays and found that persons engaged in fewer incidents of HIV risk behavior in prison, but that activities in prison were associated with increased risk. Those who reported engaging in penetrative sex while in prison also reported doing so with greater frequency outside, although they used condoms only outside. Reported sharing of syringes increased during imprisonment, as did less effective methods of syringe cleaning.(31) In another report from the United Kingdom, IDUs who were former prisoners reported a high prevalence of injection and sexual risk behaviors while in prison; 33 of 50 had injected drugs, and 5 of 50 had engaged in sex with 2 to 16 men.(32)

Although imprisoned IDUs do not use drugs with the frequency that they can when they are not incarcerated, they share injection equipment more and sterilize it less because of scarce resources. A handmade syringe may be fashioned from (among other things) parts of pens and light bulbs. Prisoners also may share toothbrushes and shaving equipment in facilities where they are not issued, where inmates are unable to purchase their own, or where infection control precautions are not practiced adequately.

Tattooing is a widespread activity in prisons and usually is performed without fresh or sterile instruments. It involves multiple skin punctures with recycled, sharpened, and altered implements such as staples, paper clips, and the plastic ink tubes from ballpoint pens. Prison wisdom holds that tattooing that causes blood to flow results in the best quality image and is least likely to become

infected. Homemade pigment is delivered intradermally (at a sharp angle) rather than through direct puncture. Metal points connected to a battery or other electrical source are capable of producing vibration, increasing the number of skin punctures exponentially, thereby creating a better tattoo, but also increasing the risk of HIV transmission. Body piercing is becoming more popular in prison, as in the outside community, and clean instruments for this practice similarly are unavailable.

HIV and Hepatitis C

The prevalence of hepatitis C virus infection among prisoners approaches 40%, and far exceeds that of HIV in prison. Coinfection with the 2 viruses, which therefore is exceptionally common in prisoners, is associated with an accelerated course of hepatitis C disease, making treatment of both diseases particularly urgent in the correctional setting. Recognition of the existence and course of hepatitis C, and of its epidemic proportions in prison, has been relatively recent.(33,34)

HIV and Tuberculosis

TB has long been an infection of particular concern in the prison setting because of its higher incidence compared with that of the community at large and the ease and frequency of airborne transmission of TB bacilli in the crowded conditions commonly found in prisons.(35)

Reports described a 6-fold increase in the incidence of TB among inmates in the state of New York from 1976 to 1986, by which time more than 50% of inmates with TB also were infected with HIV.(36) A survey of TB cases in the United States between 1993 and 2003 found that 3.8% were reported from correctional systems, 3-4 times the rate reported outside prisons. This survey of 210,976 cases also found that 58.9% of prisoners completed treatment, compared with 73.2% of noninmates.(37)

The inconsistent treatment that often characterizes prisoners' medical care can permit the development of multidrug-resistant (MDR) strains of *Mycobacterium tuberculosis*--a medical calamity reported in the New York and California state prisons. In New York, 7 inmates and 1 immune-suppressed guard died with rapidly fatal, untreatable TB in 1991.(38) The clinical history of a California prison inmate treated for *M tuberculosis* and then MDR-TB over 3.5 years illustrates the full range of problems in prison medical care: poor record keeping at initial screening, delay in diagnosis of symptomatic disease, lack of isolation of the patient at the time of diagnosis, lack of supervision or observation of medication ingestion, lack of follow-up after completion of initial treatment, infirmary treatment in a setting with susceptible HIV patients, inadequate ventilation of patients' rooms, transfers among 3 different prisons, and inadequate screening and testing of prison staff and inmate contacts.(39) Illustrating the dangers of TB to HIV-infected prisoners, a 1999 CDC report described multiple tuberculin skin test (TST) conversions in 1995-96 among California prisoners, staff, and community contacts despite TB control practices. Two HIV-positive inmates--one with a documented negative TST, the other previously treated for positive TST, with *M tuberculosis*-negative sputum smears and cultures--proved to be infected with TB after initial placement in open prison HIV housing units. Similarly, during 1999-2000, 31 HIV-positive prison contacts of an inmate with unsuccessfully treated latent TB were diagnosed with TB in South Carolina. Rapid spread of TB can be a consequence of segregated housing for HIV-positive inmates.(40,41) TB outbreaks continue to evade infection control programs; reports have come from many correctional systems, including Alabama in 2003, Kansas in 2004, Florida in 2005, and Georgia in 2006.

In jails, many inmates are not incarcerated long enough to permit diagnosis or treatment. Clinical investigation for suggestive signs and symptoms is critical. To detect active pulmonary disease in the setting of rapid inmate turnover, the Los Angeles County Jail system features "mini chest films" at intake--single-view, low-dose screening radiographs--at much greater cost than the widely practiced skin test, but with immediate results. Although they will not detect all cases of TB, these radiographic

images identify persons with communicable disease who require immediate treatment and isolation.(42)

In addition to intake screening for TB, subsequent routine follow-up and surveillance programs are essential for inmates and prison staff. The CDC published recommendations for prevention and control of TB in correctional institutions in 1989 and 1996. In December 2005, the Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings published by the CDC included correctional facilities as health care settings.(43,44,45)

Medical Treatment of HIV-Infected Prisoners

Prisons and jails, designed to confine and punish people (many of whom are poor and lack influential outside advocates), frequently fail to provide the level of health services required by patients with HIV. As with other chronic illnesses, HIV requires health services that are expensive in terms of staff effort and expertise, laboratory testing, and medication. Prisons often have escaped outside attention to serious failures of care. HIV has placed an enormous fiscal burden on prisons, which already are stressed financially. The cost of HIV care in the 21st century in prisons now is rivaled by the cost and controversies surrounding management of hepatitis C, which affects up to 40% of prison inmates, and by the cost of psychotropic agents for the large number of individuals with mental illness who are imprisoned in the United States.

Prisons increasingly are recognizing the need for consultation and treatment of HIV by medical specialists, and several states provide care in conjunction with outside university-based clinic systems. Participation by HIV specialists is by no means the rule, however.(46) Treatment with potent antiretroviral therapy is the standard of care for HIV and AIDS in prisons, as in the community at large. A survey of treatment regimens of the 3,563 prisoners supplied through Stadtlander Pharmacy's Corrections Division in February 1999 found that 45% were receiving drug regimens recommended by 1998 U.S. Department of Health and Human Services guidelines. Seven percent were on regimens categorized as "alternative," 28% "not generally recommended," 8% "not recommended," and 12% were reported as "unclassified."(47)

Often, prison conditions undermine the consistent dosing schedules essential to the long-term effectiveness of antiretroviral therapy. Gaps in treatment occur due to transfers of inmates among correctional institutions. Confiscation of all medications from prisoners is also a common practice of prison staff in the course of searches for contraband. Court appearances, transfers among facilities, punitive detentions, and release from custody are all part of the prisoner's life, and provisions must be made to continue therapy through these events without interruption.

In many prisons, antiretroviral therapy is administered under direct observation to prisoners. Observers have reported that adherence to antiretroviral therapy among prisoners apparently has been good. At Rikers Island in New York City, patients' CD4 counts rose in a pattern almost identical to that found in clinical trials.(48) Among 170 prison patients in Wisconsin who self-administered medications, improvements in CD4 and viral measures were comparable with those found in community patients.(49) A 1996 survey of 205 HIV-infected prisoners eligible for potent antiretroviral therapy that found an acceptance rate of 80% and an adherence rate of 84% also found that adherence was 82% in those who received directly observed therapy, and 85% in those who self-administered medications.(50)

Every jurisdiction is responsible for providing health care to its prisoners. In 2006, no required guidelines or standards of care exist, although several organizations have developed voluntary health care standards for correctional facilities. The American Correctional Association, the American Public Health Association (APHA), and the National Commission on Correctional Health Care (NCCHC)

have published standards for health care and HIV management in jails and prisons. The NCCHC also provides accreditation for subscribing institutions that meet its standards. The World Health Organization (WHO) published guidelines for management of HIV in prison 1987 and 1993,(51) and the APHA included guidelines in its book of standards in 1986, updated in 1996 and 2003.(52,53) Medical personnel, public health advisers, prison administrators, legislators, courts, and the electorate all have influenced policy development for management of HIV in prisons.

Among 19 countries in an international survey prepared for the WHO, the United States was 1 of 4 that did not have a national policy for HIV management in prison.(12) The National Commission on AIDS, in its March 1991 report, proposed that the U.S. Public Health Service develop guidelines for the prevention and treatment of HIV in all U.S. correctional facilities.(1)

In the fall of 1987, the WHO Special Programme on AIDS held a consultation on the prevention and control of HIV in prisons, and specialists from 26 nations attended. This group's consensus statement recognized the risks of HIV transmission in prisons and recommended the following general approaches:

> Treatment of prisoners in a manner similar to the treatment of other members of the community
> Consideration of compassionate release for prisoners with AIDS
> Implementation of nondiscriminatory practices relating to HIV infection
> Provision of information on HIV to staff as well as prisoners
> Implementation of means to obtain informed consent and ensure confidentiality in the event of HIV antibody testing
> Devotion of additional human and financial resources to HIV management in prisons, but not at the expense of other health services and activities

A subsequent WHO conference held in Geneva in 1992 drafted more extensive and specific guidelines outlining applications of the principles above.(51)

HIV Testing Policies

HIV in prisons raises a number of issues that do not exist for the general community; one of these is mandatory HIV antibody testing. The earliest public policy debates on HIV in prisons focused not on care and prevention but on whether to mandate testing. In 2003, 19 state prison systems and the Federal Bureau of Prisons had mandatory HIV screening policies for their incoming inmates.(54)

Prisoners cannot give true, free informed consent. In every area of life, inmates bargain for privileges, better conditions, and, ultimately, release. Where HIV testing is not mandatory, prisoners require more information than others to make informed decisions about taking the test. To give informed consent, prisoners must understand the institutional consequences of a positive HIV antibody test result, such as segregation and loss of access to activity programs, visitation, and jobs. Even this information may not permit prisoners to make a free choice about testing, as many prisons have policies of segregating prisoners who refuse testing with the policy that they can join the general population only after they have been "medically cleared."

HIV testing has benefited inmates in institutions that offer antiretroviral therapy and prophylaxis against opportunistic infections. Voluntary testing increasingly has become available to prisoners since early medical intervention has been offered. A review of HIV infections identified through voluntary counseling and testing programs for prisoners in 48 project areas in the United States between 1992 and 1998 found a steady increase in the use of testing services. There were 16,797 reactive tests (3.4%), 56% of which involved individuals who had been unaware of their serostatus at

the time of testing.(55) Acceptance rates for seroprevalence testing by new inmates in Maryland and Wisconsin have been reported at 47-83%.(48) In 2003, 45 of 49 responding state prison systems and the federal prison system reported testing for HIV at inmates' request.(3)

Confidentiality

Confidentiality of medical information in the prison setting is virtually impossible to maintain. Where quarantines exist, confidentiality cannot. Persons other than medical staff members may handle medical records, and medical personnel may not be meticulous about protecting privacy. Once information is released in a prison, it travels rapidly. Many people in the prison setting believe they have a particular need to know who in the institution is infected with HIV. It has been argued that prisoners have a greater need for privacy than those outside because they live in a closed community where violence is common.

Prison policies vary in regard to disclosure of test results. Fear of disclosure and its consequences may discourage voluntary testing. Prison officials use HIV antibody test results to make decisions about housing and segregation, work assignments, and visiting privileges, among other matters. It has been common practice to bar inmates with HIV (or AIDS) from kitchen work. In some jurisdictions, results of HIV tests go directly to the prison staff. In 1988, California voters passed Proposition 96, an initiative authored by the sheriff of Los Angeles County requiring prison and jail physicians to give lists of known or suspected HIV-infected prisoners to custodial staff members. Such policies reflect the fear and misinformation prevalent in many prisons, and undermine the message and practice of universal precautions.

Prevention

Means of prevention of HIV transmission, and their use in prisons, always have provoked controversy and implementation of divergent policies. Prisons historically have approached prevention of HIV either by quarantine and segregation or by education. Other specific preventive practices include dispensing of condoms, bleach and clean injecting equipment, and methadone maintenance treatment.

By 2005, only the state of Alabama tested and placed all those identified as HIV positive in segregated housing. The trend over time has been away from segregation and toward case-by-case determination of housing placement.

Increasing staff-to-prisoner ratios, classifying and housing inmates carefully, decreasing overcrowding, and providing activities for inmates help to prevent transmission through nonconsensual risk behavior (eg, violence, including rape). Preventing violence is the ongoing responsibility of prison staff. Effective staffing and education help prevent consensual but risky behavior (eg, sharing contaminated needles, unsafe sex).

For the purpose of HIV infection control in most U.S. prisons, the educational message is that no risk activity is safe, and exposure to semen and bloody body fluids should be avoided.

Education

Prisoners represent a crucial and huge target population for HIV education programs; prisons concentrate persons at risk who are not easily reached in the community by such efforts. As many as 50% of U.S. prisoners are functionally illiterate, and many are not native English speakers; to be

effective, educational programs must be modified to reach them. The generally available literature on HIV infection and AIDS either cannot be understood by most inmates or fails to address many of their particular needs.

Although the primary goal of HIV education in prisons is prevention, other critical objectives include promoting an understanding that engenders rational and humane treatment of affected inmates. Because of the dynamics of the correctional setting, information provided by people who are not prisoners, from general facts to specific medical advice, often is not trusted. Recommendations to begin antiretroviral therapy, for instance, have not been accepted as readily in prisons as in the general community. Therefore, HIV education in prisons must transmit information in a manner that addresses and bridges not only language, culture, and literacy gaps, but also the distrust of people on the other side of the bars. Individual counseling, peer counseling, support groups, and special programs for women, designed by and for prisoners, have been successful in a number of institutions and seem to be the best educational tools. Several gripping and effective videotapes have been made by and for prisoners.

Coupling educational programs with voluntary testing and counseling services has been effective in identifying individuals with previously unknown infection, promoting acceptance of and adherence to treatment interventions and postrelease follow-up, and reducing risk behavior in custody and after release.(55,56) An analysis of the cost effectiveness of HIV counseling and testing in U.S. prisons identified cost benefits from reduction of HIV transmission among otherwise unidentified and uninformed people.(57)

Accurate and adequate information for staff and inmates can reduce fears and ultimately affect institutional policies in ways that can alter prisoners' lives profoundly. All persons entering prison must be informed in clear, simple terms, and in their own language, about how to avoid transmission of HIV and other communicable diseases. Educational programs can reduce fears about HIV and its transmission among staff members and inmates.

A Quebec City study of staff members from probation agencies, halfway houses, and prisons found that prison officers were the group least informed about HIV transmission and prevention and expressed the most negative attitudes about HIV-infected people.(58) A Pennsylvania prison study reported that prisoners, staff, community groups, and legal authorities believe the "quality of life for HIV-positive inmates was most influenced by education of prison staff. Effective education for staff and inmates was live and interactive, targeted to the perceived risk of distrustful audiences, delivered by a trusted source, accurate, and aimed at reducing risk-perception."(59)

Condoms

Condom availability in prison is one of the many issues over which legal interests and public health interests conflict. Most prison administrators in the United States have not permitted the distribution of condoms to inmates. Statutes in many jurisdictions make sexual activity in prison a punishable crime. It is argued that condom distribution would condone and promote this behavior. Another objection to condoms in institutions is that they are considered contraband--a container for hiding drugs or other illegal things that inmates may swallow and later retrieve.

In the United States, condoms are available in state prisons in Vermont and Mississippi and in urban jail systems in New York City, Philadelphia, Los Angeles, San Francisco, and the District of Columbia. Condoms have been available in most European prisons for more than 10 years. Studies have found few incidents of improper condom use (eg, as a container for swallowed illegal drugs) and a high level of reported safer sex.

Sterile Syringes

The distribution of sterile syringes to inmates also has been discussed as a means of preventing HIV transmission but does not occur in any U.S. prison. A survey conducted in December 2000 identified 19 prison-based needle exchange programs in Europe.(60) Evaluations of these programs found decreased needle sharing and no newly identified cases of HIV, hepatitis B, or hepatitis C. The Swiss Hindelbank pilot project performed a 1-year study of the effects of a needle exchange program, observing that needles were not used as weapons and that fewer abscesses occurred among inmates.(61) As with condoms, syringes usually have been available through dispensing machines or prison health personnel.

Bleach

Safer injecting practice information (including providing bleach for cleaning syringes)is included in the education and counseling programs of many correctional systems in Europe, whereas correctional systems in the United States do not systematically provide bleach. Half of 20 European countries' prison systems surveyed provided disinfectant for injection materials in 1998.(62)

Methadone Maintenance

Although methadone maintenance treatment rarely is available to prisoners in the United States, it is offered to inmates in most Western European systems, some Eastern European systems, and Australia and Canada. Studies indicate reduced use of illicit injections among participants in these programs.(12,63)

Discharge Planning

As noted above, one quarter of HIV-positive people in the United States have spent time in the correctional system. Connecting released prisoners to community resources is a critical opportunity and responsibility for jails and prisons. Recognizing the potential for public health and educational interventions in prisons to reduce the disease's devastation in the larger community, prisons and jails gradually are making efforts to assure continuity of care and follow-up of AIDS patients after their release from custody. The transition for prisoners from custody to community often is chaotic and difficult, and health care concerns often take a lower priority than the search for jobs and housing, rebuilding personal relationships, and a myriad of other chores. Many policies exist on paper but not in practice. The planning that does occur ranges from giving inmates information about outside resources, to making appointments, to accompanying released inmates and assisting with enrollment for housing, health care, drug rehabilitation, financial benefits, HIV counseling, and psychosocial support. Several states provide case management services, establishing contact with prisoners and beginning to plan several months before scheduled release dates. A review of women who had participated in Rhode Island's intervention and discharge planning program found that their rate of return to prison was reduced by 26% a year after release, suggesting that these women had reduced the risk activities in the community that in the past had led to their incarceration.(64)

AIDS Research

The Nuremberg Code, developed after World War II as the result of hearings regarding Nazi treatment of prisoners, stated that "the voluntary consent of the human subject is absolutely essential" for medical research. Many countries subsequently outlawed all research on prisoners. The pharmaceutical industry regularly performed medical research involving prisoners in the United States

until banned by federal prisons and several states in the 1970s. Prisoners who participated often lived in separate and superior housing units, ate better food, earned more money than was available for other prison work, and were offered hope of parole. No pharmaceutical agents were being used in clinical trials in the U.S. state prison systems in 2005.(65)

The issue of medical experimentation and research on prisoners arose in a new context in the 1980s and 1990s, as HIV and related conditions were treated in the community with experimental drugs that the Food and Drug Administration had not yet approved and that generally were not available to prisoners. There is a clear distinction between experimental drug treatments used primarily for the benefit of the imprisoned HIV-infected patients and those used to test the hypotheses of drug developers or others.(66) In 1994, 15 of the 51 state or federal systems surveyed reported offering experimental therapies to inmates with HIV disease.(67) A Connecticut prison survey of 101 eligible inmates in 1996 found that 50% were willing to participate in clinical trials within the prison, whereas 66% were willing to do so "outside."(68)

Legal Issues in U.S. Prisons

Prisoners have a constitutional right to health care that people "on the outside" do not have. Under the Eighth Amendment, prisoners are entitled to protection from "cruel and unusual" punishment, and to a "safe and humane environment." In an important U.S. Supreme Court decision, this right was further defined as prohibiting "deliberate indifference to serious medical need" (*Estelle* v *Gamble*, 429 US 97 [1976]). In 1991, the U.S. Supreme Court ruled that to show "deliberate indifference," plaintiffs must demonstrate that correctional officials actually intended to cause the alleged inadequate treatment (*Wilson* v *Seiter*, 111 SCt 2321 [1991]). This narrowed standard is much more difficult for prisoners to prove.(69)

Since the mid-1970s, prison health services have improved as civil rights advocates and attorneys advocating prisoners' rights have challenged conditions of confinement. Prisoners do not vote, and legislators generally have not granted resources for their health care. Litigation, or fear of it, has compelled state and local governments and prison administrations to provide a level of care closer to that available for the general community. Case law regarding HIV in prison has involved a wide range of issues and has contributed to policy development.

Historically, the U.S. courts have been reluctant to scrutinize or challenge prison and jail conditions, assuming that the complexities and peculiarities of those institutions were best dealt with by the prison authorities. Since the critical *Estelle* v *Gamble* decision, courts generally have continued to support existing institutional policies when these are challenged by prisoner plaintiffs. In the area of HIV management and care, courts also have tended to defer to prison managers, despite their lack of medical or public health credentials. Courts have upheld policies of segregation of HIV-seropositive persons as well as policies of no segregation. In 1990, for the first time, a court overturned one state's mandatory HIV testing policy for prisoners. The Ninth Circuit Court of Appeals declared that the state of Nevada failed to show that its policy "was reasonably related to legitimate penological interests." Several settlements modified strict policies of segregation of HIV-positive inmates by prisons, including those in Connecticut and California. In contrast, a federal court upheld mandatory testing and segregation in the Alabama state prison in 1990 and stated that prisoners who requested zidovudine treatment were not entitled to "state of the art" treatment, only reasonable care according to the community standard.(69,70) In January 2000, the U.S. Supreme Court refused to consider an appeal by Alabama inmates who challenged their segregation in that state's prisons. In 2006, the Limestone Correctional Facility in Alabama houses all that state's HIV-positive male prisoners, and a January 2004 court decision affecting these inmates allowed integration for work and educational programs. Two years later, only 2 or 3 inmates were participating in these programs. Other prison HIV issues that have been challenged in the courts include breaches of confidentiality, conspicuous special handling of HIV-positive inmates in court and other public places, inadequate medical and

psychological care, HIV antibody testing without consent, lack of mandatory HIV testing, incorrect HIV diagnosis, and lack of HIV education. In addition, prisoners have been tried for aggravated assault, assault with a deadly weapon, and attempted murder for alleged biting, spitting, or spilling blood in altercations with guards. A Texas prisoner serving a 2-year term was sentenced to life in prison after being convicted of spitting at a prison guard.(71) In August 1997, a former inmate of the Illinois state prison system sued prison staff, claiming he was infected with HIV as a result of ongoing sexual abuse by prison gang members while his requests for help from staff were ignored. He had a documented seroconversion while in custody. His claim was disputed and ultimately was rejected after 2 trials (*Blucker* v *Washington*, 95c50110, U.S. District Court [ND Ill]).

Incarceration also has been used as a means of punishing and controlling persons who are believed to be knowingly infecting others. Many statutes have created criminal sanctions against HIV-infected people believed to be spreading the virus through irresponsible behavior.

References

1. U.S. National Commission on AIDS. HIV Disease in Correctional Facilities. Washington: U.S. National Commission on AIDS; 1991.

2. Harrison P, Beck AJ. Prisoners in 2004. Washington: U.S. Department of Justice, Bureau of Justice Statistics; October 2005.

3. Maruschak L. HIV in Prisons, 2003. Washington: U.S. Department of Justice, Bureau of Justice Statistics; September 2005.

4. Maruschak L. HIV in Prisons and Jails, 2002. Washington: U.S. Department of Justice, Bureau of Justice Statistics; December 2004.

5. Hammett TM, Harmon P, Rhodes W. The Burden of Infectious Disease Among Inmates and Releasees from Correctional Facilities. In: The Health Status of Soon-to-Be-Released Inmates: A Report to Congress. Vol. 2. Chicago: National Commission on Correctional Health Care; March 2002.

6. Dean-Gaitor HD, Fleming PL. Epidemiology of AIDS in incarcerated persons in the United States, 1994-1996. Aids 1999; 13:2429-35.

7. Wang L, Smith L, et al. Disparity in Trends and Changing Patterns of Predictors of HIV Infection among Inmates Entering the New York State Department of Correctional Services: 1998-2003, NYS Department of Health, Albany. In: Program and abstracts of the 13th Conference on Retroviruses and Opportunistic Infections; February 5-8, 2006; Denver. Poster abstract 291.

8. Kassira EN, Bauserman RL, Tomoyasu N, Caldeira E, Swetz A, Solomon L. HIV and AIDS surveillance among inmates in Maryland prisons. J Urban Health 2001; 78:256-63.

9. Gido RL, Gaunay W. Acquired Immune Deficiency Syndrome: A Demographic Profile of New York State Inmate Mortalities. 4th ed. Albany, NY: New York State Commission of Correction; 1990.

10. Lyons JA, Greifinger RA, Flannery T. Deaths of New York State Inmates 1978-1992. Albany, NY: New York State Department of Correctional Services; 1994.

11. Harding TW. HIV/AIDS and Prisons. Report for WHO Global Programme on AIDS. May 1990.

12. Harding TW, Schaller G. HIV/AIDS and prisons: updating and policy review. A Survey Covering 55 Prison Systems in 31 Countries. Geneva: University Institute of Legal Medicine for the WHO Global Programme on AIDS; 1992.

13. Thomas PA, Moerings M. AIDS in Prison. Aldershot, England: Dartmouth Publishing Co.; 1994.

14. Hernandez R, Gutierrez C, Granados C, et al. Drug addiction and AIDS in prison populations. In: Program and abstracts of the XI International Conference on AIDS; July 7-12, 1996; Vancouver, British Columbia. Abstract D.1411.

15. Hammett TM. The burden of HIV among prisoners. In: Program and abstracts of the XIV International AIDS Conference; July 7-12, 2002; Barcelona. Abstract MoPEE3800.

16. Autores VV, Menoyo C, Suarez M, et al. Needle exchange programmes in prison are feasible. In: Program and abstracts of the XIV International AIDS Conference; July 7-12, 2002; Barcelona. Abstract TePuF5484.

17. Mikl J, Kelly KF, Smith PF, et al. Survival among NY State prison inmates with AIDS. In: Program and abstracts of the VII International Conference on AIDS; June 16-21, 1991; Florence, Italy. Abstract M.C.3124.

18. Sharp V, Andrews A, Heyman R, et al. Comparison of first episode of PCP in community patients and inmates. In: Program and abstracts of the IV International Conference on AIDS; June 4-9, 1989; Montreal. Abstract T.B.P.18.

19. The Correctional Association of New York. AIDS in Prison Report. June 1988.

20. Guerrero RA, Humet V, Laliga A, et al. Diagnostic delay related to HIV infection in patients with prison history. In: Program and abstracts of the XIV International AIDS Conference; July 7-12, 2002; Barcelona. Abstract MoPeC3390.

21. Castro K, Shansky R, Scardino V, et al. HIV transmission in correctional facilities. In: Program and abstracts of the VII International Conference on AIDS; June 16-21, 1991; Florence, Italy. Abstract M.C.3067.

22. Brewer TF, Vlahov D, Taylor E, Hall D, Munoz A, Polk BF. Transmission of HIV-1 within a statewide prison system. Aids 1988; 2:363-7.

23. Horsburgh CR, Jr., Jarvis JQ, McArther T, Ignacio T, Stock P. Seroconversion to human immunodeficiency virus in prison inmates. Am J Public Health 1990; 80:209-10.

24. Mutter RC, Grimes RM, Labarthe D. Evidence of intraprison spread of HIV infection. Arch Intern Med 1994; 154:793-5.

25. Yirrell DL, Goldberg DJ, Robertson P, et al. Molecular investigation confirming an outbreak of HIV in a Scottish prison. In: Program and abstracts of the XI International Conference on AIDS; July 7-12, 1996;

Vancouver, Canada. Abstract Mo.C.1532.

26. Centers for Disease Control and Prevention (CDC). HIV transmission among male inmates in a state prison system--Georgia, 1992-2005. MMWR Morb Mortal Wkly Rep. 2006 Apr 21;55(15):421-6.

27. Hammett TM. 1990 Update: AIDS in Correctional Facilities. Washington: U.S. Department of Justice; 1991.

28. Nacci P, Kane T. Sex and Sexual Aggression in Federal Prisons. Washington: Federal Bureau of Prisons; 1982.

29. Decker MD, Vaughn WK, Brodie JS, Hutcheson RH, Jr., Schaffner W. Seroepidemiology of hepatitis B in Tennessee prisoners. J Infect Dis 1984; 150:450-9.

30. Mahon N. New York inmates' HIV risk behaviors: the implications for prevention policy and programs. Am J Public Health 1996; 86:1211-5.

31. Turnbull PJ, Dolan KA, Stimson GV, et al. Prison decreases the prevalence of behaviours but increases the risks. In: Program and abstracts of the VIII International Conference on AIDS; July 19-24, 1992; Amsterdam. Abstract PoC4321.

32. Carvell AL, Hart GJ. Risk behaviours for HIV infection among drug users in prison. Bmj 1990; 300:1383-4.

33. Reindollar RW. Hepatitis C and the correctional population. Am J Med 1999; 107:100S-103S.

34. Colton C. Hepatitis C Virus and HIV Co-infection in Corrections. Infectious Disease in Corrections Report, October 2005 8(10) 1-4.

35. Snider DE, Jr., Hutton MD. Tuberculosis in correctional institutions. Jama 1989; 261:436-7.

36. Braun MM, Truman BI, Maguire B, DiFerdinando GT, Jr., Wormser G, Broaddus R, Morse DL. Increasing incidence of tuberculosis in a prison inmate population. Association with HIV infection. Jama 1989; 261:393-7.

37. MacNeil JR, Lobato MN, Moore M. An unanswered health disparity: tuberculosis among correctional inmates, 1993 through 2003. Am J Public Health 2005; 95:1800-5.

38. Transmission of multidrug-resistant tuberculosis among immunocompromised persons in a correctional system--New York, 1991. MMWR Morb Mortal Wkly Rep 1992; 41:507-9.

39. Probable transmission of multidrug-resistant tuberculosis in a correctional facility--California. MMWR Morb Mortal Wkly Rep 1993; 42:48-51.

40. Tuberculosis outbreaks in prison housing units for HIV-infected inmates--California, 1995-1996. MMWR Morb Mortal Wkly Rep 1999; 48:79-82.

41. Drug-susceptible tuberculosis outbreak in a state correctional facility housing HIV-infected inmates--

South Carolina, 1999-2000. MMWR Morb Mortal Wkly Rep 2000; 49:1041-4.

42. Hammett TM, Harrold L. Tuberculosis in Correctional Facilities. Washington: U.S. Department of Justice; 1994.

43. Prevention and control of tuberculosis in correctional institutions: recommendations of the Advisory Committee for the Elimination of Tuberculosis. MMWR Morb Mortal Wkly Rep 1989; 38:313-20, 325.

44. Prevention and control of tuberculosis in correctional institutions: recommendations of the Advisory Committee for the Elimination of Tuberculosis. MMWR Morb Mortal Wkly Rep. 1996;45:RR-8.

45. Jensen PA, Lambert LA, Iademarco MF, Ridzon R. Guidelines for preventing the transmission of Mycobacterium tuberculosis in health-care settings, 2005. MMWR Recomm Rep 2005; 54:1-141.

46. Bernard K, Sueker JJ, et al. Provider Perspectives about the Standard of HIV Care in Correctional Settings and Comparison to the Community Standard of Care: How Do We Measure Up? Infectious Diseases in Corrections Report. March 2006 9(3) 1-5.

47. Gajewski-Verbanac L, Lewis SM, Chrisman C, et al. Retrospective analysis of antiretroviral treatment guidelines in a national correctional base. In: Program and abstracts of the 39th Interscience Conference on Antimicrobial Agents and Chemotherapy; September 26-29, 1999; San Francisco. Abstract 600.

48. Shuter J. Communicable Diseases in Inmates; Public Health Opportunities. In: The Health Status of Soon-to-Be-Released Inmates: A Report to Congress. Chicago: National Commission on Correctional Health Care; March 2002.

49. Sosman JM, Baker J, Catz SL, et al. Clinical and immune recovery during antiretroviral therapy among HIV-infected prisoners. In: Program and abstracts of the XIV International AIDS Conference; July 7-12, 2002; Barcelona. Abstract MoPeB3263.

50. Altice FL, Mostashari F, Friedland GH. Trust and the acceptance of and adherence to antiretroviral therapy. J Acquir Immune Defic Syndr 2001; 28:47-58.

51. WHO Guidelines on HIV Infection and AIDS in Prisons. Geneva: World Health Organization; 1993.

52. National Commission on Correctional Health Care. Clinical Guideline for Correctional Facilities. Management of Persons with HIV Infections. Chicago: National Commission on Correctional Health Care; November 11, 2001.

53. Standards for Health Services in Correctional Institutions, 3rd ed. Washington: American Public Health Association; 2003.

54. Personal communication with L Maruschak, Bureau of Justice Statistics, March 2006.

55. Sabin KM, Frey RL, Jr., Horsley R, Greby SM. Characteristics and trends of newly identified HIV infections among incarcerated populations: CDC HIV voluntary counseling, testing, and referral system, 1992-1998. J Urban Health 2001; 78:241-55.

56. Andrus JK, Fleming DW, Knox C, McAlister RO, Skeels MR, Conrad RE, Horan JM, Foster LR. HIV testing in prisoners: is mandatory testing mandatory? Am J Public Health 1989; 79:840-2.

57. Varghese B, Peterman TA. Cost-effectiveness of HIV counseling and testing in US prisons. J Urban Health 2001; 78:304-12.

58. Allard F, April N, Martin C, et al. Knowledge and attitudes of correctional facilities staff towards HIV and HBV infections. In: Program and abstracts of the VIII International Conference on AIDS; July 19-24, 1992; Amsterdam. Abstract PuD 9003.

59. Stewart L. The relationship between AIDS education, risk perception and quality of life for HIV-infected inmates in Pennsylvania prisons. In: Program and abstracts of the VIII International Conference on AIDS; July 19-24, 1992; Amsterdam. Abstract PoD 5070.

60. Dolan K, Rutter S, Wodak AD. Prison-based syringe exchange programmes: a review of international research and development. Addiction 2003; 98:153-8.

61. Nelles J, Fuhrer A, Hirsbrunner H, Harding T. Provision of syringes: the cutting edge of harm reduction in prison? Bmj 1998; 317:270-3.

62. Laporte JD, Bolinni P. Management of HIV/AIDS-related problems: situation in European prisons. In: Program and abstracts of the XII World AIDS Conference; June 28-July 3, 1998; Geneva. Abstract 44193.

63. Dolan KA, Wodak AD, Hall WD. Methadone maintenance treatment reduces heroin injection in New South Wales prisons. Drug Alcohol Rev 1998; 17:153-8.

64. Vigilante KC, Rich JD, Affleck P, et al. The women's HIV prison prevention program: reduction of prison recidivism may suggest HIV risk reduction. In: Program and abstracts of the 4th Conference on Retroviruses and Opportunistic Infections; January 22-26, 1997; Washington. Abstract 524.

65. Paar D, Thomas D, et al. Research in corrections. Infectious Diseases in Corrections Report. September 2005 8(9) 1-3.

66. Dubler NN, Sidel VW. On research on HIV infection and AIDS in correctional institutions. Milbank Q 1989; 67:171-207.

67. Hammett TM, Widom R, Epstein J, et al. 1994 Update: HIV/AIDS and STDs in Correctional Facilities. Washington: U.S. Department of Justice, National Institute of Justice, Centers for Disease Control and Prevention; 1995.

68. Altice FL, Mostashari F, Thompson AS, et al. Perceptions, acceptance and adherence to antiretrovirals among prisoners. In: Programs and abstracts of the 4th Conference on Retroviruses and Opportunistic Infections; January 22-26, 1997; Washington. Abstract 253.

69. Gostin L, Porter L. AIDS Litigation Project II: A National Survey of Federal, State and Local Cases Before Courts and Human Rights Commissions. Objective Description of Trends in AIDS Litigation. Washington: Department of Health and Human Services, Public Health Service, National AIDS Program Office; 1991.

70. Gostin L, Porter L, Sandomire H. AIDS Litigation Project: A National Survey of Federal, State and Local Cases Before Courts and Human Rights Commissions. Washington: Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office of Public Health Service HIV/AIDS Coordination; 1990.

71. Greenspan J. Transmission laws: the repression of HIV positive persons. In: The Exchange. San Francisco: National Lawyers Guild; October 1990;13:3-5.

APPENDIX 11

95TH GENERAL ASSEMBLY
State of Illinois
2007 and 2008
HB0686

Introduced 2/6/2007, by Rep. Monique D. Davis

SYNOPSIS AS INTRODUCED:

730 ILCS 5/3-7-2 from Ch. 38, par. 1003-7-2

Amends the Unified Code of Corrections. Provides that all institutions and facilities of the Department of Corrections shall permit a committed person to purchase, possess, and use condoms. Provides that a committed person may not be denied any privileges or good conduct credit because of the committed person's purchase, possession, or use of condoms. Provides that neither the Department of Corrections nor an institution or facility of the Department may declare condoms as contraband. Provides that by January 1, 2008, the Department of Corrections shall develop a plan to make condoms available to committed persons according to established public health practices and in a manner that protects the health, safety, and privacy of committed persons and correctional facility staff. Effective immediately.

LRB095 07299 RLC 27438 b

FISCAL NOTE ACT MAY APPLY

A BILL FOR

AN ACT concerning criminal law.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Unified Code of Corrections is amended by changing Section 3-7-2 as follows:

(730 ILCS 5/3-7-2) (from Ch. 38, par. 1003-7-2)

Sec. 3-7-2. Facilities.

(a) All institutions and facilities of the Department shall provide every committed person with access to toilet facilities, barber facilities, bathing facilities at least once each week, a library of legal materials and published materials including newspapers and magazines approved by the Director. A committed person may not receive any materials that the Director deems pornographic.

(b) (Blank).

(c) All institutions and facilities of the Department shall provide facilities for every committed person to leave his cell for at least one hour each day unless the chief administrative officer determines that it would be harmful or dangerous to the security or safety of the institution or facility.

(d) All institutions and facilities of the Department shall provide every committed person with a wholesome and nutritional diet at regularly scheduled hours, drinking water, clothing

adequate for the season, bedding, soap and towels and medical and dental care.

(e) All institutions and facilities of the Department shall permit every committed person to send and receive an unlimited number of uncensored letters, provided, however, that the Director may order that mail be inspected and read for reasons of the security, safety or morale of the institution or facility.

(f) All of the institutions and facilities of the Department shall permit every committed person to receive visitors, except in case of abuse of the visiting privilege or when the chief administrative officer determines that such visiting would be harmful or dangerous to the security, safety or morale of the institution or facility. The chief administrative officer shall have the right to restrict visitation to non-contact visits for reasons of safety, security, and order, including, but not limited to, restricting contact visits for committed persons engaged in gang activity. No committed person in a super maximum security facility or on disciplinary segregation is allowed contact visits. Any committed person found in possession of illegal drugs or who fails a drug test shall not be permitted contact visits for a period of at least 6 months. Any committed person involved in gang activities or found guilty of assault committed against a Department employee shall not be permitted contact visits for a period of at least 6 months. The Department shall offer every

visitor appropriate written information concerning HIV and AIDS, including information concerning how to contact the Illinois Department of Public Health for counseling information. The Department shall develop the written materials in consultation with the Department of Public Health. The Department shall ensure that all such information and materials are culturally sensitive and reflect cultural diversity as appropriate. Implementation of the changes made to this Section by this amendatory Act of the 94th General Assembly is subject to appropriation.

(g) All institutions and facilities of the Department shall permit religious ministrations and sacraments to be available to every committed person, but attendance at religious services shall not be required.

(h) Within 90 days after December 31, 1996, the Department shall prohibit the use of curtains, cell-coverings, or any other matter or object that obstructs or otherwise impairs the line of vision into a committed person's cell.

(i) All institutions and facilities of the Department shall permit a committed person to purchase, possess, and use condoms. A committed person may not be denied any privileges or good conduct credit because of the committed person's purchase, possession, or use of condoms. Neither the Department nor an institution or facility of the Department may declare condoms as contraband. By January 1, 2008, the Department shall develop a plan to make condoms available to committed persons according

to established public health practices and in a manner that protects the health, safety, and privacy of committed persons and correctional facility staff.

(Source: P.A. 94-629, eff. 1-1-06.)

Section 99. Effective date. This Act takes effect upon becoming law.

Assembly Bill No. 1677

Passed the Assembly June 1, 2005

Chief Clerk of the Assembly

Passed the Senate August 24, 2006

Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2006, at _____ o'clock ___M.

Private Secretary of the Governor

CHAPTER _____

An act to add Section 5012 to the Penal Code, relating to inmates.

LEGISLATIVE COUNSEL'S DIGEST

AB 1677, Koretz. Corrections: condom distribution.

Under existing law, the Director of Corrections is responsible for the administration of the state prisons. Existing regulation prohibits inmates from participating in illegal sexual acts.

This bill would require the director to allow any nonprofit or health care agency to distribute sexual barrier protection devices, as specified. The bill would state that the distribution of those devices shall not be considered a crime nor shall it be deemed to encourage sexual acts between inmates. The bill would specify that possession of one of those devices shall not be used as evidence of illegal activity for purposes of administrative sanctions. The bill would require that these provisions be implemented in a manner that protects the health and safety of correctional officers.

The people of the State of California do enact as follows:

SECTION 1. Section 5012 is added to the Penal Code, to read:

5012. (a) The Director of Corrections shall allow any nonprofit or public health care agency to distribute sexual barrier protection devices such as condoms and dental dams to inmates. Any agency that distributes those devices shall be subject to all relevant laws and regulations regarding visitors to correctional facilities.

(b) The distribution of those devices shall not be considered a crime nor shall it be deemed to encourage sexual acts between inmates.

(c) Possession of a device distributed pursuant to subdivision (a) shall not be used as evidence of illegal activity for purposes of administrative sanctions.

(d) This section shall be implemented in a manner that protects the health and safety of correctional officers.

Approved _____, 2006

_____

Governor

Appendix 13

Legislation Relative to Harm Reduction

KRS 217.177 Sale and disposal of hypodermic syringes or needles.

(1) No person engaged in sales at retail shall display hypodermic syringes or needles in any portion of the place of business which is open or accessible to the public.
(2) Every person engaged in sales of hypodermic syringes or needles at retail shall maintain a bound record in which shall be kept:
    (a) The name of the purchaser; and
    (b) The address of the purchaser; and
    (c) The quantity of syringes or needles purchased; and
    (d) The date of the sale; and
    (e) Planned use of such syringes or needles.
(3) Said record shall be maintained for a period of two (2) years from the date of the sale and shall be available for inspection during business hours by any law enforcement officer, agent or employee of the Cabinet for Health and Family Services or Board of Pharmacy engaged in the enforcement of KRS Chapter 218A.
(4) No person shall present false identification or give a false or fictitious name or address in obtaining or attempting to obtain any hypodermic syringe or needle.
(5) No person engaged in the retail sale of hypodermic syringes or needles shall:
    (a) Fail to keep the records required by this section; or
    (b) Fraudulently alter any record required to be kept by this section; or
    (c) Destroy, before the time period required by this section has elapsed, any record required to be kept by this section; or
    (d) Sell, or otherwise dispose of, any hypodermic syringe to any person who does not present the identification required by this section; or
    (e) Disclose the names in said book except to those required by this section.
(6) Any physician, other licensed medical person, hospital, or clinic disposing of hypodermic syringes or needles shall crush the barrel of same or otherwise render the instrument incapable of further use.

Effective: June 20, 2005
History: Amended 2005 Ky. Acts ch. 99, sec. 513, effective June 20, 2005. -- Amended 1998 Ky. Acts ch. 426, sec. 458, effective July 15, 1998. -- Created 1974 Ky. Acts ch. 404, sec. 1.

KRS 218A.500 Definitions for KRS 218A.500 and 218A.510 -- Unlawful practices -- Penalties.

As used in this section and KRS 218A.510:
(1) "Drug paraphernalia" means all equipment, products and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting,

ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this chapter. It includes, but is not limited to:

(a) Kits used, intended for use, or designed for use in planting, propagating, cultivating, growing, or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived;

(b) Kits used, intended for use, or designed for use in manufacturing, compounding, converting, producing, processing, or preparing controlled substances;

(c) Isomerization devices used, intended for use, or designed for use in increasing the potency of any species of plant which is a controlled substance;

(d) Testing equipment used, intended for use, or designed for use in identifying, or in analyzing the strength, effectiveness or purity of controlled substances;

(e) Scales and balances used, intended for use, or designed for use in weighing or measuring controlled substances;

(f) Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose, used, intended for use, or designed for use in cutting controlled substances;

(g) Separation gins and sifters used, intended for use, or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining marijuana;

(h) Blenders, bowls, containers, spoons, and mixing devices used, intended for use, or designed for use in compounding controlled substances;

(i) Capsules, balloons, envelopes, and other containers used, intended for use, or designed for use in packaging small quantities of controlled substances;

(j) Containers and other objects used, intended for use, or designed for use in storing or concealing controlled substances;

(k) Hypodermic syringes, needles, and other objects used, intended for use, or designed for use in parenterally injecting controlled substances into the human body;

(l) Objects used, intended for use, or designed for use in ingesting, inhaling, or otherwise introducing marijuana, cocaine, hashish, or hashish oil into the human body, such as: metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens, permanent screens, hashish heads, or punctured metal bowls; water pipes; carburetion tubes and devices; smoking and carburetion masks; roach clips which mean objects used to hold burning material, such as marijuana cigarettes, that have become too small or too short to be held in the hand; miniature cocaine spoons, and cocaine vials; chamber pipes; carburetor pipes; electric pipes; air-driven pipes; chillums; bongs; ice pipes or chillers.

(2) It is unlawful for any person to use, or to possess with intent to use, drug paraphernalia for the purpose of planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packing, repacking, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this chapter.

(3) It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this chapter.

(4) It is unlawful for any person to place in any newspaper, magazine, handbill, or other publication any advertisement, knowing, or under circumstances where one reasonably should know, that the purpose of the advertisement, in whole or in part, is to promote the sale of objects designed or intended for use as drug paraphernalia.

(5) Any person who violates any provision of this section shall be guilty of a Class A misdemeanor for the first offense and a Class D felony for subsequent offenses.

Effective: July 14, 1992

History: Amended 1992 Ky. Acts ch. 441, sec. 8, effective July 14, 1992. -- Created 1982 Ky. Acts ch. 413, sec. 2, effective July 15, 1982.

KRS 218A.1404 Prohibited activities relating to controlled substances -- Penalties.

(1) No person shall traffic in any controlled substance except as authorized by law.

(2) No person shall possess any controlled substance except as authorized by law.

(3) No person shall dispense, prescribe, distribute, or administer any controlled substance except as authorized by law.

(4) Unless another specific penalty is provided in this chapter, any person who violates the provisions of subsection (1) or (3) of this section shall be guilty of a Class D felony for the first offense and a Class C felony for subsequent offenses and any person who violates the provisions of subsection (2) of this section shall be guilty of a Class A misdemeanor for the first offense and a Class D felony for subsequent offenses.

Effective: July 14, 1992

History: Created 1992 Ky. Acts ch. 441, sec. 27, effective July 14, 1992.

Appendix 14

Legislation Regarding Continuing Medical Education

KRS 214.610 Educational course to be completed by health-care workers and social workers -- Approval by licensing board or certifying entity -- Publication of courses.

(1) (a) The Cabinet for Health and Family Services or the licensing board or certifying entity, subject to the board's or entity's discretion, shall approve appropriate educational courses on the transmission, control, treatment, and prevention of the human immunodeficiency virus and acquired immunodeficiency syndrome, that may address appropriate behavior and attitude change, to be completed as specified in the respective chapters by each person licensed or certified under KRS Chapters 311, 311A, 312, 313, 314, 315, 320, 327, 333, and 335. Each licensing board or certifying entity shall have the authority to determine whether it shall approve courses or use courses approved by the cabinet. Completion of the courses shall be required at the time of initial licensure or certification in the Commonwealth, as required under KRS 214.615 and 214.620, and shall not be required under this section or any other section more frequently than one (1) time every ten (10) years thereafter, unless the licensing board or certifying entity specifically requires more frequent completion under administrative regulations promulgated in accordance with KRS Chapter 13A.

(b) The Department for Public Health shall publish on its Web site the current informational resources for the development of the educational courses or programs. To the extent possible, the educational courses or programs under this subsection shall:

1. Include changes in Kentucky law affecting HIV testing and reporting; confidentiality and privacy of HIV-related data, information, and reports; and advances in treatment protocols, intervention protocols, coordination of services, and other information deemed important by the Department for Public Health and the Centers for Disease Control and Prevention (CDC);
2. Inform all professions involved with or affected by the birthing process about the importance of HIV testing of pregnant women and the probability of preventing perinatal transmission of HIV with appropriate treatment; and
3. Update all health care professionals identified under paragraph (a) of this subsection requesting information about the potential involvement of their occupation in the treatment or prevention of blood-borne pathogens with the latest CDC guidelines on occupational exposure to HIV and other blood-borne pathogens.

(2) Each licensee or certificate holder shall submit confirmation on a form provided by the cabinet of having completed the course by July 1, 1991, except persons licensed under KRS Chapters 314 and 327 for whom the completion date shall be July 1, 1992.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 465, effective June 20, 2005. – Amended 2002 Ky. Acts ch. 211, sec. 47, effective July 15, 2002. -- Amended 2001 Ky. Acts ch. 61, sec. 1, effective June 21, 2001. -- Amended 2000 Ky. Acts ch. 343, sec. 26, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 426, sec. 412, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 369, sec. 3, effective July 15, 1996. -- Created 1990 Ky. Acts ch. 443, sec. 3, effective July 13, 1990.

Appendix 15

902 KAR 2:020. Disease Surveillance.

RELATES TO: KRS 211.180(1), 214.010, 214.645, 333.130
STATUTORY AUTHORITY: KRS 194A.050, 211.090(3), EO 2004-726
NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health and Family Services and placed the Department for Public Health under the Cabinet for Health and Family Services. KRS 211.180 requires the cabinet to implement a statewide program for the detection, prevention, and control of communicable diseases, chronic and degenerative diseases, dental diseases and abnormalities, occupational diseases and health hazards peculiar to industry, home accidents and health hazards, animal diseases which are transmissible to man, and other diseases and health hazards that may be controlled. KRS 214.010 requires every physician and every head of family to notify the local health department of the existence of diseases and conditions of public health importance, known to him or her. This administrative regulation establishes notification standards and specifies the diseases requiring urgent, priority, or routine notification, in order to facilitate rapid public health action to control diseases, and to permit an accurate assessment of the health status of the Commonwealth.

Section 7. Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) Surveillance. (1) Physicians and Medical Laboratories shall report:

(a)1. A positive test result for HIV infection including a result from:

a. Elisa;

b. Western Blot;

c. PCR;

d. HIV antigen; or

e. HIV culture;

2. CD4+ assay including absolute CD4+ cell counts and CD4+%;

3. HIV detectable Viral Load Assay; and

4. A positive serologic test result for HIV infection; or

(b) A diagnosis of AIDS that meets the definition of AIDS established within the Centers for Disease Control and Prevention (CDC) guidelines and reported in the:

1. "Adult HIV/AIDS Confidential Case Report Form," or

2. "Pediatric HIV/AIDS Confidential Case Report Form."

(2) An HIV infection or AIDS diagnosis shall be reported within five (5) business days and, if possible, on the "Adult HIV/AIDS Confidential Case Report form" or the "Pediatric HIV/AIDS Confidential Case Report form."

(a) A report for a resident of Jefferson, Henry, Oldham, Bullitt, Shelby, Spencer, and Trimble Counties shall be submitted to the HIV/AIDS Surveillance Program of the Louisville-Metro Health Department.

(b) A report for a resident of the remaining Kentucky counties shall be submitted to the HIV/AIDS Surveillance Program of the Kentucky Department for Public Health, or as directed by the HIV/AIDS project coordinator.

(3) A report for a person with HIV infection without a diagnosis of AIDS shall include the following information:

(a) The patient's full name;

(b) Date of birth, using the format MMDDYY;

(c) Gender;

(d) Race;

(e) Risk factor, as identified by CDC;

(f) County of residence;

(g) Name of facility submitting report;

(h) Date and type of HIV test performed;

(i) Results of CD4+ cell counts and CD4+%;

(j) Results of viral load testing;

(k) PCR, HIV culture, HIV antigen, if performed;

(l) Results of TB testing, if available; and

(m) HIV status of the person's partner, spouse or children.

(4) Reports of AIDS cases shall include the information in subsections (1) through (3) of this section; and

(a) The patient's complete address;

(b) Opportunistic infections diagnosed; and

(c) Date of onset of illness.

(5) (a) Reports of AIDS shall be made whether or not the patient has been previously reported as having HIV infection.

(b) If the patient has not been previously reported as having HIV infection, the AIDS report shall also serve as the report of HIV infection.

Appendix 16

Kaiser Daily HIV/AIDS Report

Wednesday, April 11, 2007

Across The Nation

Alabama Corrections Department To Expand Re-Entry Program for HIV-Positive Inmates to General Prison Population

The Alabama Department of Corrections is expanding a program that helps HIV-positive inmates transition to life outside of prison in an effort to lower the number of inmates who commit new crimes after they are released, the *AP/Tuscaloosa News* reports. The Alabama Prison Initiative, a joint project of the corrections department and the Department of Public Health, provides almost all HIV-positive inmates with transition services up to three months before their probation, parole or end-of-sentence dates. The program currently serves 23 HIV-positive women and 250 HIV-positive men, Elana Parker, who will serve as the re-entry coordinator and public health liaison for the program, said. "What we're looking at doing is taking that model and expanding that to the general population and making this something that involves more community organizations as well as other agencies and faith-based groups," Parker said. According to the *AP/News*, the new program aims to help former inmates re-establish their identities by obtaining Social Security cards, driver's licenses and birth certificates in some cases. The program also will assist participants in finding jobs and housing prior to their discharge. The corrections department has not determined the cost of expanding the program, and a start date has not been set, but it could begin by this fall, Parker said. "The more support [inmates] have that first year when they're out, the less likely they are to come back," prisons Commissioner Richard Allen said, adding, "We've got the [inmates living with HIV/AIDS] in pretty good shape right now, we've just got to take care of the rest of the population" (Hunter, *AP/Tuscaloosa News*, 4/8).

Appendix 17

Legislation affecting access to HIV information

KRS 214.620 Planning for implementation of professional education requirement -- Information and education requirements for certain groups.

(4) Information on the human immunodeficiency virus infection shall be presented to any person who receives treatment at any hospital, however named, skilled-nursing facilities, primary-care centers, rural health clinics, outpatient clinics, ambulatory care facilities, ambulatory surgical centers, and emergency-care centers licensed pursuant to KRS Chapter 216B. The information shall include but not be limited to methods of transmission and prevention and appropriate behavior and attitude change.

Appendix 18

April 18, 2003 CDC Initiative

Advancing HIV Prevention: New Strategies for a Changing Epidemic --- United States, 2003

In several U.S. cities, recent outbreaks of primary and secondary syphilis among men who have sex with men (MSM) (*1*) and increases in newly diagnosed human immunodeficiency virus (HIV) infections among MSM and among heterosexuals have created concern that HIV incidence might be increasing. In addition, declines in HIV morbidity and mortality during the late 1990s attributable to combination antiretroviral therapy appear to have ended. Until now, CDC has mainly targeted its prevention efforts at persons at risk for becoming infected with HIV by providing funding to state and local health departments and nongovernmental community-based organizations (CBOs) for programs aimed at reducing sexual and drug-using risk behavior. Some recent programs have focused on prevention efforts for persons living with HIV (*2*). Funding HIV-prevention programs for communities heavily affected by HIV has promoted community support for prevention activities. At the same time, these communities recognize the need for new strategies for combating the epidemic. In addition, the recent approval of a simple rapid HIV test in the United States creates an opportunity to overcome some of the traditional barriers to early diagnosis and treatment of infected persons. Therefore, CDC, in partnership with other U.S. Department of Health and Human Services agencies and other government agencies and nongovernmental agencies will launch a new initiative in 2003, Advancing HIV Prevention: New Strategies for a Changing Epidemic.

Trends in HIV/AIDS Morbidity and Mortality

The first cases of acquired immunodeficiency syndrome (AIDS) were reported in the United States in June 1981, and the number of cases and deaths among persons with AIDS increased rapidly during the 1980s. During 1981--2001, an estimated 1.3--1.4 million persons in the United States were infected with HIV (*3*), and 816,149 cases of AIDS and 467,910 deaths were reported to CDC (*4*). During the late 1990s, after the introduction of combination antiretroviral therapy, the numbers of new AIDS cases and deaths among adults and adolescents declined substantially. From 1995 to 1998, the annual number of incident AIDS cases declined 38% from 69,242 to 42,832, and deaths from AIDS declined 63% from 51,670 to 18,823. The annual number of incident AIDS cases and deaths has remained stable since 1998, at approximately 40,000 and 16,000, respectively (*4*). The number of children in whom AIDS attributed to perinatal HIV transmission was diagnosed peaked in 1992 at 954 and declined 89% to 101 in 2001 (*4*).

Since the early 1990s, an estimated 40,000 new HIV infections have occurred annually in the United States. During 1999--2001, in the 25 states that had HIV reporting since 1994, the number of persons who had HIV infection newly diagnosed increased 14% among MSM and 10% among heterosexuals. The number of persons in the United States living with HIV

continues to increase, and of an estimated 850,000--950,000 persons living with HIV, an estimated 180,000--280,000 (25%) persons are unaware of their serostatus (*3*).

HIV Testing

Many HIV-infected persons do not get tested until late in their infection, and many persons who are tested do not return to learn their test results. In 2000, of an estimated two million CDC-funded tests for HIV, approximately 18,000 tests represented new HIV diagnoses. During 2000, of persons with positive tests for HIV, 31% did not return to learn their test results (CDC, unpublished data, 2000). Of 573 HIV-infected young MSM who were studied in six U.S. cities, 77% were unaware that they were infected (*5*). During 1994--1999, of 104,780 persons in whom HIV was diagnosed, AIDS was diagnosed in 43,089 (41%) persons within 1 year after their positive HIV test (*6*).

Reasons for HIV testing vary. In a study of 7,236 persons in whom HIV was newly diagnosed, the reason given most frequently (42%) for seeking the test was illness. Only 10% of HIV-infected men and 17% of HIV-infected women reported that they were tested primarily because the test was offered or recommended by a health-care facility or provider (CDC, unpublished data, 2002).

Many persons who learn that they are HIV infected adopt behaviors that might reduce the risk for transmitting HIV (*7*). In a study of 1,363 HIV-infected men and women, among the 69% who were sexually active during the preceding 12 months, 78%--96% used a condom at most recent anal or vaginal intercourse with a known HIV-negative partner, and 52%--86% reported condom use with a partner of unknown serostatus (CDC, unpublished data, 2002).

The development of new tests for HIV creates new prospects for expanding HIV testing to identify and treat HIV-infected persons earlier. The OraQuick® HIV rapid test (OraSure Technologies, Inc., Bethlehem, Pennsylvania) was approved by the Food and Drug Administration in November 2002 and categorized as a waived test under the Clinical Laboratory Improvement Amendments in January 2003. This simple, rapid test provides HIV results in 20 minutes, can be stored at room temperature, requires no special equipment, and can be performed outside clinical settings. Although the use of the OraQuick® test facilitates receipt of test results, HIV-positive test results will require confirmation by Western Blot or immunofluorescence assays.

Reported by: *RS Janssen, MD, IM Onorato, MD, Div of HIV/AIDS Prevention--Surveillance and Epidemiology; RO Valdiserri, MD, TM Durham, MS, WP Nichols, MPA, EM Seiler, MPA, HW Jaffe, MD, National Center for HIV, STD, and TB Prevention, CDC.*

Editorial Note:

The new initiative, Advancing HIV Prevention: New Strategies for a Changing Epidemic, is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services. The HIV initiative emphasizes the use of proven public health approaches to reducing the incidence and spread of disease. As with

other sexually transmitted diseases (STDs) or any other public health problem, principles commonly applied to prevent disease and its spread will be used, including appropriate routine screening, identification of new cases, partner notification, and increased availability of sustained treatment and prevention services for those infected.

Stable HIV-associated morbidity and mortality, concerns about possible increases in HIV incidence, and the recent availability of a simple, rapid HIV test combined with strong prevention collaborations among communities heavily affected by HIV support the need to reassess and refocus some of CDC's HIV-prevention activities. An emphasis on greater access to testing and on providing prevention and care services for persons infected with HIV can reduce new infections and lead to reductions in HIV-associated morbidity and mortality (*2,8*). In addition, simplifying prenatal and other testing procedures can lead to more effective use of resources that CDC provides to prevent perinatal and other HIV transmission.

The initiative consists of four key strategies:

- **Make HIV testing a routine part of medical care.** CDC will work with professional medical associations and other partners to ensure that all health-care providers include HIV testing, when indicated, as part of routine medical care on the same voluntary basis as other diagnostic and screening tests. Previously, CDC has recommended that patients be offered HIV testing in high HIV-prevalence acute care hospitals (*9*) and in clinical settings serving populations at increased risk (e.g., clinics that treat persons with STDs). This initiative adds to those recommendations to include offering HIV testing to all patients in all high HIV-prevalence clinical settings and to those with risks for HIV in low HIV-prevalence clinical settings (*10*). Because prevention counseling, although recommended for all persons at risk for HIV, should not be a barrier to testing, CDC will promote adoption of simplified HIV-testing procedures in medical settings that do not require prevention counseling before testing. In 2003, CDC will support state and local health departments in conducting demonstration projects offering HIV testing to all patients in high HIV-prevalence health-care settings and referral into care, treatment, and prevention services, and will assess the outcomes of these projects.

- **Implement new models for diagnosing HIV infections outside medical settings.** In 2003, CDC will fund new demonstration projects using OraQuick® to increase access to early diagnosis and referral for treatment and prevention services in high-HIV prevalence settings, including correctional facilities. In addition, CBOs will pilot new models, particularly in non-medical settings, for diagnosis and referring persons for treatment and prevention services. Also, because 8%--39% of partners tested in studies of partner counseling and referral services (PCRS) were found to have previously undiagnosed HIV infection (*11*), CDC will increase emphasis on PCRS. In 2004, CDC will implement these new models through health departments and CBOs.

- **Prevent new infections by working with persons diagnosed with HIV and their partners.** Although many persons with HIV modify their behavior to reduce their risk for transmitting HIV after learning they are infected, some persons might require ongoing prevention services to change their risk behavior or to maintain the change. In 2003, CDC, in collaboration with the Health Resources and Services Administration (HRSA), the National Institutes of Health, and the HIV Medical Association of the Infectious Diseases Society of America, will publish

Recommendations for Incorporating HIV Prevention into the Medical Care of Persons with HIV Infection. CDC will work with professional associations to disseminate the new guidelines to primary care providers and infectious disease specialists and to assess their integration into medical practice. CDC will work closely with HRSA and other partners to reach persons in whom HIV infection has been diagnosed but who are not in ongoing medical or preventive care. CDC also will conduct demonstration projects through state and local health departments to provide prevention case management for persons living with HIV to reduce HIV transmission. Finally, CDC will increase emphasis on partner notification and also will support new models of partner notification, including offering rapid HIV testing to partners and using peers to conduct partner prevention counseling and referral. In 2004, acting through health departments and CBOs, CDC will implement these prevention services for persons living with HIV. CDC also will require grantees to employ standardized procedures for prevention interventions and evaluation activities.

- **Further decrease perinatal HIV transmission.** CDC will promote recommendations for routine HIV testing of all pregnant women, and, as a safety net, for the routine screening of any infant whose mother was not screened. CDC will work with prevention partners, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Nurse-Midwives, to disseminate the recommendations and support their implementation. CDC also will develop guidance for using rapid tests during labor and delivery, or post partum if the mother was not screened prenatally, and provide training for health departments and providers in conducting prenatal testing. In 2003, CDC will expand its activities to monitor the integration of routine prenatal testing into medical practice.

Reporting of HIV infections to public health authorities is now required in 49 states. In 2002, CDC initiated a pilot system to monitor HIV incidence. To track the impact of the new initiative, beginning in 2003, CDC is expanding this surveillance system by implementing a national behavioral surveillance system. In addition, CDC will monitor the implementation of these new activities through several systems, including new performance indicators for state and local health departments and CBOs.

Stable HIV morbidity and mortality, increased numbers of syphilis and HIV cases, and growing concern about increasing HIV incidence in some communities require new strategies to control the spread of HIV in the United States. Through Advancing HIV Prevention: New Strategies for a Changing Epidemic, every HIV-infected person should have the opportunity to be tested and have access to state-of-the-art medical care and to the prevention services needed to prevent HIV transmission.

References

1. CDC. Primary and secondary syphilis among men who have sex with men---New York City, 2001. MMWR 2002;51:853--6.
2. Janssen RS, Holtgrave DR, Valdiserri RO, Shepherd M, Gayle HD, DeCock KM. The serostatus approach to fighting the HIV epidemic: prevention strategies for infected individuals. Am J Pub Health 2001;91:1019--24.

3. Fleming P, Byers RH, Sweeney PA, Daniels D, Karon JM, Janssen RS. HIV prevalence in the United States, 2000. [Abstract]. In: Program and abstracts of the 9th Conference on Retroviruses and Opportunistic Infections, Seattle, Washington, February 24--28, 2002. Alexandria, Virginia: Foundation for Retrovirology and Human Health.
4. CDC. HIV/AIDS Surveillance report, 2001;13(2).
5. MacKellar DA, Valleroy LA, Secura GM, Behel SK. Unrecognized HIV infection, risk behaviors, and misperceptions of risk among young men who have sex with men---6 United States cities, 1994--2000. [Abstract]. In: Final program and abstracts of the XIV International AIDS Conference, Barcelona, Spain, July 5--12, 2002.
6. Neal JJ, Fleming PL. Frequency and predictors of late HIV diagnosis in the United States, 1994 through 1999. In: Final program and abstracts of the 9th Conference on Retroviruses and Opportunistic Infections, Seattle, Washington, February 24--28, 2002. Alexandria, Virginia: Foundation for Retrovirology and Human Health.
7. CDC. Adoption of protective behaviors among persons with recent HIV infection and diagnosis---Alabama, New Jersey, and Tennessee, 1997--1998. MMWR 2000;49:512--5.
8. Institute of Medicine. No time to lose: getting more from HIV prevention. Washington, DC: National Academy Press, 2001.
9. CDC. Recommendations for HIV testing services for inpatients and outpatients in acute-care hospital settings. MMWR 1993;42(No. RR-2).
10. CDC. Revised guidelines for HIV counseling, testing, and referral. MMWR 2001;50(No. RR-19).
11. Golden MR. HIV partner notification: a neglected prevention intervention [editorial]. Sex Transm Dis 2002;29:472--5.

Appendix 19

Big Idea: Personal Wellness (Health Education) – Continued

High School Skills and Concepts – Personal and Physical Health
Students will

- understand the importance of assuming responsibility for personal health behaviors by:
  - predicting how decisions regarding health behaviors have consequences for self and others
  - explaining how body system functions can be maintained and improved (e.g., exercise, nutrition, safety)
  - explaining how decision-making relates to responsible sexual behavior (e.g., abstinence, preventing pregnancy, preventing HIV/STDs), impacts physical, mental and social well being of an individual
- apply goal-setting and decision-making skills in developing, implementing and evaluating a personal wellness plan
- evaluate the effectiveness of communication methods for expressing accurate health information and ideas
- evaluate how an individual's behaviors and choices of diet, exercise and rest affect the body

High School Skills and Concepts – Growth and Development
Students will

- explain basic structures and functions of the reproductive system as it relates to the human life cycle (e.g., conception, birth, childhood, adolescence, adulthood)

High School Skills and Concepts – Social, Mental and Emotional Health
Students will

- demonstrate social interaction skills by:
  - identifying and utilizing management techniques needed for dealing with intrapersonal and interpersonal relationships throughout life
  - using and explaining the importance of effective social interaction skills (e.g., respect, self-advocacy, cooperation, communication, identifying different perspectives and points of view, empathy, friendship)
  - recommending and justifying effective strategies (e.g., problem solving, decision making, refusal skills, anger management, conflict resolution) for responding to stress, conflict, peer pressure and bullying
  - identifying and explaining changes in roles, responsibilities and skills needed to effectively work in groups throughout life (e.g., setting realistic goals, time and task management, planning, decision- making process, perseverance)
- recommend and justify effective self-management and coping strategies (e.g., setting realistic goals, time, task and stress management, decision making, learning style preference, perseverance) for maintaining mental and emotional health
- demonstrate the ability to use various strategies when making decisions related to health needs and risks of young adults
- demonstrate refusal, negotiation and collaboration skills to use in avoiding potential harmful situations

http://www.education.ky.gov/users/jwyatt/POS/High.doc

Big Idea: Personal Wellness (Health Education) – Continued

High School Skills and Concepts – Family and Community Health
Students will

- access and use a variety of resources from home, school and community that provide valid health information
- understand and analyze how personal, family and community health can be influenced and challenged by:
  - family traditions/values
  - peer pressure
  - technology and media messages
  - cultural beliefs and diversity
  - interrelationships between environmental factors and community health
- use print and non-print sources to:
  - analyze how the prevention and the control of health problems are influenced by research and medical advances
  - investigate the role of health care providers in disease prevention
  - analyze how public health policies and government regulations influence health promotion and disease prevention

High School Skills and Concepts – Communicable, Non-Communicable and Chronic Diseases Prevention
Students will

- demonstrate an understanding of diseases by:
  - describing symptoms, causes, patterns of transmission, prevention and treatments of communicable diseases (colds, flu, mononucleosis, hepatitis, HIV/STD, tuberculosis)
  - describing symptoms, causes, patterns of transmission, prevention and treatments of non-communicable diseases (cancer, cardiovascular disease, diabetes, obesity, asthma, emphysema)
- explore family history, environment, lifestyle and other risk factors related to the cause or prevention of disease and other health problems
- demonstrate an understanding of how to maintain a healthy body by:
  - analyzing the impact of personal health behaviors on the functioning of body systems
  - analyzing how behavior can impact health maintenance and disease prevention during adolescence and adulthood

High School Skills and Concepts – Alcohol, Tobacco and Other Drugs
Students will

- demonstrate an understanding of the use and misuse of alcohol, tobacco and other drugs by:
  - distinguishing between legal (e.g., over the counter, prescription drugs) and illegal drugs (e.g., inhalants, marijuana, stimulants, depressants) and describing how their usage affects the body systems
  - predicting the immediate/long-term effects of alcohol, tobacco and illegal drug usage and analyzing the impact on an individual's health
  - recommending interventions (e.g., cease enabling activities), treatments (e.g., AA, outpatient therapy, group therapy) and other strategies (e.g., enhancing self esteem, building skills for success) as forms of help for negative behaviors or addictions (e.g., drug addictions, eating disorders)

http://www.education.ky.gov/users/jwyatt/POS/High.doc

MEMBERSHIP AND AFFLIATIONS

Executive Committee

Robert Stone	Chairperson
Paul Trickel	Chair, Policy and Promotion Committee
Robert Edelen	At-Large
Ann Dills	At-Large

Members per Legislation

William Hacker, MD	Commissioner, Kentucky Department for Public Health
Glenn Jennings	Commissioner, Kentucky Department for Medicaid Services

Members from State Agencies

Paul Trickel	Northern Kentucky Independent District Health Department

Members from Community Based Organizations

Gary Fowler	Matthew 25
Aunsha Hall	AIDS Volunteers
Beth Harrison Prado	Volunteers of America
Robert Stone	Owensboro Task Force
Deborah Wade	WINGS Clinic
Krista Wood	Heartland CARES, Inc.

Members of the Public

Robert Edelen	Charles Kessinger
Michael Logsdon	Bruce Mullan

Physician Representatives

Carl LeBuhn, MD