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ABOUT IDCR

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

IDCR and AAHIVM have united to improve the quality of health care delivery in the nation's correctional facilities by leveraging the knowledge, experience and resources of two diverse and accomplished groups of HIV and correctional health care experts.

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PERSPECTIVE:

HIV BEHIND BARS: MEETING THE NEED FOR HIV TESTING, EDUCATION, AND ACCESS TO CARE

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Introduction

Over the last several decades, the proportion of persons incarcerated in the United States has been steadily increasing. The United States incarcerates the greatest number and the highest proportion of persons compared to any other country and by mid-year 2005, more than two million persons were incarcerated in the United States, representing one in every 145 individuals.¹ Studies have demonstrated that prior to incarceration, persons engage in increased rates of high-risk behaviors including substance use and risky sex.²⁻⁶ In addition, there is a higher prevalence of HIV within the correctional setting compared to the community among both males and females.⁷⁻⁹ In a 1997 study, it was estimated that approximately one-quarter of all HIV-infected persons in the United States passed through the correctional system in one year.¹⁰ The AIDS rate has been estimated to be more than three times greater in prison than in the community.¹¹ There are less data on the HIV prevalence in jails compared to prisons. However, the estimated jail HIV prevalence rates range from 2.1-2.5%.¹² Given high rates of risk behavior in inmates and the increased HIV prevalence rates behind bars, correctional HIV testing programs provide an opportunity for persons at risk of infection to access HIV testing services, education, and for HIV-infected persons to receive care.

Persons entering correctional systems are often marginalized in their communities due to factors such as active substance abuse, mental health disorders, and racial disparities relative to the delivery of health care.^{5,13} This marginalization leads to decreased access to health care in the community. Incarceration, therefore, may be the only chance for many to access HIV testing services and have an opportunity to receive HIV care. This may be particularly true for racial and ethnic minorities who are disproportionately incarcerated in the United States and are also disproportionately infected with HIV.¹⁴ According to the Centers for Disease Control and Prevention (CDC), blacks and Hispanics accounted for 48% and 18% respectively of all HIV/AIDS cases diagnosed in 2005 in the US.¹⁵

Incarceration provides an opportunity to intervene and provide HIV testing, medical care, and linkage to HIV services upon release from the correctional setting.

Advantages to HIV Screening in Correctional Settings

There are unique advantages to correctional HIV programs. When incarcerated, health care and prevention programs can be effectively administered because clients are logistically easier to access, clients are relieved from the financial burdens of medical care, and at least theoretically, are not engaged in ongoing risk behavior.¹⁴ Correctional HIV testing programs have the potential to increase the number of at-risk persons tested for HIV as well as to increase the number of persons who are aware of their HIV serostatus. HIV-infected inmates can be educated about their infection, learn how it is transmitted to others, and receive prevention counseling, and antiretroviral therapy can be initiated when indicated. Addiction treatment and mental health services can be provided in conjunction with HIV care, which serves to improve adherence with therapy both inside and outside of the correctional environment. In addition, a detailed reentry plan can be formulated to link the inmate to HIV clinical care, mental health treatment, and substance use treatment in the community upon release. Further, HIV-uninfected inmates can receive prevention counseling, which may reduce their risk of subsequent HIV infection.

Critical to the implementation of a quality correctional HIV health program is a routine HIV testing policy. HIV testing is offered in all state correctional systems within the United States; however, local policies typically govern the manner by which testing is offered. Correctional testing policies include (1) mandatory upon entrance or exit; (2) routinely offered, but not mandatory; (3) voluntary, upon request by an inmate; (4) performed when clinically indicated,

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LETTER FROM THE EDITOR

Dear Correctional Colleagues,

As the introduction to most every article on the topic of HIV in corrections is obliged to remind us, there are a lot of people infected with the virus entering, living in and leaving our prisons and jails. Therefore, it is not surprising to hear renewed calls for correctional facilities to become a centerpiece of a broad effort to identify persons unaware of their HIV infection. The Centers for Disease Control and Prevention (CDC) recent recommendation that HIV testing be expanded to general healthcare settings has certainly fueled the latest interest in HIV screening in these settings and follow-up CDC statements regarding testing in correctional facilities are expected.

No rationale individual can disagree that incarceration provides a valuable opportunity to detect infectious diseases such as HIV, other sexually transmitted diseases, latent tuberculosis and viral hepatitis. Indeed, to not look for such infections among incarcerated individuals in our country would smack of callousness and willful disregard.

But, as always, the devil is in the details. How and when should HIV screening be done? Mandatory testing in prisons is not uncommon but raises important concerns regarding autonomy. Rapid HIV testing seems well suited for jails but some inmates are jailed for less than 48 hours and are often inebriated or intoxicated, making informed consent problematic. Is it best to test at entry only or annually during incarceration? Logistically, widespread testing will draw personnel and resources from other valuable healthcare activities. In addition, testing can be perceived as an un-funded mandate with the cost of testing itself and the expense of health care of those detected not typically provided for by those making HIV testing recommendations. The cost of antiretroviral therapy for a small proportion of prison or jail inmates can strain the zero-sum budgets of these facilities.

The many facets of this topic are reflected in the perspectives and commentaries we have assembled in this issue of the IDCR. Drs. Curt Beckwith and Michael Poshkus from Rhode Island have published widely on HIV screening in their state and provide their rationale for calls for ramped-up voluntary, opt-out testing for HIV as part of a comprehensive program to manage HIV/AIDS in correctional settings. Ravi Kavasey and Rick Altice, MD both of Yale offer their own view of the challenges to HIV screening of inmates. Topping off these thoughtful perspectives is a candid interview with Drs. Joe Bick and David Paar, experts in correctional healthcare, on their takes on testing.

Reading these articles, it becomes evident, even for someone such as myself who feels that HIV testing of persons in our jails and prisons must be greatly expanded, that the proposition is not a 'slam-dunk'. Screening for HIV in jails and prisons is a priority but has to be accompanied by recognition that additional cases of HIV infection will be detected and that these individuals will require counseling, care and referral. If the CDC's dreams of expanded testing are to be realized, state and federal support needs to materialize. Otherwise, we are left with well-intentioned and justified recommendations that we can argue over implementing but which do not lead to the reductions in new cases of HIV we can all agree we want to see.

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as deemed by the correctional medical staff, and (5) ordered by the court. Most correctional facilities offer HIV testing when requested by the inmate or when a clinical syndrome consistent with HIV infection has been identified.¹⁶

Approaches to HIV Screening in Prisons and Jails

Recently the CDC has issued recommendations for expanded HIV testing in health care settings. The lynchpin of these recommendations is the proposal that HIV testing be conducted for patients in all health care settings after the patient is notified that testing will be performed unless the patient declines (i.e. "opt-out" screening).¹⁷ We strongly support a universal, routine, opt-out HIV testing policy in correctional settings whereby all inmates would undergo HIV testing upon entrance to the correctional facility unless declined. The ability of the inmate to decline testing is paramount because opt-out testing must be differentiated from mandatory testing. Routine opt-out testing has the advantages of decreasing stigma associated with requesting an HIV test and makes HIV testing accessible to all inmates. In an effort to improve the delivery of HIV testing services to those at risk of infection, the CDC has also recommended that voluntary opt-out HIV screening be performed in correctional health care facilities.¹⁸

Mandatory HIV testing of inmates is performed in a number of correctional institutions. While mandatory testing certainly accomplishes the objective of increasing testing among incarcerated individuals, we favor a routine opt-out policy over mandatory testing given the advantages listed above. We hope that correctional administrators and health care providers capitalize upon the opportunity that incarceration presents by engaging at-risk persons who are marginalized from the health care system. The goal should be to provide high-quality health care to individuals who cannot, or do not, otherwise access it. This includes a comprehensive HIV counseling and testing program that is accessible to all.

Incarcerated persons should have the ability to make health care decisions, such as opting-out of an HIV test if they so choose, unless there is a court order denying them of that right. HIV testing should not be punitive. Rather, the delivery of HIV and other medical services to inmates should be a component of the therapeutic and rehabilitative services from which incarcerated individuals can benefit.

Because all persons who enter the correctional system are, at one time or another, held in a jail system, routine HIV testing in jails offers the most comprehensive approach to HIV screening because screening at this point will reach the greatest number of people. However, jails have rapid turnover rates and short inmate stays, complicating HIV screening efforts.¹⁶ With the Food and Drug Administration (FDA) approval of a variety of rapid HIV tests, new opportunities for correctional screening pro-

grams have emerged. Rapid testing technology provides definitive antibody-negative and preliminary antibody-positive test results in approximately 20 minutes.

Although preliminary positive rapid tests need to undergo confirmatory western blot testing, rapid test results can be delivered immediately in conjunction with result-specific post-test counseling and risk reduction interventions. To promote knowledge of HIV status among inmates, routine HIV testing policies should be considered by correctional administrations and the utilization of rapid HIV testing should be evaluated for use in jail settings.

Rapid HIV testing programs with point-of-care test result delivery have been successful in a number of non-correctional settings including labor and delivery, community outreach programs, outpatient clinics and emergency rooms.¹⁸⁻²⁴ Rapid testing has been shown to be preferred over standard HIV testing among patients attending an urgent care center due to results being available within one testing session.²⁵ In the April 2006 issue of *IDCR*, the Broward County Jail reported on its successes with voluntary rapid HIV testing in their jail system.²⁶ A pilot of study of rapid HIV testing at the Rhode Island Department of Corrections jail demonstrated that rapid testing was acceptable to jail detainees, was feasible to perform, and improved HIV test result delivery.²⁷ Further investigation into the utilization of rapid HIV testing in the jail setting is needed including examination of rapid testing: 1) in facilities with different HIV testing policies; 2) among male and female inmates; 3) with respect to the influence of rapid HIV testing on subsequent HIV risk behavior in the community; 4) in conjunction with development of effective HIV prevention programs for use in jails; 5) with respect to cost effectiveness; and 6) with respect to safety in reducing needle-stick exposures among providers.

"We strongly support a universal, routine, opt-out HIV testing policy in correctional settings whereby all inmates would undergo HIV testing upon entrance to the correctional facility unless declined."

An effective HIV testing policy upon incarceration is only appropriate if comprehensive HIV clinical care services are provided within the correctional facility after diagnosis. These services should include a baseline medical evaluation with determination of CD4+ cell count and HIV plasma viral load, initiation of antiretroviral therapy for appropriate patients, prophylaxis of opportunistic infections, and screening for other conditions, including other sexually transmitted infections, tuberculosis, viral hepatitis, drug addiction, and mental illness. Vaccination for hepatitis B virus should be performed in all susceptible patients, given the risk factors for hepatitis B virus infection are identical to those for HIV infection. Furthermore, HIV care providers working

inside a correctional setting must have effective lines of communication developed with community-based HIV providers so ongoing treatment plans can be continued inside and outside the correctional setting with minimal interruption. This communication is critical to the ongoing care of persons who continually cycle through the correctional system.

Conclusion

Incarceration is a reality of our current justice system. But, incarceration brings with it an opportunity to engage our society's most at-risk individuals. We encourage and support the development of comprehensive correctional HIV programs that are comprised of the following elements: 1) routine voluntary opt-out HIV testing upon incarceration; 2) comprehensive medical evaluation; 3) provision of HIV care during incarceration, and 4) implementation of detailed re-entry practices that engage community providers. Further work is needed to make this type of program more prevalent across the United States. This requires a multidisciplinary effort with input from correctional and community HIV providers, correctional medical staff, administrators, correctional officers, mental health providers, inmate advocates, and discharge planning staff, to name a few. The goal is to promote HIV education and health among our inmates that translates into reduced HIV morbidity and mortality in our communities.

Stop AIDS in Prison Act of 2007 is approved by House Judiciary Committee

The House Judiciary Committee recently passed a bill that would establish HIV/AIDS testing, treatment, and education programs in all federal prisons. The bill, entitled the "Stop AIDS in Prison Act of 2007," is aimed at preventing the spread of the HIV, both within the federal prison system and the free-community, by educating inmates on the virus's modes of transmission, prevention methods, treatment, and disease progression. Proposed HIV/AIDS programs would conduct mandatory testing upon each inmate's entry to prison and before their reentry into the community, but would allow inmates the option of declining testing unless they are known to have been exposed to the virus. The bill would require both pre and post test counseling for inmates and mandates that inmates receive their test results in a timely manner. Inmates who test seropositive for HIV must be provided with "comprehensive medical treatment" during their incarceration, in addition to pre-release counseling and linkage to community care after their release. The bill has yet to be scheduled for general debate in the House.

Source: <http://www.govtrack.us/congress/bill.xpd?bill=h110-1943>

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ROUTINE HIV TESTING IN JAILS: ADDRESSING THE CHALLENGES

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Because prisons and jails house a population facing a disproportionate share of the burden of HIV infection and many of whom are unaware of their HIV status, these facilities serve as important sites for the testing and treatment of HIV.¹ Routine HIV testing presents a promising opportunity for correctional institutions to provide individuals with knowledge of their HIV status, education and counseling services, and access to treatment both within the correctional setting and upon release into the community. Traditionally, prisons and jails have operated outside of the purview of our public health infrastructure. Screening of HIV within these settings provides an innovative approach to facilitate community-correctional linkages.

Jails are distinct from prisons due to their high rate of turnover, varying states of intoxication, lack of uniform intake procedures, and typically brief lengths of stay. In order to implement successful routine HIV testing programs in jails, a number of logistical challenges must be properly addressed before implementation can be successful.

A major challenge to implementing routine HIV testing in jails is choosing the optimal time to conduct testing.² Although immedi-

ate testing at intake might confer the largest public health benefit since many inmates will be released within the first few days of incarceration, such a testing approach creates additional logistical challenges. While there is never an ideal time to deliver "bad news", the timing of delivering non-emergent bad medical news (such as a preliminary positive result in an asymptomatic patient) must be carefully considered. Newly incarcerated detainees experience high rates of suicidal behavior, acute intoxication and abstinence syndromes, and psychological distress at the time of entry.^{3,4} It is currently unclear from the empirical literature if individuals under such stresses have medical competence to "opt out" of routine testing. If individuals do not "opt out" and are provided with a "preliminary positive" despite their fragile circumstances, they are almost certainly unprepared to consider and respond to the consequences of a preliminary positive HIV test result.^{5,6}

"The costs for providing care will remain a concern in our nation's jails. Jails are often under local jurisdiction and resources are often limited."

It is daunting to imagine routine HIV testing upon intake at some of the largest and busiest jails. Several hundred people may be processed daily, with intake procedures taking place 24 hours a day. While routine HIV testing might be sufficiently managed, it is often the case that staffing is suboptimal. Adding HIV testing (with associate HIV counseling for preliminary positives) will require additional inmate movement within the facility, working with inmates in various

states of intoxication and withdrawal, and squeezing additional service requirements into the already-limited available time. All of this would have to be accomplished through coordinated efforts with custodial staff who typically try to avoid any unnecessary movement within the facility.

One of the unresolved issues for routine testing in jails is ensuring delivery of confirmatory HIV test results for those who test preliminarily positive. Confirmatory test results often require up to a week to receive and, given the high rates of release early in the course of incarceration, many individuals will be released without truly knowing their status. Community public health systems must be adequate to provide contact tracing after release to ensure delivering confirmatory results. For individuals who remain incarcerated, additional resources will be required to provide routine and necessary testing and provision of antiretroviral medications if medically indicated.

The costs for providing care will remain a concern in our nation's jails. Jails are often under local jurisdiction and resources are often limited. Determining who will pay for testing, counseling, and treatment must also be taken into consideration. The ability to link with public health and national health care programs must be included; not the least of these is the Medicaid program.

Prisons and jails are excluded from both general disease-specific programs (funds are channeled to public health departments and publicly run health care facilities) and third party payers (insurance, Medicare, and Medicaid typically stop upon confinement).

ROUTINE HIV TESTING IN JAILS... (continued from page 4)

Although government funded programs such as Medicare, Medicaid and Ryan White subsidies exist to offset the costs of treatment, the incarcerated remain the only demographic group in this country that is broadly and specifically excluded from federal and state third party coverage for their care. On the other hand, local legislation and other legal precedents at least tacitly require that correctional facilities in the United States provide the community standard of medical care for HIV-infected inmates. Prisons and jails already face significant resource limitations in providing existing medical services to their continually increasing inmate population. It is estimated that one quarter of HIV-infected individuals in the United States pass through a correctional facility every year and it is believed that anywhere from one third to one half of these persons are unaware of their HIV status.⁷⁻⁹ If this is indeed the case, then prison and jail administrators face a huge financial disincentive for conducting widespread HIV screening programs in their facilities.

“Serious ethical considerations are also raised when correctional settings test individuals for HIV and initiate treatment without ensuring adequate follow-up and treatment services upon re-entry into the community.”

Extensive cost-benefit analyses support expanded HIV screening in all settings where the HIV seroprevalence of undiagnosed is greater than 1%.^{10, 11} In jails, however, there is a political disincentive for correctional administrators to be viewed as providing care and spending scarce resources on prisoners. In the case of routine testing in jails in the current funding environment, jails will bear the direct costs of these programs but will not directly reap the benefits. The case for prisons may differ as many of these individuals are incarcerated for prolonged periods of time. It will therefore require a shift in philosophy by jail

administrators to promote a more societal approach, perhaps with the assistance of public health incentives and support. In order for routine HIV testing to be adopted by jails, they must become part of the larger public health infrastructure. By doing so, the costs of screening and treatment could be shared more globally by the rest of society.

Programs that facilitate linkage to community-based treatment for HIV-infected prisoners are another important challenge that must be addressed for jail screening to be successful. As marginalized members of society, those with criminal records do not enjoy steady access to health care in the community and some are chronically subjected to episodic care.¹² Furthermore, because of the high rate of recidivism among the incarcerated, one of the major challenges to treating HIV-infected individuals is providing continuity of care as they cycle in and out of the correctional system. Understanding the effects of the unstructured interruptions in HAART care for these individuals remains an important area of study.¹³ Serious ethical considerations are also raised when correctional settings test individuals for HIV and initiate treatment without ensuring adequate follow-up and treatment services upon re-entry into the community.

Despite these obstacles, routine HIV testing programs represent best public health practices and should be implemented. The authors are calling for review and consideration not only of the implementation of broad testing, but also for resolution of the associated challenges. While there are currently initiatives to overcome these obstacles, we still do not know how to resolve them all, even on a limited scale, much less if testing were to become universal in jails. The authors also want to underscore the mounting need for a public health approach to the delivery of correctional health care, including access to the general funding mechanisms that serve so much of the American public.

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RESOURCES

CDC's National HIV Testing Resource Website
<http://www.hivtest.org/>

CDC's Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

Community HIV/AIDS Mobilization Project
<http://www.champnetwork.org/>

HIV InSite (University of California San Francisco)
<http://hivinsite.ucsf.edu>

**Food and Drug Administration
List of HIV Tests Approved by FDA**
<http://www.fda.gov/cber/products/testkits.htm>

**AIDS.gov
Information on Types of HIV Tests**
<http://www.aids.gov/testing/types/index.html>

**Department of Health and Human Services
2006 Adult and Adolescent Antiretroviral Treatment Guidelines**
<http://www.aidsinfo.nih.gov/guidelines/>

**International AIDS Society-USA Panel
2006 Recommendations of the Treatment for Adult HIV Infection**
<http://jama.ama-assn.org/cgi/content/full/296/7/827>

National HIV/AIDS Clinician's Consultation Center
Warmline: National HIV Telephone Consultation Services
1-800-933-3413
PEpline: National Clinician's Post-Exposure Prophylaxis Hotline
1-888-448-4911
Perinatal Hotline: National Perinatal HIV Consultation and Referral Services
1-888-448-8765

American Academy of HIV Medicine
<http://www.aahivm.org/>

CME-accredited web-stream of "Occupational & Non-Occupational Post-Exposure Prophylaxis"
www.amc.edu/hivconference

**Slides from the NCHC Pre-conference Seminar
Infectious Diseases in Corrections: An Expert Panel
October 28, 2006**
<http://www.idcronline.org/archives.html>

SPOTLIGHT: ROUTINE HIV TESTING IN THE CORRECTIONAL SETTING: AN INTERVIEW WITH DR. JOE BICK AND DR. DAVID PAAR

To get their perspectives on the role of routine screening for HIV infection in correctional settings, IDCR intern Christine Devore recently spoke with Dr. Joseph Bick, Chief Medical Officer, California Medical Facility, and Dr. David Paar, Associate Professor of Medicine at the University of Texas.

Christine Devore (CD): What do you see as the most significant barriers to implementing routine HIV testing in correctional facilities?

Dr. Joe Bick (JB): One of the first barriers would be the enormous volume of inmates. Over three million Americans are currently incarcerated and an estimated ten million Americans enter and leave incarceration in any given year, many of whom have only short stays in jail or prison. As a result, there are many logistical challenges to ensuring routine testing in that type of setting. Incarcerated persons are moved frequently and such moves are not always coordinated between custody and medical systems. Trying to keep track of people as they move through the penal system can be difficult. Making HIV testing routine has major workload implications for correctional staff, as care providers must ensure that every inmate who undergoes HIV testing is provided with pre and post-test counseling. Ensuring that every person who tests positive has access to HIV knowledgeable providers will be difficult for many correctional facilities. Another perceived barrier is the associated cost of HIV testing and counseling. While increased testing will certainly lead to a decrease in morbidity and mortality, prevention of costly hospitalizations, and decreased risk of further transmission of HIV, the individual jail or prison may not feel the effects of these benefits.

David Paar (DP): I gave a talk last fall about the CDC's guidelines at a correctional meeting that included people from the community who provide services to inmates in prisons. Many of these workers were very concerned about implementing these guidelines in the prison. Some thought that prisons should not be viewed as a health care setting, while others thought it would be logistically impossible for most prisoners to give informed consent if the CDC guidelines were implemented. That being said, I'm in favor of the CDC's new testing policies. I believe that these policies can and should be implemented. I think it is best to test prisoners upon intake, although the volume of inmates being processed would make testing difficult.

CD: Some states have laws or regulations that dictate the HIV testing policies in prisons and jails. Does your state have any laws that could pose as barriers to implementing the CDC's recommendations?

JB: HIV testing regulations and laws vary from state to state. In California, there are policies and laws that can serve as disincentives for inmates to opt for HIV testing. Some of these laws can lead to restrictions on job assignments, potential housing sites, and educational opportunities for incarcerated persons. Inmates who are HIV+ may be subject to harsher penalties if they participate in

activities that involve sharing blood or bodily fluids than their HIV negative peers would face. Although some of the state's regulations are valid and reasonable, they can lead to patients deciding to forgo voluntary or opt-out testing.

DP: Texas recently passed legislation that would make HIV testing mandatory in prisons on intake. Texas had previously held a policy of routine, opt-out testing that was first implemented in 1988. Texas also passed legislation in the fall of 2005 that required prisoners to be tested before release. Although few new cases of HIV were discovered this way, the program was well-received by inmates in that there are no documented refusals for testing that I am aware of.

CD: The CDC suggests that providers do not need separate, written consent for HIV testing. Rather, "general consent for medical care should be considered sufficient to encompass consent for HIV testing." Do you feel that this form of consent is appropriate in the correctional setting?

JB: My personal opinion is that some type of written consent is still worthwhile in the correctional setting. The process of being booked into a jail or a prison can be an extremely disorienting experience for many people. Many of the inmates may be under the influence of alcohol or drugs upon intake and could be unsure as to what types of medical care and testing they are allowed to refuse. As a result, some type of separate consent process for HIV testing is valuable if we are going to truly have informed consent in the correctional setting.

DP: I believe that the longer and more complicated the consent process, the less number of people who are actually tested. Of course, everybody should be informed of testing and understand what's going on. In Texas, we use a policy of oral consent for testing. Inmates don't have to sign a consent form; we simply ask them if they want to be tested for HIV. I think that allowing oral consent could violate a person's ability to give proper consent if the process is done hastily, but we can also limit a person's ability to consent by making the process overly complicated with several forms.

CD: Could the CDC's recommendations for informed consent deepen feelings of mistrust between correctional care providers and their inmates?

JB: I think so. I believe that many of our patients are already distrustful of authority and do not implicitly understand that when we ask them if we can provide general medical care, that that also involves testing for HIV and other sexually transmitted diseases. I think it's valuable to have a separate conversation with each inmate to discuss why they should want to know their HIV status, as well as the possible benefits and outcomes of testing. This process of gaining informed consent can certainly be streamlined, but I feel that it is still valuable to keep HIV testing consent separate from consent for general medical care.

CD: How do issues of confidentiality affect HIV testing in the correctional setting?

JB: I think confidentiality can be a significant barrier to testing, both in the correctional setting and in other settings. Confidentiality is one of the reasons why anonymous testing elsewhere in the country has been so valuable. Once a person tests positive in a correctional setting or elsewhere, it automatically signals a chain of events that a person cannot control, including the possibility that those results will impact access to work, career choice, health care insurance, and life insurance.

For example, one challenge for our population is the ability to afford a college education after incarceration. In this country, many people join the military in order to be compensated for their education, but people who are known to be HIV positive are prohibited from joining the military. As a result, inmates who are concerned about the confidentiality of their HIV test results or of the impact of these results on their future might refuse testing. No matter how hard we stress the issue of confidentiality in the correctional setting, it's impossible to have a diagnosis such as HIV not be known by a significant portion of the employees and residents of a correctional facility. An inmate's HIV serostatus becomes part of both their medical file and custodial file. Their status is considered in every decision about housing, programming, work, school, and release. In addition, fellow inmates are very adept at figuring out a person's HIV status based upon what type of doctor an inmate sees, what medicines he receives, and how often he receives medicines.

DP: Confidentiality is an issue that is important to everybody, both in and out of the correctional setting. In my experience, most inmates will often risk a breach of confidentiality in order to know their own HIV status. While maintaining confidentiality is a major priority for care providers, it is also very difficult to keep a person's HIV status confidential in the correctional setting. Most inmates recognize and accept this risk when they undergo testing. I don't think that the implementation of the new guidelines, per se, will affect confidentiality.

CD: Patient mistrust of care providers is often cited as a barrier to HIV testing and treatment in the correctional setting. What steps can correctional providers take to alleviate these feelings of mistrust?

JB: Trust is not just a correctional issue. There are a number of studies that demonstrate that patients' adherence to therapy is directly related to their belief that the therapy is going to help them and their trust for their care provider. If you're in an environment where you think your provider is not HIV knowledgeable and you don't believe that the medicines themselves are going to be of any value, then you have little incentive to get tested. Patients should be educated as to how they can benefit from knowing their HIV

ROUTINE HIV TESTING IN THE CORRECTIONAL SETTING...
(continued from page 6)

status by decreasing their likelihood to get sick and increasing their lifespan.

DP: I think it's important for care providers to demonstrate compassion in dealing with inmates. For example, care providers must respect an inmate's decision to refuse an HIV test, as forcing a test would only engender mistrust. I feel strongly that inmates should always have the right to opt-out of HIV testing.

CD: What do you think are the most important steps for facilities to take in implementing the CDC's guidelines for regular, mandatory opt-out HIV testing?

JB: I think it's important for each correctional system to have an in-depth conversation with everyone who will be impacted by the CDC's guidelines, including medical staff, custody officers, inmates, and the pharmaceutical staff. There is tremendous room for benefit by implementing guidelines, but also significant opportunities for doing harm if the guidelines are not implemented in a thoughtful way. For example, if a facility implements routine testing for inmates as they leave the facilities, it is likely that some of the inmates who are tested will not receive their results. Most people assume that, if they didn't hear anything about their test results, then the results must have been good. Patients could then return to the community and unknowingly pass HIV to other people.

DP: First of all, facilities must discern what steps need to be taken in order to implement routine testing. In most systems, this will require more than sending a memorandum describing the needed changes. Facilities must really examine the recommendations, understand them, and understand

what needs to be done to implement them. For example, facilities need to consider how many inmates they intake, how many blood drawers they have, and how many counselors they have. Facilities must then use this assessment to prepare for a likely increase in the number of inmates being tested.

CD: The CDC recommends annual testing for at-risk populations as a minimum. Do you feel that annual testing is appropriate for incarcerated individuals?

JB: I would say that there's ample evidence that HIV transmission occurs in the correctional setting, albeit in low levels. The overall majority of people leaving prison with HIV were infected at entry, although we do have some data that demonstrates new cases of HIV-infection occurring during incarceration. So I think that, at least in some select correctional settings, it would be worthwhile to have follow-up, if not annual, testing. The most cost-effective part of testing will be testing people when they enter the system. I do think there is some additional benefit to testing at-risk individuals either at annual time frames or at the time of release.

DP: I think annual testing is appropriate. I think exactly how you target the "at-risk" population is questionable. Obviously, facilities can use self-reported questionnaires to determine individuals' behaviors that place them at risk for HIV infection. I think that providing annual voluntary testing for all inmates might be easier than attempting to assess which individuals are at risk. Facilities can also offer some sort of HIV education program so that people know what behaviors can lead to infection.

CD: What are the greatest benefits to implementing routine HIV testing?

JB: We know that up to a quarter of persons infected with HIV don't know their serostatus and that the prevalence among the incarcerated population is five to ten times higher than among general population. We also know that when routine opt-out testing has been implemented in corrections, inmates have generally accepted testing. Inmates are a high-risk population, who might not have tested in a setting outside of corrections. As a result, we have the opportunity to test a large population of at risk people who do not know their status.

In addition, the available therapies can decrease the likelihood of a person becoming sick with opportunistic infection and can extend their lives. This has been demonstrated both in the free community and correctional setting. We have opportunity to benefit the particular individuals with HIV. We also have the opportunity to decrease transmission of HIV to sexual and drug-using partners. Lastly, we have an opportunity to save the health care system money. People who are diagnosed with HIV when they present with an AIDS-associated infection or cancer, cost the health care system a lot of money. So initiating treatment earlier can not only benefit that person and any people they've infected, but the general health care system as well.

DP: The statistics vary, but supposedly a quarter of Americans living with HIV do not know that they are HIV positive. Incarceration provides a unique opportunity to educate, test, and treat at-risk persons in order to interrupt the HIV epidemic.

IDCR-O-GRAM

HIV Testing Policies: A Comparison of New and Old CDC Recommendations

Testing	Consent	Pre-test Counseling
<p>Old Policy Voluntary testing provided as a routine part of medical care. Targeted testing encouraged on the basis of risk screening.</p>	<p>Old Policy Specific consent for HIV testing required.</p>	<p>Old Policy Prevention counseling required.</p>
<p>New Policy Screening conducted after notifying the patient that an HIV test will be performed unless the patient declines (opt-out screening) is recommended in all health care settings. Persons at high risk for HIV should be screened at least annually.</p>	<p>New Policy General informed consent for medical care should be considered sufficient to encompass informed consent for HIV testing.</p>	<p>New Policy Prevention counseling should not be required in the health care setting, but should be strongly encouraged for persons at risk for HIV (e.g., persons at STD clinics).</p>
<p>Rationale Screening for HIV has been proven to be effective in identifying new cases of HIV among pregnant women, while targeting testing among all health care patients has been relatively unsuccessful. Many people do not perceive themselves to be at risk for HIV or do not disclose their risks, thereby making targeted testing ineffective.</p>	<p>Rationale Testing should only be undertaken with the patient's knowledge and understanding that HIV testing is planned. Studies indicate that patients are more likely to consent to HIV testing if it is treated the same as screening for any other disease, without special procedures such as written permission from the patient.</p>	<p>Rationale Health care providers often cite timely and expensive pre-test counseling as a barrier to HIV testing. Patients should be informed of what HIV infection is, the meanings of positive and negative test results, and should be offered an opportunity to ask questions.</p>

SAVE THE DATES

The 17th Meeting of the International Society for Sexually Transmitted Diseases Research

Seattle, Washington
July 29 - August 1, 2007
Visit:<http://www.isstdr.org/>

Treating HIV in the Correctional Setting

Gainesville, FL
August 10-12
Visit:www.faetc.org/Corrections/

Substance Use and HIV/AIDS: Improving Outcomes in Case Management

Manhattan, NY
August 22-23
Visit:www.health.state.ny.us/diseases/aids/training/addition.htm#sub-use

Bridging Theory and Practice: Applying Behavioral Theory to STD/HIV Prevention

Long Beach, CA
September 5-6
Visit:www.stdhivtraining.org/upcoming_classes.html

Correctional Medicine Institute 2007 Intensive Review in Correctional Medicine

St. Louis, MO
September 7-8, 2007
Visit:<http://www.cm-institute.org>

HIV Therapy, Management & Emerging Treatment Options

Live Satellite Videoconference & Webcast
October 3, 2007
12:30-2:30 p.m. EST
Visit:www.amc.edu/hivconerence
518.262.4674 or
ybarraj@mail.amc.edu

National Conference on Correctional Health Care

Nashville, TN
October 13-17
Visit:<http://www.ncchc.org/education/national2007.html>

15th Annual HIV/AIDS Update and Border Health Summit

South Padre Island, TX
24 to 26 October, 2007
Visit:<http://www.valleyaids.org>

AIDS in Culture IV: Explorations in the Cultural History of AIDS

Mexico City
December 9-13, 2007
Visit:www.aidsinculture.org

NEWS AND LITERATURE REVIEWS

New Study Demonstrates Entecavir's Activity in Inhibiting Replication of HIV-1, Raises Concerns Regarding Resistance to Anti-HIV-1 Drugs

A new study found evidence that contradicts previous findings that entecavir does not inhibit replication of HIV-1 in clinically relevant doses. The study, conducted by researchers at the Johns Hopkins University School of Medicine and the Howard Hughes Medical Institute, found that the drug, which is used to treat chronic hepatitis B virus infection (HBV), does indeed lead to 1-log₁₀ decreases in HIV-1 RNA when administered in clinically relevant doses. These findings were based on a case study of three HIV and HBV-infected patients and included both an in vitro and in vivo analysis of the drug's effects. Entecavir had previously been recommended for use in HIV-1 and HBV coinfecting individuals who required treatment for HBV, but not HIV-1, as it was not believed to inhibit replication of HIV-1 or pose any threat of causing anti-HIV drug resistance in patients. Researchers, however, also found that entecavir could select the M1847 mutation and thereby confer a high level of resistance to the antiretroviral (ARV) drugs lamivudine and emtricitabine in some patients. This discovery suggests that previous recommendations on the use of entecavir in persons who are not being treated for HIV-1 should be reconsidered in order to prevent resistance to anti-HIV-1 treatment options.

In an editorial on this topic, Dr. Martin Hirsch explained that the difference in findings between the two studies on entecavir as a replication inhibitor for HIV-1 could be the result of a difference in the sensitivity of the assays, virus strains, or amount of virus used in each of the two studies. In addition, Dr. Hirsch stated that guidelines for entecavir's use are now being reconsidered. The company that manufacturers the drug has issued a letter to health care providers to reiterate that the drug had not been evaluated in coinfecting patients who were not simultaneously receiving HIV-1 treatment. Also, the Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents no longer recommends entecavir for coinfecting patients who are not also receiving anti-HIV-1 treatment.

The HBV Drug Entecavir --- Effects on HIV-1 Replication and Resistance. McMahon M. et al. *New England Journal of Medicine.* 2007;356:2614-21.

Entecavir Surprise. Hirsch, Martin S. *New England Journal of Medicine.* 2007;356:2641-43.

Young Incarcerated Men's Perceptions of and Experiences with HIV Testing

An analysis of the formative research phase of Project START (STD and AIDS Risk Reduction Trials) reveals former incarcerated men's experiences with and opinions of HIV testing, both inside and outside the correctional setting. Project START, which is funded by the CDC, conducted both qualitative and quantitative face-to-face interviews with 105 men at 5 separate time-intervals-before each prisoner's release and 1 week, 1 month, 3 months, and 6 months after release. The interviews revealed that, while nearly all of the men had been tested for HIV and most had been tested on multiple occasions, the men had fairly consistent themes in discussing their reasons for getting tested, as well as the barriers that they encountered. Most men cited their perceptions of testing being mandatory, convenient, or free as factors in getting tested for HIV in prison. Conversely, the men consistently reported

lack of health insurance, employment, and time as barriers to testing outside of prison.

Also, many men stated that they only sought health care in emergency situations and it did not occur to them to get tested for HIV or even consider their risk factors. Other men reported that they knew that they were at risk for HIV, but feared knowing their HIV-status. The study also discussed the prevalent perception that "no news is good news," revealing that most men believed themselves to be HIV-negative if they did not receive their test results. Only half of the men reported receiving test results and most men did not receive posttest counseling. These findings emphasize the need to strengthen test result notification and counseling guidelines, as inadequate procedures can lead to missed opportunities for prevention and risk-reduction counseling.

Young Incarcerated Men's Perceptions of and Experiences with HIV Testing. Kacanek, D. et al. *American Journal of Public Health.* 2007;97(7):1-7.

Release from Prison - A High Risk of Death for Former Inmates

Researchers from the Puget Sound Veterans Affairs Medical Center recently published a retrospective cohort study comparing the risk of death between all inmates released from the Washington State Department of Corrections between July 1999 and December 2003 and the rest of Washington State's residents. The study, which was published in the *New England Journal of Medicine*, obtained data on the Washington State residents from the Wide-ranging OnLine Data for Epidemiologic Research system of the Centers for Disease Control and Prevention. All data was analyzed using indirect standardization and was adjusted for age, sex, and race, so as to prevent the influence of confounding variables on the study's evaluation.

Former inmates were found to have an adjusted risk of death that was 3.5 times higher than that of the state's general populous. In addition, the study revealed that former inmates were at a shocking 12.7 times higher adjusted risk of death during the first two weeks after their release from prison than other Washington State residents. The leading causes of death for former inmates were drug overdose, cardiovascular disease, homicide, and suicide. Many of the deaths linked to drug overdose involved cocaine, methamphetamine, heroin, and methadone, while firearms were involved in many of the suicides and homicides. The excess risk of suicide could be attributable to the prevalence of mental illness in inmates, in combination with the stress of reentry and possible lack of access to mental health care. Researchers suggest that factors such as level of education, employment status, level of income, neighborhood of residence, and health insurance status could account for some of the disparity between former inmates and other state residents, although it is unlikely that socioeconomic status could account for all of the variation. This study underscores the need for increased planning for the transition from prison to the community, which could include intensive case management during the period immediately following release in order to ensure that inmates have proper access to medical and mental health care.

Release from Prison --- A High Risk of Death for Former Inmates. Binswanger, I. Et al. *New England Journal of Medicine.* 2007;356:157-65.

Compiled by Christine Devore, IDCR Intern

SELF-ASSESSMENT TEST FOR CONTINUING MEDICAL EDUCATION CREDIT

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for continuing Medical Education through the joint sponsorship of Medical Education Collaborative, Inc. (MEC) and IDCR. MEC is accredited by the ACCME to provide continuing medical education for physicians.

Medical Education Collaborative designates this educational activity for a maximum of 1.25 AMA PRA Category 1 Credit(s)[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity. Statements of credit will be mailed within 6 to 8 weeks following the program.

Objectives:

- The learner will understand effective HIV testing policies.
- The learner will understand the challenges to implementing HIV testing in correctional facilities.
- The learner will understand the new HIV testing policies recommended by the CDC in 2006.

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| <p>1. According to the authors of the main article, an effective HIV testing policy upon incarceration is only needed if the following HIV clinical care services are provided within the correctional facility after diagnosis:</p> <ul style="list-style-type: none"> A. Initiation of HIV antiretroviral therapy for appropriate patients. B. A baseline medical evaluation with a determination of CD4+ count and HIV plasma viral load. C. Prophylaxis of opportunistic infections D. Screening for other conditions including viral hepatitis, tuberculosis, and sexually transmitted infections E. All of the above <p>2. Which of the following HIV testing policies do the authors of the main article support?</p> <ul style="list-style-type: none"> A. Mandatory upon entrance or and exit B. Voluntary, opt-out, routine testing offered upon entrance C. Performed when clinically indicated or ordered by the court D. Both A and C <p>3. Which of the following is NOT cited by Drs. Paar and Bick as a barrier to implementing routine HIV testing in correctional facilities?</p> <ul style="list-style-type: none"> A. The frequency with which incarcerated individuals move from facility to facility and the difficulty of tracking HIV-positive individuals through moves | <ul style="list-style-type: none"> B. Employing an increased number of pre-test and post-test counselors C. Ensuring that every HIV-positive inmate has access to providers experienced in caring for HIV-positive patients D. The cost of HIV testing and counseling E. Logistically impossible for prisoners to give informed consent <p>4. All are new HIV testing policies outlined by the CDC's new HIV testing recommendations from October 2006 EXCEPT:</p> <ul style="list-style-type: none"> A. Screening conducted after notifying the patient that an HIV test will be performed unless the patient declines (opt-out screening) is recommended in all health-care settings B. General informed consent for medical care should be considered sufficient to encompass informed consent for HIV testing C. Prevention counseling required D. All of the Above <p>5. Which of the following is NOT cited by Altice and Kavasery as a challenge to implementing routine HIV testing in jails?</p> <ul style="list-style-type: none"> A. Reluctance of correctional health staff to provide testing and treatment for incarcerated individuals B. Bearing cost associated with implementing testing and the care once HIV-positive individuals are identified C. Ensuring confirmatory testing results for those who test preliminarily positive D. Choosing the optimal time to conduct testing |
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In order to receive credit, participants must score at least a 70% on the post test and submit it along with the credit application and evaluation form to the address/fax number indicated. Statements of credit will be mailed within 6-8 weeks following the program.

Instructions:

- Applications for credit will be accepted until July 31, 2008.
- Late applications will not be accepted.
- Please anticipate 6-8 weeks to receive your certificate.



Please print clearly as illegible applications will result in a delay.

Name: _____ Profession: _____

License #: _____ State of License: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Please check which credit you are requesting ACCME or Non Physicians

I certify that I participated in IDCR monograph - Summer 2007 Issue

Please fill in the number of actual hours that you attended this activity.

Date of participation: _____

Number of Hours (max. 1.25): _____

Signature: _____

Please Submit Completed Application to:

Medical Education Collaborative
 651 Corporate Circle, Suite 104, Golden CO 80401
 Phone: 303-420-3252 FAX: 303-420-3259
 For questions regarding the accreditation of this activity, please call 303-420-3252

COURSE EVALUATION

I. Please evaluate this educational activity by checking the appropriate box:

Activity Evaluation					
	<i>Excellent</i>	<i>Very Good</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>
Faculty					
Content					
How well did this activity avoid commercial bias and present content that was fair and balanced?					
What is the likelihood you will change the way you practice based on what you learned in this activity?					
Overall, how would you rate this activity?					

II. Course Objectives

Were the following overall course objectives met? At the conclusion of this presentation, are you able to:

- | | | | |
|------------------------------------------------------------------------------------------------------|------------|-----------|-----------------|
| • The learner will understand effective HIV testing policies. | YES | NO | SOMEWHAT |
| • The learner will understand the challenges to implementing HIV testing in correctional facilities. | YES | NO | SOMEWHAT |
| • The learner will understand the new HIV testing policies recommended by the CDC in 2006. | YES | NO | SOMEWHAT |

III. Additional Questions

a. Suggested topics and/or speakers you would like for future activities.

b. Additional Comments
