Crime Victims and Corrections

SETTING THE AGENDA
FOR THE 1990'S

HIV AND AIDS ISSUES RELEVANT TO CRIME VICTIMS AND CORRECTIONS

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HIV AND AIDS ISSUES RELEVANT TO CRIME VICTIMS AND CORRECTIONS

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Crime Victims and Corrections: Setting the Agenda for the 1990's

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INTRODUCTION

The increase in reported cases of Human Immunodeficiency Virus (HIV) in the United States has raised serious implications for both crime victims and correctional professionals. Exposure to HIV -- either by an inmate who is incarcerated or during the occurence of a crime in the civilian population -- can result in death. And regardless if the person who was exposed to HIV actually contracts the virus, he or she is likely to incur considerable mental or emotional trauma resulting from the exposure.

The Federal government and state legislatures have responded to such scenarios by passing laws to protect and inform innocent persons who have unwillingly been exposed to HIV. Similarly, correctional agencies have instituted greatly needed policies and procedures which attempt to protect offenders' confidentiality rights and, at the same time, make sure that correctional officials who may have been exposed to HIV receive proper notification and treatment.

HIV TESTING RELATIVE TO CRIME VICTIMS

In the past five years, there has been increased attention paid to victims of sexual assault -- men, women and children -- who may have been exposed to HIV as a result of the crimes committed against them. The National Victim Center has noted reports from rape crisis centers which point to a tremendous increase in sexual assault victims' concerns about being exposed to HIV at the time of the rape. Such fears add to rape victims' existing physical and emotional trauma resulting from the criminal act alone.

According to the AIDS Policy Center at George Washington University, victims in five states -- California, Florida, Kansas, Oregon and Texas -- may request that their offenders be tested for HIV (June, 1990). An additional 15 states have laws that allow HIV test results to be disclosed to victims. (Please see Appendix A for a compendium of state laws)

Victim advocacy organizations and rape crisis centers have responded to this emerging crisis by developing and implementing

policies and protocol to assist rape victims in matters related to HIV testing. These include, but are not limited to:

- With the victim's knowledge and consent, testing the victim at the time of the assault (often as part of the rape kit examination) and establishing a "baseline" (to determine that the victim was not HIV positive at the time of the assault).

- Testing such victims at three-month intervals for at least one year following the assault.

- Passing and implementing laws to cover the costs of HIV testing from state victim compensation programs.

- Establishing comprehensive procedures for pre-test and post-test counseling for rape victims who wish to be tested for HIV.

- Establishing comprehensive education programs to educate rape victims about HIV, their related risks, and risk reduction methods that should be practiced prior to receiving final negative HIV test results.

There is, however, an important role correctional agencies play in regards to HIV and sexual assault victims. More and more states are implementing laws (both statutory and case law) relevant to voluntary and mandatory testing of alleged and/or convicted sex offenders for HIV. Such laws directly affect correctional agencies when a convicted sex offender is sentenced to prison.

The model statute relevant to testing of persons both alleged and convicted of sex offenses is currently implemented in the state of Florida (please see Appendix B for a copy of the statute). The Florida law requires that the results of the initial HIV test of an incarcerated offender "shall be disclosed to the victim or the victim's legal guardian, or the parent or guardian of the victim if the victim is a minor, upon request." In addition, ..."the request for disclosure shall be considered a standing request for any subsequent HIV results obtained within one year after the initial HIV test performed, and need not be repeated for each test administration."

Recommended Agency Policy for HIV Testing of Inmates and Disclosing Results

An agency policy relevant to HIV testing of convicted sex offenders requires the cooperation and input of prosecutors, sexual assault victims, convicted sex offenders and the correctional agency in which the offender is incarcerated.

Based upon the legal parameters of the Florida law noted above, along with sexual assault victims' concerns, the following policy is recommended for the testing of incarcerated sex offenders and appropriate notification of victims:

1. The prosecutor shall notify the victim of his or her right to request that a convicted offender be tested for HIV, and that the results of such testing shall be provided to the victim, upon request.

2. The victim shall request in writing that the convicted offender be tested for the HIV virus during incarceration, and that the test results be provided in a timely manner.

3. The victim shall be notified of his or her obligation to notify the correctional agency of any change in his or her address and/or telephone number to expedite prompt and accurate dissemination of test results.

4. The victim's request for HIV testing of the offender shall be considered a standing request that will be honored for **at least** twelve months from the time of the assault.

5. The prosecutor shall provide the victim's written request for notification of HIV test results to the correctional agency for inclusion in the inmate's file. Such requests shall be confidential.

6. The correctional agency shall test the convicted sex offender upon incarceration, and every three months thereafter for a period of up to **at least** one year from the time of the assault.

7. The results of each HIV test of the inmate shall be disclosed to the victim within 30 days of the test. All such test results are confidential; it shall be a misdemeanor for the victim to disclose test results to anyone else.

8. In the event that an offender tests positive for HIV, the correctional agency shall notify the prosecutor in the case, who can arrange for appropriate counseling and support services for the victim prior to and after 8the test results have been disclosed to that victim.

HIV TESTING POLICIES RELATIVE TO CORRECTIONAL PERSONNEL

Statutory and correctional agencies' policies relative to testing of incarcerated offenders vary considerably from state to state. According to the "1989 Update: AIDS in Correctional Facilities" published by the U.S. Department of Justice National Institute of Justice, the Federal Bureau of Prisons and 15 states conduct mandatory mass screenings of inmates. In addition, the Federal Bureau of Prisons and 30 states allow testing of inmates when there is an incident involving possibility of exposure to blood or certain bodily fluids. However, only four prison systems allow for disclosure and notification of inmates' HIV antibody test results to the victims, either in the community and/or in prison (please see Appendix C).

Clearly, the policies of the majority of prison systems are aimed toward protecting the confidentiality and privacy rights of inmates. While the risk of HIV exposure for correctional personnel at the hands of inmates is relatively low, this factor does not diminish the concerns of correctional staff about exposure to HIV. An important key to addressing these valid concerns is **education.**

HIV EDUCATION FOR CORRECTIONAL PERSONNEL

The best way to address correctional employees' concerns and fears about HIV as it relates to their work is for correctional agencies to implement comprehensive training programs for **all** personnel, from line staff to top administrators. Such education efforts should be included as part of initial training for new staff, and as a component of continuing education (at least on an annual basis).

In AIDS: Improving the Response of the Correctional System, authors Anna T. Laszlo and Marilyn B. Ayres recommend that correctional agencies address the following issues in staff training:

- History and definition of AIDS;
- Causes, symptoms, and transmission of the disease;

- Legal and liability issues in the management of inmates with AIDS;

- Initial response and arrest procedures for inmates suspected or diagnosed with AIDS;

- Intake/booking procedures for inmates suspected of or diagnosed with AIDS;

- Intake medical procedures for inmates suspected of or diagnosed with AIDS;

- Administrative and management issues including housing, work assigments, and prerelease strategies for inmates suspected of or diagnosed with AIDS;

- Infection control and safety procedures for medical staff providing treatment of AIDS-infected inmates; and

- Mental health and counseling considerations for AIDS-infected inmates.

Issues and a model curriculum for staff and inmate training recommended in AIDS: Improving the Response of the Correctional System are included in Appendix D.

Current research about HIV has resulted in myriad data and new information about the disease, how it is transmitted, strategies for prevention, and related public policy initiatives. As such, it is imperative that correctional agencies obtain and teach the most current HIV information to staff and inmates. The National Victim Center has a substantial collection of publications and data relevant to HIV, correctional agencies and crime victims. For additional information, please contact the National Victim Center's Washington office.

DEVELOPING AN AGENCY POLICY

All correctional agencies should develop an agency policy relevant to HIV and related issues which includes, but is not limited to, the following concerns:

- Inmate testing;
- Methods for reporting exposure incidents and requests from staff for inmate testing which result from possible exposure to HIV;
- Guidelines for disclosure of test results to both inmates who are tested and correctional staff who request the testing;
- Appeals procedures for HIV testing;
- Disclosure of HIV test results;
- Penalties for unauthorized disclosures of test results;
- HIV pre-test and post-test counseling for inmates and correctional personnel;
- HIV education and training for staff and inmates; and
- Availability of certified HIV counselors for staff and inmates.

The General Policy on AIDS and Other Communicable Diseases implemented by the California Youth Authority is one of the most comprehensive, far-reaching agency initiatives identified by the faculty of "Crime Victims and Corrections: Setting the Agenda for the 1990's." CYA's policy addresses all the issues noted above; it also provides for notification of inmates' HIV test results to correctional staff who request such testing. The California Youth Authority General Policy on AIDS and Other Communicable Diseases is included in Appendix E.

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STATES THAT MAKE IT A CRIME TO KNOWINGLY TRANSMIT/EXPOSE ANOTHER TO HIV INFECTION?

Alabama, H.B. 338, Act 87-574 (87) - misdemeanor - "risks transmitting or conducts himself in a manner likely to transmit the disease)

Arkansas, H.B. 1496, Act 614 (89) - felony - "sexual intercourse" (without 1st informing others)

California, S.B. 1002, Chapter 1154 (88) - felony, blood donation

Colorado, H.B. 1255 (90) - class 5 felony for knowingly performing, offering or agreeing to perform certain sexual acts with persons other than their spouses in exchange for money or any other thing of value. Persons who are knowingly infected with HIV who patronize prostitutes are guilty of a class 6 felony

Delaware, H.B. 637, Chapter 335 (88) - felony, blood donation

Florida, H.B. 1519 (88) - felony of the third degree, blood/body fluids donation

Florida, H.B. 1313, Chapter 86-220 (86) - misdemeanor "sexual intercourse"; (88) - misdemeanor (if person has been informed of modes of transmission)

Georgia, H.B. 1281, Act 1440 (88) - felony (after obtaining knowledge of infection) knowing intercourse, donation, sharing syringes

Idaho, H.B. 653, Chapter 70 (86) - prohibits knowing or willful exposure; H.B. 433 (88) - felony (provides affirmative defense if sexual activity occurred between consenting adults)

Idaho, H.B. 433 (88) - felony, knowing transmission or transmit with the intent of infection

Illinois, H.B. 1871 (89) - class 2 felony for criminal transmission = intimate contact; blood, semen, tissue or organ donation; sell, exchange, etc. nonsterile IV drug paraphernalia. Provides an affirmative defense if the person exposed knew that the infected persons was infected with HIV, knew that the action could results in HIV infected and consented to the action with that knowledge.

Indiana, S.B. 9, Public Law 88-123 (88) - Class C felony, blood donation

Kentucky, H.B. 50 (88) - Class C felony, blood donation (also any health facility, physician or health care worker who knowingly transfuses untested blood when there is not an emergency situation is guilty of Class C felony

H.B. 425 (90) - felony for donating organs, skin or other human tissues; class A misdemeanor for persons who commits prostitution; class D felony for committing prostitution or who procures another to commit prostitution by engaging in sexual activity in a manner likely to transmit HIV infection.

Louisiana, H.B. 1728, Act 663 (87) - fine of not more than $5,000, imprisonment with or without hard labor for not more than 10 years "sexual contact" without knowing consent of other person

Source:AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, June 1990.

Maryland, S.B. 719, Chapter 789 (89) - misdemeanor (may not knowingly transfer or attempt to transfer)

Michigan, H.B. 5026, Public Act 490 (88) - felony, sexual penetration (if they do not inform other person of the presence of disease)

Mississippi, H.B. 515, chapter 557 (88) - knowingly and willfully violating health department orders

Missouri, H.B. 1151 and 1044 (88) - Class D felony, donation of blood, organ, sperm, tissue; sexual contact

Nevada, S.B. 73 (89) - subject to confinement by court order as well as other penalties (which are not specified)

Oklahoma, H.B. 1796 (88) - felony (with intent to infect)

South Carolina, H.B. 2807, Ramification 547 (88) -sale, donation, exchange of blood products; "exposing another person to HIV without first informing"

Texas, S.B. 959 (89) - felony for "engaging in conduct likely to transfer"

Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, June 1990.

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VICTIM'S RIGHTS (Disclosure to, Requesting offenders to be tested)

Arkansas, H.B. 1496, Act 614 (89) - Provides that if the victim or person with whom the defendant engaged in sexual penetration during the course of the crime consents, the court must provide the person or agency administering the test with the name, address and telephone number of the victim or person. After the defendant is tested, the person or agency administering the test must immediately provide the defendant's test results to the victim or person with whom the defendant engaged in sexual penetration during the course of crime, and the victim must be referred for appropriate counseling.

California, A.B. 4209 (88) - DOH must develop a brochure for victims re: exposure; S.B. 1007 (88) - requires county health officers to establish counseling programs for victims of specified sexual offenses who take HIV test; S.B. 2643 (88) - Victims may request a search warrant from court to test the accused. Local health official responsible for disclosing results to victim and accused after counseling. Victim can disclose results as deemed necessary but results can't be used in criminal proceedings

Colorado S.B. 8 (88) - test result must be reported to the court; victims may decide whether or not they want to receive results

Florida, H.B. 1590 (89) - victim may request a defendant to be tested in a prosecution for any type of sexual battery where a blood sample is taken from the defendant voluntarily or pursuant to a court order; test results can be disclosed solely to the defendant and the victim

Georgia, H.B. 1281 (88) - + test results and name of person shall be reported to the victims of crime which poses a reasonable risk of transmitting HIV; counseling must be provided to victim

Idaho, H.B. 351, Chapter 220 (89) - Upon application to the court by the victim(s), or if the victim(s) is a minor, by the minor's parent, guardian, or legal custodian, the court may release the test results if the court determines that the health or safety of the victim(s) may be threatened. Authorizes the court to impose such conditions on the release of the test results as it deems necessary and just.

H.B. 638, Chapter 310 (90) - Upon the victims's application to the court, or if the victim(s) is a minor, by the minor's parent, guardian or legal custodian, the court may release test results if it determines that the health or safety of the victim(s) may be threatened. The court may impose conditions on the release of test results as it deems necessary and just.

Illinois, H.B. 4005 (88) - court has the discretion to notify victim of test results.

Indiana, S.B. 9 (88) - board of health shall notify victims of specified crimes offender's test results = +; counseling must be provided to victims

Kansas, H.B. 2659 (88) - Victims (their guardians or parents if v. = minor) may request that the convicted person submit to a test. Victim must designate a health care provider or counselor to receive such info. If test -, court shall order convicted person to be tested 6 mos. later.

Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, June 1990.

Results disclosed to court ordering test, convicted person, victim, designated person parents (if person = minor). If test +, results reported to secretary of health and envir. secretary of corrections. Counseling will be provided for victim.
Michigan, H.B. 4008 (88) - If the victim consents, the court shall provide the person or agency administering the test to the convicted person with the victim's name, address and telephone number; requires person or agency administering test to notify victim and refer her for appropriate counseling

Minnesota, S.B. 2046, Chapter 436 (90) – Requires hospitals to give written notice about STD to a person receiving medical services in the hospital who reports or evidences a sexual assault or other unwanted sexual contact or sexual penetration. When appropriate, the notice must be given to the parent or guardian of the victim. The commissioners of public safety and corrections, in consultation with sexual assault victim advocates and health care professionals, will develop the required notice. The notice must inform the victim of: (1) the risk of contracting STD as a result of sexual assault; (2) the symptoms of STDs; (3) recommendations for periodic testing for the diseases, where appropriate; (4) locations where confidential testing is done and the extent of the confidentiality provided; and (5) other medically relevant information.

Missouri, S.B. 138 (89) - Requires the Department of Health to pay for the cost of conducting HIV testing for victims of rape, sodomy or incest if the person who is convicted of such crime is determined to be infected with HIV based on HIV testing conducted upon delivery to the Department of Corrections and Human Resources.

Nevada, S.B. 73 (89) - requires the health authority to disclose the test results to the victim or the victim's parent or legal guardian if the victim is a minor

Ohio, S.B. 2 (89) - requires the court to inform the victim that a HIV test was performed on the offender and that the victim has the right to receive the results upon request; fact that accused was tested for HIV inadmissible in evidence over the objection of the accused, in a prosecution for any offense or a different offense arising out of same circumstances as the offense charged

Oregon, H.B. 2030 (89) - provides that if a convicted offender fails to submit to the HIV test, the court may order the convicted person to submit to an HIV test if the victim or the victim's parent or guardian requests the court to make such order after the victim has submitted to an HIV test; requires the alleged victim of a crime likely to involve transmission of body fluids or her parents/guardian to be notified that testing and counseling is available; if test ordered, victim shall designate an attending physician to receive test results; test results are available to victim

South Carolina, H.B. 2807 (88) - requires the solicitor ordering test of person convicted to notify the victim and offender of test results

Texas, S.B. 6-XX (87) - Victim may request that a person indicted for sexual assault and aggravated sexual assault be tested. Results must be made available to local health authority who must notify for victim. Prohibits fact that the test was performed or results to be used in criminal proceedings.

STATES WHERE TEST RESULTS MAY BE DISCLOSED TO VICTIMS

Arkansas, H.B. 1496 (89)
California
Colorado, S.B. 8 (88)

Source:AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, June 1990.

Florida, H.B. 1590 (89)
Georgia, H.B. 1281 (88)
Idaho, H.B. 351 (89)
Illinois, H.B. 4005 (88)
Indiana, S.B. 9 (88)
Kansas, H.B. 2659 (88)
Michigan, H.B. 4008 (88)
Nevada, S.B. 73 (89)
Ohio, S.B. 2 (89)
Oregon, H.B. 2030 (89)
South Carolina, H.B. 2807 (88)
Texas, S.B. 6-XX (87)

STATES WHERE VICTIMS MAY REQUEST THAT THEIR OFFENDERS BE TESTED

California, A.B. 4209 (88)
Florida, H.B. 1590 (89)
Kansas, H.B. 2659 (88)
Oregon, H.B. 2030 (89)
Texas, S.B. 6-XX (87)

Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, June 1990.

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PROSTITUTES, SEX OFFENDERS (Testing, Education)

Arkansas, H.B. 1496 (89) - authorizes testing for persons charged with certain offenses

California, S.B. 1007 (88) - mandates testing for persons convicted of sexual offenses

Colorado, S.B. 8 (88) - mandates testing for person awaiting trial subsequent to preliminary hearing for sexual assault; H.B. 1255 (90) - Mandates testing for persons convicted of prostitution and requires the person to pay for the test

Florida, S.B. 576 (86) - mandates testing for persons convicted of prostitution; H.B. 1519 (88) - mandates testing for person convicted of prostitution or procuring another to commit prostitution; H.B. 1590 (89) - informed consent not required for HIV testing of persons convicted of prostitution or convicted of procuring another to commit prostitution with him/herself

Georgia, H.B. 1281 (88) - mandates testing upon verdict or plea of guilty or no contest to prostitution

Idaho, H.B. 432 (88) - authorizes testing for persons charged with prostitution or sex offense; H.B. 351 (89) - authorizes testing for persons charged with prostitution or other sex offense; H.B. 638 (90) - requires all persons confined in any county or city jail and who are charged with sex offenses, drug related charges, prostitution or other changes as recommended by public health authorities to be tested for the venereal diseases enumerated in section 39-601, Idaho Code.

Illinois, H.B. 2044 (87) - mandates testing when a defendant convicted of a sex-related offense, including prostitution, solicitation, operating a house of prostitution, patronizing a prostitute, criminal sexual assault, aggravated criminal sexual assault, criminal sexual abuse or aggravated criminal sexual abuse

Indiana, S.B. 9 (88) - mandates testing for persons convicted of sex crime

Iowa, S.B. 2157 (88) - mandates offering testing and counseling to male and female prostitutes

Kansas, H.B. 2659(88) - authorizes testing upon conviction of crime that involved or may have involved transmission of body fluids

Kentucky, H.B. 425 (90) - mandates testing for persons convicted of prostitution or procuring another to commit prostitution. Requires convicted prostitutes to submit to treatment and counselling as a condition of release from probation, community control or incarceration. Test results will be made available by the Cabinet for Human Resources to medical personnel, appropriate state agencies or courts of appropriate jurisdictions to enforce these provisions.

Louisiana, H.B. 460 (88) - persons convicted of prostitution may be referred to parish health unit for counseling

Maryland, S.B. 719 (90) - mandates AIDS education for persons who plead guilty or nolo contendere or who are found guilty of prostitution or any drug offense

Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, June 1990.

Michigan, H.B. 4008 (88) - authorizes testing for persons arrested and convicted of prostitution, certain crimes capable of transmitting HIV infection, criminal sexual misconduct

Nevada, A.B. 550 (87) - mandates testing for prostitutes arrested for not practicing in a licensed house of prostitution; A.B. 273 (89) - mandates testing for persons arrested for certain violations, requires convicted persons to pay $100 for the test; S.B. 73 (89) - mandates testing for person arrested for a crime involving sexual penetration

North Dakota, S.B. 2048 (89) - mandates testing for persons imprisoned or not who are convicted of sexual offense

Ohio, S.B. 2, (89) - mandates persons charged with sexual offenses; if person has been convicted of the charge of a different offense arising out the same circumstances of the offense charged, the court shall order the test to be repeated not earlier than 3 months nor later than 6 months after the original test

Oregon, H.B. 2067 (87) - mandates testing for persons convicted of sex crimes; H.B. 2030 (89) - at appearance before district or circuit court judge on a criminal charge, judge shall inform every person arrested or charged with a crime in which may have involved transmission of body fluids of the availability of HIV testing and counseling; upon conviction of crime involving possible transmission of body fluids, court shall seek consent for testing; absence or failure to consent court may order the convicted person to submit to HIV test if the victim of the crime requests the court to make such order after the victim has submitted to a test

Rhode Island, S.B. 3438 (88) - mandates testing for persons convicted of prostitution

South Carolina, H.B. 2807 (88) - mandates testing within 15 days of conviction involving sexual battery or sexual conduct where victim exposed to blood, vaginal or seminal fluids

Texas, S.B. 66-XX (87) - authorizes testing for indicted for sexual assault and aggravated sexual assault; S.B. 959 (89) - authorizes testing of persons convicted of certain crimes subject to control measures

Virginia, H.B. 815 (90) - provides that persons charged with any crime involving sexual assault or any offense against children may be requested to take an HIV test. If persons refuses, court will determine probable cause using evidence that individual has committed the crime. Upon finding probable cause, mandates HIV testing. Mandates testing of sexual assault or any offenders against children upon conviction; S.B. 340 (90) - mandates testing for prostitutes after conviction

Washington, S.B. 6221 (88) - authorizes testing for persons convicted of sexual offense or prostitution

West Virginia, H.B. 303 (88) - mandates testing for persons convicted prostitution, sexual abuse, sexual assault, incest or molestation

Source:AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, June 1990.

960.003 Human immunodeficiency virus testing for persons charged with sex offenses; disclosure of results to victims.—

(1) LEGISLATIVE INTENT.—The Legislature finds that a victim of a sexual offense is entitled to know at the earliest possible opportunity whether the person charged with the offense has tested positive for human immunodeficiency virus (HIV) infection. The Legislature finds that to deny victims access to HIV test results causes unnecessary mental anguish in persons who have already suffered trauma. The Legislature further finds that since medical science now recognizes that early diagnosis is a critical factor in the treatment of HIV infection, both the victim and the person charged with the offense benefit from prompt disclosure of test results. The Legislature finds that HIV test results can be disclosed to the victim of a sexual offense while confidentiality is protected in other respects.

(2) TESTING OF PERSON CHARGED WITH SEX OFFENSE.—In any case in which a person has been charged by information or indictment with any sexual offense proscribed in chapter 794 or s. 800.04 which involves the transmission of body fluids from one person to another, upon request of the victim or the victim's legal guardian, or of the parent or legal guardian of the victim if the victim is a minor, the court shall order such person to undergo HIV testing. The testing shall be performed under the direction of the Department of Health and Rehabilitative Services in accordance with s. 381.609. The results of an HIV test performed on a defendant pursuant to this subsection shall not be admissible in any criminal proceeding arising out of the alleged sexual offense.

(3) DISCLOSURE OF RESULTS.—

(a) The results of the test shall be disclosed, under the direction of the Department of Health and Rehabilitative Services, to the person charged with the offense, and, upon request, shall also be disclosed to the victim or the victim's legal guardian, or the parent or legal guardian of the victim if the victim is a minor. The test results shall not be disclosed to any other person except as expressly authorized by law or court order.

(b) At the time that the results are disclosed to the victim or the victim's legal guardian, or to the parent or legal guardian of a victim if the victim is a minor, the same immediate opportunity for face-to-face counseling which must be made available under s. 381.609(3)(e) to those who undergo HIV testing shall also be afforded to the victim or the victim's legal guardian, or to the parent or legal guardian of the victim if the victim is a minor. The Department of Health and Rehabilitative Services is responsible for ensuring that test results are disclosed in accordance with the terms of this subsection.

(4) POST-CONVICTION TESTING.—If, for any reason, the testing requested under subsection (2) has not been undertaken, then upon request of the victim or the victim's legal guardian, or the parent or legal guardian of the victim if the victim is a minor, the court shall order the offender to undergo HIV testing following conviction. The testing shall be performed under the direction of the Department of Health and Rehabilitative Services, and the results shall be disclosed in accordance with the provisions of subsection (3). The test results shall not be disclosed to any other person except as expressly authorized by law or court order.

(5) EXCEPTIONS.—The provisions of subsections (2) and (4) do not apply if:

(a) The person charged with or convicted of a sexual offense as described in subsection (2) has undergone HIV testing voluntarily or pursuant to procedures established in s. 381.609(3)(i)6. or s. 951.27, or any other applicable law or rule providing for HIV testing of criminal defendants or inmates, subsequent to his arrest or conviction for the sexual offense for which he was charged; and

(b) The results of such HIV testing have been furnished to the victim or the victim's legal guardian, or the parent or legal guardian of the victim if the victim is a minor.

[1](6) TESTING DURING INCARCERATION; DISCLOSURE.—In any case in which a person convicted of a sexual offense described in subsection (2) has not been tested under subsection (2), but undergoes HIV testing during his incarceration, the results of the initial HIV testing shall be disclosed to the victim or the victim's legal guardian, or to the parent or legal guardian of the victim if the victim is a minor, upon request. Except as otherwise requested by the victim or the victim's legal guardian, or the parent or guardian of the victim if the victim is a minor, if the initial test is conducted within the first year of the inmate's imprisonment, the request for disclosure shall be considered a standing request for any subsequent HIV test results obtained within 1 year after the initial HIV test performed, and need not be repeated for each test administration. Where the inmate has previously been tested pursuant to subsection (2) the request for disclosure under this subsection shall be considered a standing request for subsequent HIV results conducted within one year of the test performed pursuant to subsection (2). If the HIV testing is performed by an agency other than the Department of Health and Rehabilitative Services, that agency shall be responsible for forwarding the test results to the Department of Health and Rehabilitative Services for disclosure to the victim or the victim's legal guardian, or the parent or legal guardian of the victim if the victim is a minor in accordance with subsection (3). This subsection shall not be limited to results of HIV tests administered subsequent to June 27, 1990, but shall also apply to the results of all HIV tests performed on inmates convicted of sexual offenses as described in subsection (2) during their incarceration prior to June 27, 1990. The test results shall not be disclosed to any other person except as expressly authorized by law or court order.

History.—s. 1, ch. 90-210.

[1]Note.—As amended by s. 1, ch. 90-210 retroactively operative to testing previously performed on inmates.

U.S. Department of Justice
Office of Justice Programs
National Institute of Justice

1989 Update: AIDS in Correctional Facilities

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Chapter 6

HIV Antibody Testing, Counseling, and Notification Policies

Testing Policies for Inmates

Advances in treatment regimens for HIV infection have resulted in an increasing emphasis on early identification and early intervention. Therefore, in the world outside correctional institutions, there has been a transformation of attitudes toward HIV antibody testing. Once seen primarily as a means of preventing infection (either through protecting the blood supply or identifying infected people), testing is now increasingly viewed as an integral part of medical treatment. The situation is not quite the same in correctional facilities, where testing is still considered by some to be an infection control tool. But many correctional systems are now offering voluntary or on-request testing. This trend is at least in part responsive to the movement toward early therapeutic intervention.

Mandatory Mass Screening

As shown in Figure 14, sixteen state/federal prison systems conduct mandatory HIV antibody screening of all incoming inmates, all current inmates and/or all inmates at release. Fifteen of the sixteen systems screen all intakes. No responding city/county or Canadian systems have mass screening policies.

The sixteen mass screening systems represent a net increase of one since the 1988 survey. Mississippi, North Dakota and Utah have been added to the list of mass screening states since 1988, while Rhode Island and West Virginia have left the list. These changes clearly do not represent a resurgence of the strong trend to mass screening seen between 1986 and 1987. However, as a result of funding shortages, and the realization that mass testing was creating more problems than it was intended to solve, several state systems have discontinued this policy. The West Virginia prison system no longer conducts mass testing, and, due to lack of funds, Rhode Island will not institute legislatively mandated mass screening of all inmate categories. Figures 15 and 16 summarize correctional systems' testing policies.

"Risk Group" Testing

Since the 1988 survey, four prison and eight jail systems have instituted screening of identifiable members of "high risk groups," most often IV drug users (including prostitutes) and homosexual men. In the past, several of these systems tested only in the presence of clinical indications (of HIV infection or AIDS), in response to involvement in an incident (such as a fight or sexual activity, where blood or body fluid exposure may have occurred), or for blinded epidemiologic studies. While "risk group" screening may be useful to assess infection rates in particular subpopulations, the results may be subject to selection bias, since it is difficult to identify all members of these groups. On the other hand, intensive counseling and testing programs for IV drug users may be valuable HIV prevention strategies if linked with drug treatment services.[1]

Voluntary Testing or Testing on Inmate Request

As shown in Figure 15, 37 state and federal prison systems and 28 responding jail systems offer voluntary testing and/or testing on inmate request. This actually

Figure 14

CORRECTIONAL SYSTEMS CONDUCTING MANDATORY MASS SCREENING OF INMATES, OCTOBER 1989[a]

U.S. State/Federal Prison Systems (N=51)	U.S. City/County Jail Systems (N=31)	Canadian Systems (N=11)
Federal Bureau of Prisons	None	None
Alabama		
Colorado		
Georgia		
Idaho		
Iowa		
Michigan		
Missouri		
Mississippi		
Nebraska		
Nevada		
New Hampshire		
North Dakota		
Oklahoma		
Utah		
Wyoming		

[a]Defined as *mandatory* HIV antibody testing, generally identity-linked, of all new inmates, all releasees, and/or all current inmates, regardless of whether they do or do not show clinical indications of HIV infection. In terms of correctional policy, this type of testing differs in purpose and method from blinded epidemiological studies. These studies are anonymous (*not* identity-linked) screenings intended to assess seroprevalence rates in a particular population.

Source: NIJ Questionnaire Responses.

Figure 15

SUMMARY OF CORRECTIONAL POLICIES ON HIV ANTIBODY TESTING OF INMATES, OCTOBER 1989[a]

	U.S State/Federal Prison Systems (N=51)		U.S. City/County Jail Systems (N=31)		Canadian Systems (N=11)	
Testing Policies	Number of Systems	%	Number of Systems	%	Number of Systems	%
Mandatory Screening of:						
All Incoming/New Inmates	15	29%	0	0%	0	0%
All Current Inmates	9	18	0	0	0	0
All Inmates Near Release	6	12	0	0	0	0
Screening of "High Risk Groups"[b]	17	33	15	48	6	54
Voluntary/Inmate Request Testing	37	73	28	90	11	100
Testing if Clinical Indications[c]	39	76	25	81	9	82
Testing if Involvement in Incident[d]	31	61	16	52	6	54
Testing for Epidemiologic Studies[e]	15	29	7	23	3	27
No Testing/Policy Unknown	1	2	0	0	0	0

[a]This table includes actual and planned policies. The categorization is *not* mutually exclusive.

[b]Testing identifiable inmates with histories of high-risk behavior (e.g., homosexuals and intravenous drug abusers), regardless of whether they do or do not show clinical indications of HIV infection or AIDS.

[c]Clinical signs or symptoms of HIV infection or AIDS.

[d]Incident involving possibility of exposure to blood or certain body fluids.

[e]Seroprevalence or seroconversion.

Source: NIJ Questionnaire Responses.

Figure 16

HIV ANTIBODY TESTING OF INMATES, MUTUALLY EXCLUSIVE CATEGORIZATION, OCTOBER 1988 AND OCTOBER 1989[a]

	U.S. State/Federal Prison Systems				U.S. City/County Jail Systems				Canadian Systems			
	October 1988 (N=51)		October 1989 (N=51)		October 1988 (N=28)		October 1989 (N=31)		October 1988 (N=12)		October 1989 (N=11)	
Procedure	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%
Mandatory Mass Screening (all incoming inmates, current inmates and/or inmates at release)	15	29%	16	33%	0	0%	0	0%	0	0%	0	0%
Screening of "High Risk Groups"	8	16	12	22	5	18	13	42	2	17	6	55
Voluntary/Inmate Request Testing	6	12	7	14	8	28	10	32	3	25	2	18
Testing If Clinical Indications,[b] Involvement in Incident or for Epidemiologic Studies	22	43	15	29	13	46	8	26	4	33	3	27
No Testing/Policy Unknown	0	0	1	2	2	7	0	0	3	25	0	0
TOTAL	51	100%	51	100%	28	99%[c]	31	100%	12	100%	11	100%

[a]Includes actual and planned policies. This is a *hierarchical* categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that screen identifiable inmates with histories of high-risk behaviors, but do no mass screening, are placed in the "screening of high-risk groups" category regardless of whether they also do testing for diagnosis, incident involvement, or epidemiologic studies; and so on.

[b]In this table, clinical indications includes lowered CD4 (T4) counts, opportunistic infections, and TB positivity or active TB.

[c]Due to rounding.

Source: NIJ Questionnaire Responses.

represents a decline of two state/federal systems since 1988. On the other hand ten more responding city/county jail systems than in 1988 offered such testing. Two-thirds of state/federal prison systems and 90 percent of city/county systems have this type of testing policy.

Because of the recent findings regarding medical intervention for asymptomatic HIV-infected inmates, the importance of offering voluntary/on request testing has increased. Several studies have found that voluntary testing of inmates serves the needs of both inmates and correctional systems. In the Wisconsin prison system, a three-year study was conducted to assess seroprevalence and the acceptance of voluntary testing by incoming male inmates. Results based on antibody status and responses to a risk assessment questionnaire showed that voluntary testing captured a significant percentage of IV drug users and seropositive inmates. Few inmates with either of these characteristics declined the offer to be tested. Conversely, many of those inmates declining testing were, through anonymous blood samples and identity-linked questionnaire responses, discovered to be neither IV drug users nor seropositives.[2] In a similar study, the Oregon Department of Corrections found that two-thirds of newly incarcerated inmates opted for counseling and testing. These inmates included IV drug users, male homosexuals, and individuals with hepatitis B antibody—all those deemed by the corrections staff to be at highest risk for HIV infection.[3]

Re-Testing

Slightly over half (55%) of state/federal prison systems re-test initially seronegative inmates. Among these systems, circumstances under which re-testing occur vary widely. These include routine re-testing at specified intervals (as in the federal system), re-testing on request, re-testing in the presence of symptoms or identification of risk factors (as in Rhode Island), and re-testing only in response to possible exposure incidents. Only a handful of responding city/county systems re-test seronegatives.[4]

Pre- and Post-Test Counseling of Inmates

Most prison systems (90%) and jail systems (84%) provide inmates with individual counseling before and after HIV antibody testing. A few more do only post-test counseling, and a few others do so only for seropositives. It is essential that all inmates who are considering being tested and who are tested be provided with clear and sensitive counseling.

Pre-test counseling is no less important than post-test counseling. In fact, it is during pre-test counseling that information regarding confidentiality/notification and the meaning of results may be most readily absorbed by inmates. In nearly half (47%) of prison systems and nearly half (48%) of responding jail systems, pre-test counseling is 5-20 minutes long. Standard counseling protocols specify content that generally takes 15-30 minutes to cover adequately. Thus, the pre-test counseling sessions provided by some systems may not be of adequate length or content. The same may be true of post-test counseling, which is an important opportunity for explaining to seronegatives that their test result is by no means a guarantee of immunity from infection in the future. They must be told that if they engage in high-risk behaviors, they still may become infected. If the inmate is seropositive, post-test counseling must deal with the fears and anxieties such a result elicits, including suicidal reactions. The content specified in standard post-test counseling protocols generally requires 10-20 minutes for seronegatives and 30-60 minutes for seropositives. Post-test counseling in state/federal systems is 5-20 minutes long in a third (31%) and 21-45 minutes long in 41% of systems. In city/county jail systems, post-test counseling is 5-20 minutes long in about half (48%) the systems, while in about a third (29%), it is 21-45 minutes long. Here again, correctional systems should ensure that post-test counseling is of sufficient length to cover the necessary topics.[5]

Many correctional systems employ more than one type of professional in HIV test counseling. A number of both state/federal and city/county systems use nurses, nurse practitioners or licensed practical nurses (LPNs). An equal number report using doctors while a number of systems use physicians' assistants (PAs). Some systems also use clinical psychologists or psychiatric social workers, and some use health workers or AIDS educators from local agencies. About three-quarters (78%) of systems use counselors trained in HIV counseling, often by state or local public health departments and by regional AIDS organizations.

In the Texas Department of Corrections, counselors are extensively trained in HIV test counseling and also

in partner notification techniques. The training curriculum includes a comprehensive manual prepared by the state public health department. The manual is divided into several sections: Pre-test, Seronegative, Seropositive, Equivocal (test result), Notification, and Psychological. The first few sections include topics such as reflective listening, common questions and answers, and scenarios for role-playing. The section on notification of test results to inmates' recent partners (sex or needle sharing) notes that counselors should encourage inmates to give their consent to notification. It emphasizes that notification is voluntary for inmates as well as confidential from other correctional staff. The Department of Corrections cooperates with the local public health department in locating and notifying partners.[6]

Procedures for Staff Exposures

Correctional systems have been concerned about the possibility of job-related HIV infections of staff through exposure to inmates' blood or body fluids. Response procedures include assessing the exposure and testing the staff member and/or inmate(s). In the NIJ survey, a majority (88%) of prison systems and a majority of jail systems (81%) report a policy that includes first ascertaining if the "exposure" was "significant." The definition of what constitutes a "significant exposure" varies across systems. The Massachusetts Department of Correction lists three categories of "exposures of concern": puncture wounds, blood to blood contact, and mucous membrane contact.[7] The bulk of systems then test/re-test the staff member or refer the person to an outside physician. About half (53%) of prison systems and three quarters of responding jail systems (71%) report that they test/re-test the inmate(s) implicated in the accident or incident. Inmate consent to testing in these situations is required in some jurisdictions but not in others.

Disclosure/Notification of Inmate HIV Status

Policy-making regarding the confidentiality and disclosure/notification of an inmate's HIV status remains a controversial and difficult issue for correctional systems. Many states have laws protecting the confidentiality or the anonymity of individuals tested for HIV antibody.[8] Figure 17 shows that almost all state/federal and responding city/county correctional systems notify the inmate and the attending physician or health-care worker of test results. In over half the prison systems, other medical staff (community or correctional) and correctional management (central office and institutional) are also notified. Only a fraction (16%) of prison systems and a slightly larger number of responding jail systems (29%) have a policy of notifying correctional officers. These numbers apply only to actual disclosure policy, written or unwritten. It is apparent from lawsuits filed by inmates that news of a particular inmate's positive test results or seropositive status travels rapidly through an institution. Breaches of confidentiality are alleged to occur frequently.[9]

Correctional staff often claim a "need to know" inmates' HIV status. The emphasis on confidentiality may arouse suspicion and resentment among many staff who believe that protection of inmates' confidentiality should not outweigh measures to protect officers' safety. However, the fact that very few correctional systems officially give line officers access to HIV test results is presumably based on the view that "security concerns [do not] present a case for a 'need to know'. The only reasonably clear exception to that seems to be where an inmate is known to have tested positive and is also known to be aggressive."[10] In response to New York State's HIV confidentiality laws, the correctional department issued regulations stating that correctional officers who work directly with inmates are not considered to have a "need to know" those inmates' HIV status.[11] Continued staff education on the low-risk nature of most staff-inmate contacts and training on following universal precautions is necessary to ease staff concerns about transmission which prompt demands for widespread disclosure of inmate test results or HIV status. Disclosure of inmates' HIV status may, in fact, lull correctional officers into a false sense of security, leading them to believe that all infected prisoners have been identified. False negatives do occur on the antibody tests, and no testing program can guarantee the identification of all HIV-infected persons.

Figure 17

DISCLOSURE/NOTIFICATION OF INMATES' HIV ANTIBODY TEST RESULTS, OCTOBER 1989[a]

Party Notified[a] (during incarceration and/or at release)	U.S. State/Federal Prison Systems (N=51)		U.S. City/County Jail Systems (N=31)		Canadian Systems (N=11)	
	Number of Systems	%	Number of Systems	%	Number of Systems	%
Inmate	50	98%	28	90%	11	100%
Attending Physician or Health-Care Worker	51	100	27	87	11	100
Other Medical Staff (Community or Correctional)	31	61	12	39	8	73
Correctional Management—Central Office	29	57	6	19	6	55
Correctional Management—Institution	34	67	10	32	8	73
Correctional Officers (Security)	8	16	9	29	3	27
Public Health Department[b]	36	71	13	42	7	64
Spouse/Sexual Partner(s)	12	24	2	6	2	18
Victims of Inmate (in community and/or in prison/jail)	4	27	9	29	1	9
Parole Agency	18	35	2	6	2	18
Residential Placement[c]	4	8	1	3	3	27
Work Placement[c]	0	0	0	0	2	18
Other[d]	6	12	10	32	2	18

[a]Figures include both systems which specified the conditions under which disclosure/notification to certain parties could be made (e.g., only with inmate consent and/or on a "need-to-know" basis) and systems which did not specify these conditions.
[b]Most systems view notification of residential or work placements as falling in the domain of parole agencies/divisions.
[c]This category includes public agencies courts and other parties unspecified by responding systems.

Source: NIJ Questionnaire Responses.

Endnotes

1. "Coordinated Community Programs for HIV Prevention Among IVDUs—California, Massachusetts," MMWR June 2, 1989; 38:370-374.

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4. NIJ Questionnaire Responses, 1989.

5. For general guidelines and suggestions on pre- and post-test counseling, see Gabriele Dlugosch, Mark Gold and James Dilley, "AIDS Antibody Testing: Evaluation and Counseling" and "Diagnosis/Treatment: Disclosing AIDS Antibody Test Results," *Focus: A Guide to AIDS Research and Counseling* (San Francisco: The AIDS Health Project, University of California, July 1986; 1(8):1-3; Mark Gold, Neil Seymour and Jeffrey Sahl, "Counseling HIV Seropositives," in *What to Do About AIDS*, ed. Leon McKusick (Berkeley: University of California Press, 1986), pp. 103-110; Michael Helquist (ed.) *Working with AIDS: A Resource Guide for Mental Health Professionals* (San Francisco: The AIDS Health Project, University of California, 1987); and Jeffrey Kelly and Janet St. Lawrence, *The AIDS Health Crisis: Psychosocial and Social Interventions* (New York: Plenum Press, 1988).

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7. Commonwealth of Massachusetts Department of Correction, Health Services Division, "Handbook for Non-Medical Staff on Communicable Diseases—Exposure of Concern Information Sheet for DOC Employees," June 26, 1989.

8. "Recording Results of AIDS Tests Can be a Balancing Act," *Modern Healthcare* November 3, 1989.

9. State of Texas, Legislative Task Force on AIDS "Report to the Seventy-First Legislature—AIDS in Texas: Facing the Crisis," January 1989.

10. "AIDS, Confidentiality, and Disclosure: Issues in Conflict With No Clear Answers," *Correctional Law Reporter* May 1989; 1:19-24.

11. J. Gresham, Prisoners Legal Services of New York, Personal Communication, October 5, 1989.

APPENDIX D

AIDS:
Improving the Response of the Correctional System

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National Institute of Corrections

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CHAPTER IX

ISSUES AND GUIDELINES FOR STAFF AND INMATE TRAINING

This chapter discusses the need for correctional staff to undergo comprehensive training and education previous to or coincidental with dissemination of a formal, written policy on managing AIDS-infected inmates. The chapter also will address the need for inmate education programs and will specify training topics for both staff and inmate training and education.

ISSUES IN TRAINING AND EDUCATION OF CORRECTIONAL STAFF

Introduction

A recent study of issues facing correctional facilities documented persistent fears concerning AIDS among both staff and inmates. Of the correctional institutions that responded, 93 percent reported staff concern regarding the possibility of contracting the disease via methods not associated with its transmission.[1]

Staff concern focused particularly on the possibility of contracting AIDS from aggressive inmates who might bite them, spit in their faces, or jab them with sharp instruments. Correctional officers also are concerned about risks involving cell and body searches, intervention in violent confrontations among inmates, and administration of CPR and other first aid to inmates.

To ensure that correctional officers perform their duties effectively and without unnecessary fear, training programs that comprehensively address the management of inmates suspected of or diagnosed with AIDS need to be implemented in a timely and systematic manner. In jurisdictions lacking experience in managing AIDS within correctional facilities, training and education programs are critical; fear and misunderstanding concerning AIDS transmission is likely

to be great in such jurisdictions. However, by providing early training and education--well before the first AIDS case is identified--unfounded fears can be eliminated.

Training Issues

Training curricula should address GENERAL medical and legal issues related to management of inmates suspected of or diagnosed with AIDS, as well as SPECIFIC procedures for correctional staff during all phases of their work within the facility. Issues to address in staff training include:

- History and definition of AIDS;
- Causes, symptoms, and transmission of the disease;
- Legal and liability issues in the management of inmates with AIDS;
- Initial response and arrest procedures for inmates suspected of or diagnosed with AIDS;
- Intake/booking procedures for inmates suspected of or diagnosed with AIDS;
- Intake medical procedures for inmates suspected of or diagnosed with AIDS;
- Administrative and management issues including housing, work assignments, and prerelease strategies for inmates suspected of or diagnosed with AIDS;
- Infection control and safety procedures for medical staff providing treatment of AIDS-infected inmates; and
- Mental health and counseling considerations for AIDS-infected inmates.

GUIDELINES FOR TRAINING AND EDUCATION OF CORRECTIONAL STAFF

Training Needs Assessment

As a first step in training staff, correctional administrators should establish training as a priority within the administrative policy of the facility. Administrators also should conduct a short needs-assessment survey to evaluate the staff's training experience and training needs concerning the identification and management of inmates with AIDS. Needs-assessment surveys vary from comprehensive departmental assessments to brief, issue-oriented assessments that focus on specialized topics of concern. Survey results may help determine both long- and short-term staff training needs.

A less formal way to assess staff training needs is via a pretest of staff. Pretest results can identify specific gaps in knowledge concerning AIDS, staff responsibilities, and departmental policies and procedures.

The test may be administered again upon completion of educational programs to gauge program effectiveness. Figure 9.1 is a sample pretest and post-test questionnaire to assess knowledge about AIDS.

Training Methods

A variety of methods may be used to train staff about the causes, symptoms, and transmission of AIDS, and on ways to deal with inmates suspected of or diagnosed with the disease. Popular training methods include:

- Training sessions presented by trained staff or professionals from the community who have expertise in medical, legal, and correctional management issues. While the length of training sessions may vary, adequate time must be allocated to ensure that all staff thoroughly

Figure 9.1. Acquired immune deficiency syndrome pre/post test.

1. A positive AIDS antibody test means that (circle all correct responses):

   a. a high likelihood exists that the individual will develop AIDS.
   b. the individual has developed antibodies to the AIDS virus.
   c. the individual needs to restrict his or her normal day-to-day contacts.
   d. the individual has AIDS.
   e. the individual may need to modify his or her sexual practices.
   f. the individual has been exposed to the AIDS virus.

2. What evidence is required to make a diagnosis of a case of AIDS?

3. The AIDS virus is easily killed by soap and water. T F

4. In its later stages, AIDS can be spread by casual contact with the patient; e.g., by shaking hands or touching objects handled by the patient. T F

5. You can contract AIDS by doing frisk pat down searches and by searching personal effects. T F

6. AIDS is transmitted through the following mode(s) (circle all correct responses):

   a. shared eating utensils.
   b. contaminated clotting factor used by hemophiliacs.
   c. contaminated blood transfusions.
   d. mother to fetus.
   e. exchange of bodily fluids; e.g., blood, semen.
   f. shared toothbrushes.

   g. sharing of needles among IV drug abusers.
   h. other--specify: _____

7. AIDS victims have been shown to carry a high concentration of the organism in their saliva and tears. T F

8. ARC is an abbreviation for: _____

9. ARC may be defined as:

   a. conditions seen with increased frequency in high-risk populations for AIDS, but which do not meet the criteria for AIDS.
   b. conditions signaling the onset of AIDS.
   c. a cluster of symptoms that appear in the later stages of AIDS.
   d. none of the above.

10. There are no documented cases of AIDS contracted by giving CPR. T F

11. What precautions should you take when giving CPR or first aid?

    a. _____
    b. _____
    c. _____

12. There is no proven cure for AIDS. T F

Adapted from Washington State Department of Corrections training materials. Source: T.M. Hammett. AIDS in Correctional Facilities: Issues and Options. Washington, D.C.: National Institute of Justice, 1986.

understand the nature of the disease and their respective roles and responsibilities in managing inmates.

- Audiovisual training programs involving existing audiovisuals and a trainer to facilitate group discussion regarding the nature of the disease and appropriate staff responses.

- Dissemination of written materials that clearly and thoroughly describe guidelines and/or departmental policies and procedures for response by each type of correctional staff.

- Dissemination of written materials that specifically address correctional officers' concerns related to their day-to-day management of inmates supected of or diagnosed with AIDS.

- Dissemination of written materials that address general questions regarding AIDS and its transmission.*

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

Training Goals and Objectives

The overall goal of staff training is to provide correctional staff with current and accurate information regarding the causes, symptoms, and transmission of AIDS and to discuss the proper procedures for managing infected inmates.

At the completion of an AIDS training program, correctional staff should be able to:

- Define AIDS, ARC, and HIV seropositivity;

* An example of this type of informational material is AIDS: 100 Questions and Answers. National Sheriffs' Association, 1986. Reprinted with permission from the New York State Department of Health.

- List the means of transmitting the disease;

- List the ways in which the virus cannot be transmitted;

- Describe appropriate measures for transporting an inmate suspected of/or diagnosed with AIDS;

- Describe appropriate procedures for administering CPR and first aid to an individual suspected of or diagnosed with AIDS;

- Describe inmate intake and booking procedures for an inmate suspected of or diagnosed with AIDS;

- List procedures following possible contamination with infected blood;

- Describe local policies regarding housing, work assignments, and daily activities of inmates suspected of or diagnosed with AIDS;

- Describe infection control procedures for treatment of AIDS-diagnosed inmates;

- List considerations for providing mental health services for inmates diagnosed with AIDS; and

- Describe appropriate precautions for the safety of the AIDS-infected arrestees and inmates.

MODEL STAFF TRAINING CURRICULUM

The following model staff training curriculum is modular, including both "core" and "elective" modules. Core modules are fundamental to an understanding of the disease, the management of AIDS-infected inmates, and the essential precautions for the health and safety of inmates and staff. Core modules serve as

the basis for subsequent training modules. Elective modules address specialized issues in managing AIDS-infected inmates in the correctional system. By using a modular curriculam, trainers are flexible to develop and implement programs that are responsive to participants' specific needs. Figure 9.2 lists the recommended training modules for correctional staff. Figure 9.3 is a sample training agenda for correctional administrators.

Appendix D of this monograph contains lesson plan outlines for trainers. These lesson plans, which provide an introduction, overview, and discussion on the causes, symptoms, and transmission of AIDS, may be utilized for both staff and inmate training. The modular curriculum is presented in outline form allowing trainers to expand lesson plans as needed. Trainers are encouraged to work with a multidisciplinary training team, including the correctional administrator; medical, legal, and labor relations experts; and local community service providers.

ISSUES IN TRAINING AND EDUCATION OF INMATES

Introduction

The timely and accurate education of inmates is an essential component of any comprehensive effort to curtail the fear and misunderstanding regarding the causes and transmission of AIDS within the correctional facility. Inmate education also may serve as a means to limit participation in activities known to transmit the AIDS virus.

Training Issues

Of primary concern to inmates are the causes, symptoms, and methods of transmitting the disease, and the means to reduce the risk of infection. Therefore, inmate education programs should focus on the following topics:

Figure 9.2. Training modules for correctional staff.

Acquired Immune Deficiency Syndrome: Issues and Guidelines for Correctional Staff

Core Modules

Module 1: Introduction and Overview

Module 2: Medical Issues and the Management of AIDS

Module 3: Introduction to Legal Issues and the Management of the Inmate

Module 4: Initial Response and Intake Procedures

Module 5: Management of the Inmate Within the Correctional Setting

Module 6: Prerelease Strategies and Community Resources

Elective Modules

Module 7: Issues in Liability and Labor Relations for Correctional Administrators

Module 8: Policy Issues and the Management of AIDS within the Correctional Facility

Module 9: Issues and Guidelines for Medical and Mental Health Staff in the Treatment of Inmates Diagnosed with ARC and AIDS

Module 10: Issues and Guidelines for Court Officials

Figure 9.3. Sample training agenda for correctional administrators.

Acquired Immune Deficiency Syndrome (AIDS): Issues for Correctional Administrators

Module 1: Introduction and Overview

Module 2: Medical Issues and the Management of AIDS

Module 7: Issues in Liability and Labor Relations for Correctional Administrators

Module 8: Policy Issues and the Management of AIDS within the Correctional Facility

Module 6: Prerelease Strategies and Community Resources

- Definition of AIDS and ARC;
- Incidence of AIDS, ARC, and HIV seropositivity among high-risk groups;
- Symptoms of AIDS infection;
- Means of transmitting the AIDS virus;
- Contacts NOT shown to transmit the AIDS virus;
- Prevention of AIDS transmission during confinement; and
- Prevention of AIDS transmission following release.

Program participation should be mandated for all inmates and the programs need to emphasize inmate responsibility in avoiding activities known to transmit the virus. The sessions should present information on

practical, precautionary measures and recommendations for preventive steps following release from the correctional facility.

GUIDELINES FOR INMATE EDUCATION

Training Methods

A variety of methods may be used to educate inmates about the causes of AIDS and measures to reduce the risk of infection. Popular training methods for correctional facilities are:

- Information sessions led by staff or professionals from the community who are providing medical services to AIDS-infected individuals;
- Audiovisual educational programs that utilize audiovisual materials and a facilitator to answer inmates' questions; and
- Dissemination of written materials including posters, pamphlets, and brochures that specifically address inmates' questions regarding the disease.

Regardless of the media utilized to educate the audience, it is vital that the information being presented is brief, clear, and in lay terms. For inmates, live training limited to 10 minutes may be the most effective; such sessions should emphasize key practical advice, rather than complex discussions of the epidemiology of AIDS.

Training Goals and Objectives

The overall goal of inmate education is to provide current information regarding the causes, symptoms, and transmission of AIDS, and to discuss precautions that inmates should take to minimize their risk for infection.

At the completion of an AIDS education program, inmates should be able to:

- Define AIDS, ARC, and HIV seropositivity;
- List the means of transmitting the disease;
- List the ways in which the virus cannot be transmitted;
- List the symptoms of AIDS; and
- Name community medical and mental health resources which provide services for AIDS-infected persons.

MODEL INMATE EDUCATION CURRICULA

The following modules are recommended for inmate training and education on AIDS. Trainers should use the corresponding lesson plans contained in Appendix D for inmate education programs.

Module 1: Introduction and Overview to Acquired Immune Deficiency Syndrome (AIDS)

The purpose of this module is to introduce the inmate to the definition of AIDS, ARC, and HIV seropositivity and discuss the incidence of AIDS among the general population, including high-risk groups.

Module 2: Medical Issues: Causes, Symptoms, and Transmission of AIDS

The purpose of this module is to discuss the causes, symptoms, and methods of transmitting AIDS. The module also addresses incidents not known to transmit the disease.

Module 3: Issues and Guidelines in AIDS Prevention

This module will discuss practical guidelines for preventing the transmission of the AIDS virus both within the correctional facility and upon release. Principles of good hygiene are addressed as are precautions in case of contamination by infected blood or blood products.

Module 4: Community Medical and Mental Health Resources

This module will describe the existing community medical and mental health services for the AIDS-infected person. Topics such as type of services provided, fee for services, hours of operation, and referral sources are addressed.

An inmate education program may be implemented in a single training session or on a module-by-module basis over several days. It is imperative, however, to provide continuous inmate education, as inmate turnover is high, especially within city and county facilities. Trainers are encouraged to utilize the resource materials provided by the National Sheriffs' Association, U.S. Public Health Service, the Centers for Disease Control, and local public health agencies. Since information regarding all aspects of AIDS is constantly expanding, the trainer should be vigilant to the new and appropriate sources of training and educational materials for both staff and inmates.

NOTES

1. T.M. Hammett. AIDS in Correctional Facilities: Issues and Options. Washington, D.C.: National Institute of Justice, 1986.

DEWITT NELSON TRAINING CENTER	SUBJECT: AIDS AND OTHER COMMUNICABLE DISEASES	
OPERATIONS MANUAL		
CHAPTER: GENERAL ADMINISTRATION	SECTION: AIDS GENERAL POLICY	1400

AIDS AND OTHER COMMUNICABLE DISEASES

General Policy

It is the intent of the administration of DeWitt Nelson Training Center, to provide a means by which staff, volunteers, contract personnel and authorized law enforcement agencies, can obtain, report and provide information regarding Youth Authority wards with communicable diseases. The Superintendent shall be responsible for ensuring that updated information on AIDS Education and Awareness is given to all staff during yearly Block Training sessions. DeWitt Nelson AIDS trainers and certified counselors, have been delegated the responsibility for providing staff with information on an ongoing basis, regarding communicable diseases as it becomes available. DeWitt Nelson staff, volunteers and contract personnel, may also, under special circumstances and when meeting certain requirements, request that a Youth Authority ward be tested for HIV.

(Reference Section 199.99 (a), (c), Health and Safety Code)

CHIEF MEDICAL OFFICER

1. Notify Superintendent upon receipt of information regarding a ward who is infected by the AIDS (HIV) virus, has an AIDS related condition (ARC) or who has been exposed to the AIDS virus or any communicable disease.

2. Disclose the following information:

   a. Laboratory tests indicating exposure or infection by the AIDS virus, AIDS related condition or other communicable disease.

   b. Any statement by the ward to medical personnel that the ward has AIDS, an AIDS related condition, has been exposed to the AIDS virus or has any communicable disease.

   c. Results of any medical examination or test which indicates the ward has tested positive for antibodies of the AIDS virus, has been exposed to the AIDS virus, has an AIDS related condition, is infected with AIDS or any communicable disease.

Note: If the above information, subject to disclosure, was obtained by a scientific research study pursuant to prior written approval expressly waiving disclosure, the information may not be disclosed to the Superintendent.

3. Publish a daily computer generated list of all wards with a communicable disease at DeWitt Nelson Training Center.

4. Assure that the above list is maintained in a three ring binder located in the Communications Center of the institution.

SUPERINTENDENT

1. Notify all employees, medical personnel, contract personnel, and volunteers who have direct contact with the ward in question, or with the bodily fluids from such wards, of the substance of the information received from the medical officer so that such persons can take appropriate action to provide for the care of the ward, the safety of others and themselves.

COMM CENTER STAFF

1. Assure the binder with information on wards with communicable diseases is kept current on a daily (weekday) basis, is readily accessible to staff, volunteers and contract personnel 24 hours a day, seven days a week.

2. Provide continuous sight supervision of the binder to guard against removal, destruction or unlawful use of the list.

3. Avoid public discussion or sharing of information regarding names on the list when there are wards within hearing distance of the discussion.

PROCEDURE TO REQUEST FOR HIV TESTING 1410

DeWitt Nelson Training Center staff may request a confidential HIV test of a ward if there is reason to believe he/she has come into contact with the bodily fluids of the ward that could result in HIV infection or exposure.

Wards may request HIV testing of another ward in custody if there is reason to believe that exchange of bodily fluids has occurred.

Reportable Incidents

ALL STAFF

1. Observed or reported incidents involving:

   a. Sexual activity
   b. IV drug use
   c. Injury involving exchange of bodily fluids
   d. IV needle sharing, tattooing, ear piercing.

2. Incidents in which an employee has reason to believe he or she has come into contact with bodily fluids of a ward in a way that could result in HIV infection.

3. Requests from Youth Authority wards age 15 and older for HIV testing of another ward, if ward has reason to believe that he has come in contact with the bodily fluids of another potentially infected ward.

PEACE OFFICER STAFF

1. May.file a petition or complaint with the court requesting that the court order mandatory testing of a Youth Authority ward when all of the following conditions exist:

   a. Peace Officer staff was exposed to the bodily fluids of a ward.

   b. Youth Authority ward interfered with the Peace Officer's duties.

   c. A criminal complaint or 602 petition has been filed against the ward "interferring with the duties of a peace officer".

      -Interferring with a peace officer includes: biting, scratching, spitting, or transferring blood or other bodily fluids on, upon or through the skin membranes (ears, eyes, nose, mouth).

CHIEF MEDICAL OFFICER

1. Order an HIV test upon determination that clinical symptoms of AIDS or AIDS related complex, as recognized by the Centers for Disease Control is present in the ward.

DIRECTOR

1. May seek a court order to require a ward to submit to an HIV test if ward refuses to comply voluntarily with the Chief Medical Officer's order to test.

SUPERINTENDENT

1. Ensure ward who has refused HIV testing has the opportunity to appeal Chief Medical Officer's order to test directly to the Superior Court.

METHOD OF REPORTING EXPOSURE INCIDENTS AND REQUESTS FOR HIV TESTING (7510 P.C.) 1415

ALL STAFF

1. Complete a Behavior Report (YA 8.403) and Report for HIV Testing and Decision (DHS 8459).

   a. Behavior Report shall include:

   -Name of individual preparing the report or requesting the HIV test.

   -Time and date of exposure incident.

   -Description of the incident and nature of the bodily fluid exposure.

   -Name(s) of the subject of the report.

   -Names of witnesses to the incident.

   -Written statements from witnesses, if feasible.

2. Forward reports to Chief Medical Officer and Duty Lieutenant by end of work shift.

NOTE: Filing period may be extended by Chief Medical Officer for good cause.

DUTY LIEUTENANT

1. Investigate or cause to investigate all incidents where exposure to bodily fluids may have occurred.

2. Complete State Compensation Insurance Fund/Report of injury form and forward to Captain's office by end of shift.

   a. Investigation report shall include:

   -Name(s) of person(s) involved in the possible exposure incident.

   - Time and date of exposure.

   - Type of body fluid.

   - Estimated amount of body fluid spilled.

- Description of what the body fluid came into contact with (i.e., intact skin, broken skin, eye, nose, mouth, etc.).

- Length of exposure.

- Method of removal or cleaning the exposed area.

CHIEF MEDICAL OFFICER

1. Review DHS 8459 and Lieutenant's Investigation Report, to determine if exchange of bodily fluids occurred that could result in AIDS infection, using Centers for Disease Control guidelines for HIV transmission.

2. Provide or arrange to provide counseling to reporting staff and wards when exposure to wards bodily fluids has occurred.

3. Complete DHS 8459, within five calendar days, with decision whether to order an initial HIV test and follow-up testing of the subject of the incident.

4. Attach Notice of Right to Appeal (OH 1913) to decision rendered on Form DHS 8459.

5. Provide copies of DHS 8459 report and Notice of Right to Appeal (OH 1913) to:

   a. Superintendent

   b. Staff reporting incident

   c. Subject of reported incident

   d. Medical file

6. If no appeal of decision to order an HIV test:

   a. Schedule for drawing blood specimen.

   b. Provide pre-test counseling to explain meaning and implication of HIV test to subject.

   c. Obtain signed consent form (YA 8.273) or other authorization to test for HIV.

   d. Draw two blood specimens.

   e. Send specimens to approved lab for testing.

APPEAL PROCEDURES TO HIV TESTING 1420

All decisions requiring HIV testing or decisions not to require HIV testing of a subject or a formal request for testing are appealable to a three-member panel.

Exception: Those situations where the Chief Medical Officer discovers clinical evidence of HIV infection or AIDS related conditions independent of a reported incident are subject to appeal directly to Superior Court.

Levels of Appeal

First level - 3 member panel consisting of:

a. The Northern California Youth Center's Chief Medical Officer

b. A supervisory representative from the institution employing the person who filed the incident report and/or request for testing.

c. A physician or surgeon not on the staff of, or under contract with the State, County or City correctional institution or with an employer of a law enforcement employee. The State Department of Health Services shall compile a list of eligible panel doctors to serve as appeal panel members. This member of the panel shall serve as chairperson and preside the hearing.

Procedure for First Level Appeals:

a. Decisions of the Chief Medical Officer may be appealed within three calendar days of receipt of that decision. (Decision of the Chief Medical Officer is final if appeal is not filed within three days).

b. Appeals may be filed by the person required to be tested, by the staff person filing the report, or the person requesting testing.

c. Appeals shall be submitted on forms developed for this purpose by the Department of Health Services. (Interim forms will be supplied by the Department).

d. Appeal hearing shall be closed except that each of the following persons shall have the right to attend and call witnesses to testify at the hearing.

1) Witnesses called to testify at the hearing.

2) Staff person who filed the incident report or request to test.

3) Subject of the required test.

4) Those persons deemed essential to the hearing by the Chief Medical Officer or the other panel members.

5) Representative appointed by test subject or person requesting the test.

e. The appeal panel shall conduct a hearing within 10 days of the date the appeal was filed.

f. Appeal panel shall render a decision regarding testing within 20 days of the date the appeal was filed.

g. The appeal panel's decision shall be in writing, stating reasons for the decision, and signed by each panel member.

h. A unanimous vote of the appeal panel is necessary in order to require HIV testing.

i. Copies of the appeal panel's decision shall be distributed by the Chief Medical Officer.

1) Person requesting the test.

2) Subject of the test.

3) Institution Superintendent

Procedure for Second Level Appeals - Superior Court

1. Any decision by the first level appeal panel must be appealed to the Superior Court by any person permitted to file a first level appeal.

2. Chief Medical Officer decisions based solely on clinical symptoms.

3. The court shall schedule a hearing as expeditiously as possible.

4. Court hearing decisions shall be distributed by the Chief Medical Officer to the persons identified to receive first level appeal decisions.

DISCLOSURE OF HIV TEST RESULTS 1425

All disclosures of HIV test results will be accompanied with the following disclaimer:

"The test results were conducted in a medically approved manner but tests cannot determine exposure to or infection by AIDS or other communicable diseases with absolute accuracy. Persons receiving this test result should continue to monitor their own health and should consult a physician as appropriate".

All disclosures of HIV test results shall include a warning that unauthorized disclosure could result in criminal charges.

CHIEF MEDICAL OFFICER

1. Disclose HIV test results to the following persons: (Each disclosure shall be accompanied with proper counseling).

   a. Subject of the test - Instruct wards to keep their test results confidential.

   b. Staff member who prepared incident report and/or request for HIV testing.

   c. Superintendent. In addition to HIV lab test results, the Superintendent shall be informed of the identity of all wards with a diagnosis of AIDS, ARC, or other "communicable diseases" or wards who state to medical staff that they have AIDS, ARC or a "communicable disease" or have been exposed to AIDS.

   d. Test subject's known sexual partners or needle-sharing contacts at DeWitt Nelson Training Center.

      - Test subject's identity to remain confidential.

- Test result counseling shall accompany each disclosure.

e. State Department of Health Services if HIV positive.

SUPERINTENDENT 1. Notify all employees, medical personnel, contract personnel and volunteers who have or may have "direct contact" with a ward, or his body fluids who has a positive HIV test, a diagnosis of AIDS or ARC. (*Contact defined as skin-to-skin contact).

a. All notifications shall be through verbal means at regularly scheduled staff meetings (i.e., middle managers' meetings, team meetings, etc.).

2. Notify law enforcement personnel* who may have direct contact with a ward or his body fluids who has a positive HIV test, or a diagnosis of AIDS or ARC.

*(Sheriff or police officers transporting on in/out orders, county jail personnel if being detained in County jail or law enforcement personnel contacted about an HIV positive escapee).

3. Ensure test results of HIV test is maintained in ward's medical file.

4. Notify Youthful Offender Parole Board panel members, prior to the start of the Board Calendar, of any ward scheduled to appear on that calendar who has tested positive for HIV, or has a diagnosis of an AIDS related condition or any other communicable disease.

PENALTIES FOR UNAUTHORIZED DISCLOSURES (199.21 H&S) 1430

Willful disclosure of personal identifying data regarding HIV test results or confidential information is a misdemeanor.

Willful false reporting of an incident or test results, or misuse of this procedure is a misdemeanor.

Each authorized disclosure of HIV test results shall include a warning about the confidential nature of this information and unauthorized disclosure could result in criminal charges or disciplinary penalties.

RECORD KEEPING

CHIEF MEDICAL OFFICER

1. Maintain HIV test results in the ward's medical record. Normal confidentiality of the medical record shall be observed. (199.215(a) H&S)

2. Maintain a confidential file of all paperwork connected with employee reports of possible HIV exposure. Retain file for five years.

HIV TEST COUNSELING (1768.9 W&I CODE) 7502 P.C. AND 7514 P.C.)

CHIEF MEDICAL OFFICER

1. Provide HIV test counseling at the time:
   a. The initial report or request for HIV test is made.
   b. The HIV test is ordered.
   c. When test results are provided.
2. HIV counseling shall be provided to: (7514 P.C.)
   a. The reporting or requesting employee or ward.
   b. The test subject.
   c. Others requesting counseling.
3. Pre- and post-HIV test counseling shall be conducted by: (1768.9(d) W&IC) (7502 P.C.)
   a. Licensed physician or surgeon
   b. Registered nurse

c. Other health care professionals meeting Department of Health Services standards for purposes of providing counseling on AIDS to persons in custody.

d. Certified health educator

e. Psychologist

f. Licensed clinical social worker

g. Trained volunteer counselor under the preview of a physician or surgeon.

4. Counseling shall be face-to-face and include, but not be limited to: (1768.9 (b) W&IC)

a. Testing procedures, effectiveness, reliability and confidentiality.

b. Means of transmission of HIV.

c. Symptoms of AIDS and ARC.

d. Precautions to avoid transmission.

INFECTIOUS DISEASE EXPOSURE PRECAUTIONS 1435

Vigorous handwashing is the single most effective means of preventing infection.

Barrier protection (intact skin, bandages, disposable latex gloves, face masks, CPR masks or airways) are precautionary measures recommended when exposure to bodily fluids is anticipated.

Environmental surfaces (walls, floors, furniture and equipment) should be cleaned with a 10:1 water/bleach solution after a body fluid spill.

SUPERINTENDENT

1. Provide ready access to CPR protective masks or airways and disposable latex gloves for use by staff when responding to body fluid spill incidents.

NOTE: Professional standards indicate there is a general duty, for those certified to administer CPR, to provide CPR to cardiac arrest victims, with or without mechanical devices. Delay caused by waiting for a mechanical device could be considered a breach of duty.

Waste Disposal

Body fluid waste generated by residents in the living units may be disposed of as ordinary waste through the sewer system.

Infectious waste generated by medical procedures shall be "red-bagged" in accordance with standard infection control procedures.

Sharp items shall be disposed of in puncture-proof containers.

HIV EDUCATION AND TRAINING 1440

SUPERINTENDENT

1. Provide staff with AIDS Education and Awareness Training with periodic updates. Training to include:

   a. Medical facts about AIDS.

   b. Effects of HIV infection.

   c. Modes of transmission of HIV.

   d. Prevention and precautions against infection.

   e. Laws, policies, procedures and guidelines regarding employment discrimination, HIV testing and disclosure of test results (Labor Code 6710).

SUPERINTENDENT - RECEPTION CENTER-CLINICS

1. Provide all wards, shortly after arrival at the reception center for a clinic workup, with a minimum two-hour basic AIDS Education and Awareness class, to include:

   a. What is AIDS?

   b. Modes of transmitting HIV.

   c. Prevention techniques for transmitting HIV.

   d. Laws and policies about HIV testing and disclosure of test results.

e. Coping with AIDS. (W&IC Section 1123)

PAROLE AGENT III

1. Within one month of release on parole, provide each ward with a copy of the booklet entitled "What You Should Know About Aids." (W&I Code Section 1123)

HIV COUNSELORS 1445

SUPERINTENDENT

1. Ensure the availability of a cadre of "certified" HIV Counselors. (W&I Code 1768.9)

2. Establish a procedure to ensure HIV counseling is readily available to staff and wards.