STOP AIDS IN PRISON ACT OF 2007, AND THE DRUG ENDANGERED CHILDREN ACT OF 2007

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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STOP AIDS IN PRISON ACT OF 2007, AND THE DRUG ENDANGERED CHILDREN ACT OF 2007

TUESDAY, MAY 22, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIME, TERRORISM,
AND HOMELAND SECURITY
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 12:39 p.m., in Room 2226, Rayburn House Office Building, the Honorable Robert C. "Bobby" Scott (Chairman of the Subcommittee) presiding.

Present: Representatives Scott, Waters, Johnson, Forbes, and Coble.

Staff present: Bobby Vassar, Subcommittee Chief Counsel; Rachel King, Majority Counsel; Veronica Eligan, Professional Staff Member; and Michael Volkov, Minority Counsel.

Mr. SCOTT. The Subcommittee will come to order.

I am pleased to welcome you today to the hearing before the Subcommittee on Crime, Terrorism, and Homeland Security on H.R. 1199, the "Drug Endangered Children Act of 2007," and H.R. 1943, the "Stop AIDS in Prison Act of 2007."

We will first take up H.R. 1199, the "Drug Endangered Children Act of 2007." Congressman Cardoza is the primary sponsor of the bill, which would extend funding for the Drug Endangered Children Grant Program through fiscal year 2008 and 2009.

This grant program was first authorized in title 7 of the USA Patriot Improvement and Reauthorization Act of 2005, which authorizes up to $20 million a year for grants to address this problem.

One of the most troubling aspects of drug use is its impact on children. According to the Drug Enforcement Agency, over 15,000 children were found at methamphetamine labs from 2000 to 2004. The problem is not limited to methamphetamine use. A Health and Human Services study found that over 1.6 million children live in homes where a variety of illicit drugs are used.

These drug-infested conditions stretch child welfare agencies beyond their capacity because of increased violence and neglect.

On February 6 of this year, the Subcommittee held a hearing on H.R. 545, the "Native American Methamphetamine Enforcement and Treatment Act of 2007," which was passed out of this Subcommittee and out of the full Judiciary Committee.

A central provision of H.R. 545 extends eligibility for Drug Endangered Children grants to Native American tribes. However, unless this bill passes the authorization for Drug Endangered Chil-

dren grants will expire this year, negating the efforts to help Native American children.

After we take that bill up, we will take up H.R. 1943, the "Stop AIDS in Prison Act." The gentlelady from California, Ms. Waters, introduced H.R. 1943, a bill similar to H.R. 1638, which she introduced in September of 2006.

The bill would create comprehensive HIV/AIDS programs in Federal prisons that would educate, diagnose and treat prisoners who are infected with HIV/AIDS and prevent those who are not infected from becoming infected. Yet the HIV/AIDS epidemic is spreading at an alarming rate, especially in minority communities.

According to the Centers for Disease Control and Prevention, the CDC 2005 statistic states racial and ethnic minorities comprise 69 percent of all new HIV/AIDS cases. Furthermore, 41 percent of all prisoners in Federal prisons at the end of 2004 were African-American.

These statistics show a clear need to educate prisoners about HIV/AIDS prevention, to detect existing cases and to treat those infected. Education, detection and treatment will not only protect prisoners, it will protect the prison personnel. Additionally, the treatment and education that the prisoners receive while incarcerated should help decrease the spread of the disease to the community upon their release.

H.R. 1943 seeks to provide an effective HIV/AIDS program in Federal prisons for educating, detecting and treating HIV and AIDS. Under the bill, all inmates would have access to scientifically accurate education and prevention programs which may be provided by community-based organizations, local health departments or inmate peer educators. The information would be expressed in a culturally sensitive way, including the availability of a variety of languages and an audio format for those with low literacy skills.

Detection, the second portion of the program's approach, would begin upon a person's entry to the prison system. All people entering the system would be detected unless declined by the prisoner and would continue throughout the prisoner's incarceration, including annual testing available to all prisoners upon request and mandatory testing to prisoners who have been involuntarily exposed to the virus or to prisoners who become pregnant while incarcerated.

Finally, the treatment portion of the program would ensure that infected persons receive timely comprehensive medical treatment consistent with the current Department of Health and Human Services guidelines and standard medical practice. Treatment options, confidentiality, counseling and access to medications would all be available to prisoners and medical personnel would help develop and implement procedures to safeguard confidentiality.

Before re-entry into the community, HIV-infected prisoners would receive referrals to appropriate health care providers, additional education about protecting their family members and others in their community and a 30-day supply of medications to hold them over until they can connect with services in the community.

It is now my pleasure to recognize the esteemed Ranking Member of the Subcommittee, my friend and colleague from Virginia, the Honorable Randy Forbes, for his comments.

Mr. FORBES. Thank you, Chairman Scott. And I appreciate, as always, your holding this legislative hearing on H.R. 1943, the Stop AIDS in Prison Act of 2007, and H.R. 1199, the Drug Endangered Children Act.

I want to acknowledge the dedicated work of representative Maxine Waters, who has been a tireless advocate on the issue of HIV and AIDS in prison. I am proud to be an original cosponsor of H.R. 1943, the Stop AIDS in Prison Act.

I also want to acknowledge the commitment of Ranking Member Smith, who is a cosponsor of the same bill in the last Congress and a cosponsor of this year's version.

It is certainly great to see our friend Congressman Cardoza here today to testify and also a true superstar, Mr. Mitchell, who is here with us today. And we look forward to the very distinguish panel to testify.

In 2006, the Department of Justice reported that approximately 1.9 percent of State prison inmates and 1.1 percent of Federal inmates were known to be infected with HIV. The rate of confirmed AIDS cases is three times higher among prison inmates than the United States general population.

These statistics, however, may understate the problem, because the Bureau of Prisons is responsible for housing all Federal inmates, and almost all States do not test all inmates for HIV.

The need for testing at the Federal and State level is readily apparent. There are approximately 170,000 inmates in Federal prison. BOP tests inmates who requested tests, fall within a high-risk group, have clinical indications of HIV related or are involved in an incident when HIV transmission may have occurred. Forty-eight States test inmates if they have HIV-related symptoms or if the inmates request the test. Only 18 States test all incoming inmates. Only three States test inmates upon release.

H.R. 1943 requires routine HIV testing for all Federal prison inmates upon entry and prior to release from Federal Bureau of Prison facilities. Under the proposal for existing inmates, the Bureau of Prisons has 6 months from enactment to offer HIV/AIDS testing from inmates. The bill also requires HIV/AIDS awareness education for all inmates and comprehensive treatment for those inmates who test positive.

While H.R. 1943 addresses the problem in the Federal system, I hope that we can also examine the need for testing, education and prevention in State prisons. If we truly care about successful rehabilitation and re-entry of prisoners, we must address this problem at the State level as well.

I also want to indicate my support for H.R. 1199, the Drug Endangered Children Act, which is also a subject of today's hearing. The bill extends the authorization for the current grant program to address the problem of drug endangered children.

It is a sad consequence of our Nation's drug problem that drug traffickers have such a devastating impact on innocent children who happen to reside in a house used to facilitate the production and distribution of illegal drugs.

We owe it to our Nation's children to do all that we can to protect them and provide them the services needed to allow them to grow and develop in a health, loving home.

I look forward to hearing from today's witnesses.

Mr. Chairman, I yield back.

Mr. SCOTT. Thank you. Thank the gentleman.

We have with us the Ranking Member of the full Committee, and I will ask him if he has any comments.

Mr. SMITH. Thank you, Mr. Chair. I do have a statement I would like to make.

On the way to that statement, let me say to you, though, that this is the first time I have attended a meeting of the Crime Subcommittee this year and have gotten to be here while you are serving as Chairman. Not too many years ago, I was Chairman of this Subcommittee and you were the Ranking Member, so we have worked together for a long time on this and similar issues.

But it is good to be here today. Let me thank you for holding a hearing today on these two important legislative items.

And I also want to thank my colleague, Congresswoman Waters, for her leadership and her collaboration on H.R. 1943, the Stop AIDS in Prison Act of 2007. I introduced a similar bill in the last Congress, and I am pleased to be a cosponsor again with Representative Waters in this Congress.

The problem of HIV and AIDS in Federal and State prisons is difficult to measure because inmates are not routinely tested. There are 170,000 prisoners in the Federal system. In a 2006 report, the Justice Department estimated that almost 2 percent of State prison inmates and over 1 percent of Federal inmates were known to be infected with HIV.

As a percentage, this puts the occurrence of HIV and AIDS among inmates in Federal prison three times higher than within the general population of the United States.

The cost of an HIV screening is between $6 and $15 per test. So requiring that Federal inmates be tested when they enter prison and when they leave prison is just good, common, practical sense.

H.R. 1943 requires HIV testing for all Federal prison inmates upon entry and prior to release and for all existing inmates within 6 months of enactment. Identifying inmates who are infected allows prison officials to take the precautionary measures necessary to protect the health and safety of prison employees and other inmates. This also ensure that medical treatment can be administered to inmates suffering from the disease.

Finally, both the inmates themselves and the community they rejoin upon release will obviously benefit from the inmate knowing his status.

I look forward to our hearing today.

Mr. Chairman, before I stop I want to tell a quick story, and I mean this as a compliment to Maxine Waters, the congresswoman from California.

Mr. SCOTT. You have to explain that it is a compliment? It may not sound like a compliment, but here we go. [Laughter.]

Mr. SMITH. I will certainly yield to her when I am finished, but I think that she will corroborate the story.

And that is, in the last Congress and frankly in the last revision that occurred in Texas, I picked up the east side of San Antonio, which is a predominantly Black community. And I started listening to what I was hearing and trying to respond to the suggestions

that I was getting and the needs that I was witnessing and hearing about as well.

And so I looked around and saw that a bill such as the one that we are considering today had been considered, and I explored it some more. And I went to someone who is a personal friend as well as a colleague, Maxine Waters, and we decided to introduce this bill ourselves in the last Congress. We were the two primary cosponsors.

Little did I know that things were going to change so dramatically in the election, but it is an indication of I think Ms. Waters' sincerity and hopefully my cooperation that regardless of who is in the majority, we thought the issue was so important and needed to be addressed, that we would continue to do so and approach the subject in a bipartisan way, which in fact has occurred.

So I want to thank her, both for her help in the last Congress and for her instrumental help in this Congress as well, trying to achieve what we want to achieve.

And, Mr. Chairman, I will yield the balance of my time, such as it is, to the congresswoman from California.

Mr. SCOTT. With a comment like that, we will give the gentlelady from California equal time. [Laughter.]

Ms. WATERS. Mr. Chairman, just let me take a moment to thank you for holding this hearing today and our Ranking Member, Mr. Randy Forbes.

And, of course, I want you to know that not only is Mr. Lamar Smith one of the original cosponsors of my legislation—along with John Conyers, yourself, Mr. Forbes, Ms. Lee and Donna Christensen—every time I see him in the hall, he asks me, "When is our bill coming up?" And so, today you have answered the question that has been asked of me time and time again. He has been anxious to get on with this legislation, and I appreciate his interest and his passion about this subject.

And I just look forward to hearing from our witnesses today.

And while I have the microphone, let me just say that in addition to my bill, the Drug Endangered Children Act of 2007 is extremely important.

We have a Member who is here today who is going to talk about his passion related to this issue, the children that are endangered by methamphetamine, and I think that he has a compelling story to tell about what he knows about the subject. And so, I am anxious also to hear from him today, and I just thank him for the time that he has been putting in.

Thank you, Congressman Cardoza, for taking time to provide leadership on this issue.

And I yield back the balance of my time.

Mr. SCOTT. Thank you.

And, without objection, if the others will submit their statements for the record, we have a distinguished panel with us today to consider important issues that are currently before us.

The first will be Representative Dennis Cardoza, who will testify on H.R. 1199.

Representative Cardoza is in his third term representing the 18th Congressional District of California. He is the Chairman of the Agriculture Committee Subcommittee on Horticulture and Or-

ganic Agriculture. In 2007 he joined the Rules Committee, and he also serves on the Democratic Steering and Policy Committee.

Before coming to Washington, he served a term on the Atwater City Council and was later appointed to the Merced City Council, where his duties provided invaluable experience in dealing with a wide range of important local and county issues.

The remainder of the witnesses will be testifying on H.R. 1943.

Our first witness on the bill will be Mr. Devon Brown, who is the director for the District of Columbia Department of Corrections. He has more than three decades of experience in the congressional field. He recently returned to D.C. government from the state of New Jersey, where he was the commissioner of corrections from April 2002 to January 2006. Before his tenure as commissioner for the New Jersey Corrections, he served as deputy trustee of the Office of Corrections for the District of Columbia. During that time, he also served as interim director for the Department of Corrections for 6 months.

The next panel member will be Mr. Vincent Jones. Mr. Jones has been the executive director of the Center for Health Justice since December of 2006. In his role, he oversees programmatic development, manages development activities and oversees the agencies capacity to fulfill its mission to empower more people affected by HIV and incarceration. He has more than 15 years' experience in strategic planning, fundraising, organizational positioning, programmatic development and management teams.

Our third panel member is Philip Fornaci. He, in August 2003, became the director of the D.C. Prisoners Legal Services Project. In 2006 that project was merged with the Washington Lawyers Committee for Civil Rights and Urban Affairs, where he took over as director of the new organization. He litigates on behalf of prisoners in both D.C. jails and Federal institutions while also managing the project's public affairs efforts, with a particular interest in civil rights of ex-offenders and the treatment of people with disabilities within the criminal justice system.

Our fourth panel member is Rear Admiral Newton Kendig, M.D. He is the assistant director of Health Services Division, U.S. Bureau of Prisons, since August of 2006. He is a fifth-generation graduate of Jefferson Medical College in Philadelphia. He completed his residency in internal medicine at the University of Rochester and subspecialty training in infectious diseases at Johns Hopkins in 1991, where he later joined the faculty. He subsequently served as medical director of the Maryland Department of Corrections and Public Safety for 5 years.

Our final panel member is going to be introduced by the gentleman from Texas.

Mr. SMITH. Mr. Chairman, thank you for another opportunity today to go out of order. It is appreciated.

I am honored to introduce Willie Mitchell, chairman of San Antonio Fighting Back, who is from our hometown of San Antonio, Texas.

Mr. Mitchell has had a distinguished career in business, community service and politics. He currently serves as chair of San Antonio Fighting Back, Inc., sits on the United Way of San Antonio and Barrett County Board of Trustees and on the San Antonio Water

Board, as well as many other committees and boards, including the Community Anti-Drug Coalition and the America Greenhouse Coalition.

Mr. Mitchell ran for the San Antonio City Council in 1979. He has served as an active member of the Texas Council on Crime and Delinquency and has appeared on the "Today" show, representing the Center for Educational Development, teaming the athletic peer group. He has also appeared on "Texas Epidemic" in San Antonio, Texas, and is a recipient of the San Antonio Distinguished Citizen Award.

Mr. Mitchell attended Tennessee A&I State University in Nashville, Tennessee, and upon graduation was drafted by the Kansas City Chiefs, National Football League, in 1964. Mr. Mitchell played in the first Super Bowl in 1966 and was a member of the Kansas City Chiefs team that won the 1969 Super Bowl.

Mr. Chairman, I just want to say about Willie Mitchell, beyond what I just said and beyond the organizations that he is a member of, he is literally a hero to many of us in San Antonio. He is known throughout the community for his good works, for his good words, for his talks that inspire so many young people across the board. And it is just nice that he was able to make the time and come up from San Antonio today to be able to testify before our Committee.

As I say, there aren't many genuine heroes we have these days, particularly those who are living among us, but Willie Mitchell is one of those in San Antonio.

Thank you, Mr. Chairman.

Mr. SCOTT. Thank you. Thank you, Mr. Smith.

Each of the witnesses' written testimony will be made part of the record in its entirety, and I would like each of the witnesses to summarize his or her testimony in 5 minutes or less.

I think the timer is working. If it is working, the green light will come on. When 1 minute is left, the yellow light will come on. And when the red light comes on, that indicates that your time has pretty much expired.

We are going to begin with Congressman Cardoza at this time.

And we can take your testimony and then if there are any questions, and then the rest of the hearing will be on the other bill.

Mr. Cardoza?

TESTIMONY OF THE HONORABLE DENNIS CARDOZA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. CARDOZA. Thank you, Mr. Chairman. Thank you for inviting me here today.

You and your Committee have accomplished a great deal for the American people in the short time since you have taken over as Chair, and I admire your commitment to making our Nation's communities safer.

Thank you for your interest in my bill. I appreciate all the comments of Mr. Forbes and Mr. Smith and Ms. Waters.

I come here today to testify about an issue that is very close to my heart: drug endangered children.

Drug trafficking and addiction have had a harrowing effect on children across this country, contributing to domestic violence,

abuse, and neglect. According to a recent Health and Human Services study, over 1.6 million children live in a home where at least one parent abuses illicit drugs, including cocaine, methamphetamine, heroin, and prescription drugs.

I am especially concerned about the impact drug abuse is having on the foster care system. Seven years ago, my wife Kathy and I adopted two foster children, Joey and Elena. It is a little difficult for me at this time to refer to them as foster children, because after 7 years of being in our home and being part of our family, they are our children, not foster children. But in any case, they were at one time foster children.

It was truly an eye-opening experience for both Kathy and I, and I was inspired to become an advocate for improving the lives of foster kids. It breaks my heart that in communities across this country drugs like methamphetamine are harming innocent children and over-burdening the foster care system.

Methamphetamine is particularly dangerous for children because parents set up meth labs in their homes. These labs are highly toxic and susceptible to fires and explosions. Tragically, according to the Drug Enforcement Administration, children are found in over 20 percent of all meth labs seized.

It is well-documented that children exposed to drug abuse are more emotionally traumatized than other foster children and often have serious drug-related health problems. For these reasons, drug endangered children present unique challenges to the system. In fact, according to a National Association of Counties study, 69 percent of county social service agencies are working to develop special training procedures and protocols to help children with methamphetamine-addicted parents.

I recently introduced the Drug Endangered Children Act of 2007 to address the challenges nationwide. The legislation would reauthorize the Department of Justice to make $20 million grants for drug endangered children for fiscal years 2008 and 2009. The Drug Endangered Children program was originally authored as part of the Patriot Act reauthorization, but money was never appropriated.

Last June during the consideration of the Science, State, Justice and Commerce appropriations bill, I offered an amendment to provide $5 million for the program for fiscal year 2007. The amendment passed with bipartisan support, but the funding was not included in the continuing resolution adopted this year when the underlying bill from last year didn't pass through the Committee process.

The Drug Endangered Children's grants are designed to improve coordination among law enforcement, prosecutors and child protection services to help transition drug endangered children into a residential environment and as-safe-as-possible custody as soon as possible.

The Byrne JAG and COPS programs have proven that grants to local law enforcement, other government agencies are extremely effective in taking public policy and tackling public safety problems. The Drug Endangered Children program would operate in a similar manner to these highly successful Justice Department programs by funding coordination across jurisdictions to address the needs of drug endangered children. In addition, these grants would leverage

the Federal Government's investment by offering an incentive for local governments to invest their own money to confront this growing epidemic.

I want to again thank you, Mr. Chairman, for the opportunity to present my testimony today. I strongly believe that the Drug Endangered Children Act would improve the lives of the more than 1.6 million children across the country impacted by parental drug abuse. I urge the Subcommittee to support this legislation.

And as you mentioned earlier, Mr. Chairman, you have already supported legislation that would build on this in the Native American Meth Act, and without this underlying legislation, the legislation you passed earlier this year wouldn't have any impact.

[The prepared statement of Mr. Cardoza follows:]

PREPARED STATEMENT OF THE HONORABLE DENNIS CARDOZA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you, Mr. Chairman for inviting me here today. You and your committee have accomplished a great deal for the American people in the short time since you have taken over as Chairman of the Subcommittee on Crime, Terrorism, and Homeland Security, and I admire your commitment to making our nation's communities safer.

I am here today to testify about an issue that is close to my heart: drug endangered children. Drug trafficking and abuse have had a harrowing effect on children across our country, contributing to domestic violence, abuse, and neglect. According to a recent Health and Human Services study, over 1.6 million children live in a home where at least one parent abuses illicit drugs, including cocaine, methamphetamine, heroin, and prescription drugs.[1]

In my district in the Central Valley of California, I have seen the devastating impact of methamphetamine on children's lives. While visiting schools in my area, I have been told by teachers and administrators that a significant proportion of students have a parent or relative who abuses meth. I am positive that similar stories can be told in other parts of the country where drug abuse is rampant.

I am especially concerned about the impact drug abuse is having on the foster care system. Seven years ago, my wife Kathy and I adopted two foster children—Joey and Elena. It was truly an eye-opening experience for both of us, and I was inspired to become an advocate for improving the lives of foster kids. This year I introduced legislation to provide Medicaid coverage for foster kids with mental health problems who age out of the foster care program. Also, I am planning on introducing legislation to guarantee that every foster child has a Court Appointed Special Advocate (CASA)—a vital step to improving outcomes for children in foster care. Without a doubt, one of the most serious challenges facing the foster care system is parental drug abuse. In communities like mine across the country, drugs like methamphetamine are affecting innocent children and overburdening the foster care system.

Meth is extremely dangerous for children not only because meth addicts are more likely to abuse and abandon their children, but also because meth-addicted parents often set up meth labs in their homes. These labs are highly toxic and susceptible to fires and explosions and therefore place innocent children in physical danger. In my district, children have been found at labs with burns from spilled ingredients from the methamphetamine production process. In addition, there is a high risk of lasting health damage from toxic fume inhalation. Tragically, according to the Drug Enforcement Administration (DEA), children are found at 20 percent of all meth lab seizures.[2]

*ERR13*Drug endangered children present unique challenges for law enforcement agencies, prosecutors, child protective services, social service agencies, health care providers, and other government entities. These children are often traumatized and abused, and they require special attention and care to transition into a safe and healthy residential environment. According to a survey released by the National Association of Counties, 69 percent of responding officials from county social service

[1] Department of Health and Human Services, Office of Applied Studies. "The National Survey on Drug Use and Health." 2004.

[2] Swetlow, Karen. "Children of Clandestine Methamphetamine Labs: Helping Meth's Youngest Victims." 2003: p. 3.

agencies indicate that their counties have had to provide specialized training for their welfare system workers and have had to develop special protocols for workers to address the special needs of children displaced by parental meth abuse.[3]

I recently introduced the Drug Endangered Children Act of 2007 (H.R. 1199) to address the challenges facing children abandoned, neglected, or abused by parents addicted to illicit drugs. The legislation would authorize the Department of Justice to make $20 million in grants for drug endangered children for Fiscal Years 2008 and 2009. The grants are designed to improve coordination among law enforcement, prosecutors, children protection services, social service agencies, and health care providers to help transition drug endangered children into safe residential environments.

Grants to local law enforcement and other local government agencies are extremely effective in tackling public safety problems in communities across the country. The Community Oriented Policing Services (COPS) program has been critical in reducing crime across the country. The Edward Byrne Memorial Justice Assistant Grant program is another example of a program that empowers state and local governments to fight crime and respond to emerging public safety threats.

The Drug Endangered Children (DEC) program would operate in a similar manner to these highly successful Justice Department programs. By funding coordination across jurisdictions and among several different types of government agencies, the DEC program would foster cooperative efforts to address the needs of children affected by drug abuse. These grants would leverage the federal government's investment by offering an incentive for local government to invest their own money in confronting this important problem.

This legislation renews the authorization for the Drug Endangered Children program originally included as part of the USA PATRIOT Improvement and Reauthorization Act of 2005 (P.L. 109–177). Last June during the consideration of the Departments of Commerce and Justice, Science, and Related Agencies Act of 2006 (H.R. 5672), I offered an amendment to provide $5 million for the program in Fiscal Year 2007. The amendment passed by voice vote, but the funding was not included in the Continuing Resolution adopted earlier this year.

The Drug Endangered Children Act of 2007 represents a continuation of the work of the Subcommittee on Crime, Terrorism, and Homeland Security this year. On February 6, 2007, the Subcommittee reported out the Native American Methamphetamine Enforcement and Treatment Act of 2007. A central provision of this legislation is to extend Drug Endangered Children grants to tribes and territories. This provision is irrelevant without the reauthorization of the DEC program itself. H.R. 1199 builds on the prior work of the Subcommittee to help Native American communities devastated by the methamphetamine epidemic.

Thank you, Mr. Chairman, for the opportunity to present my testimony to the Subcommittee on Crime, Terrorism, and Homeland Security. I strongly believe that the Drug Endangered Children Act of 2007 would improve the lives of the more than 1.6 million children across the country impacted by parental drug abuse. I urge the Subcommittee to support this legislation.

Mr. SCOTT. Thank you very much.

Are there any questions for Mr. Cardoza?

Mr. Forbes?

Ms. Waters?

Ms. WATERS. Mr. Chairman and Members, I certainly support this legislation, and I thank Congressman Cardoza again for his leadership on this issue.

We have all heard many stories about the unfortunate situations where children find themselves in homes sometimes with both parents using meth or——

Mr. SCOTT. If the gentlelady would yield for just a minute?

We want to recognize the presence of the gentleman from North Carolina, Mr. Coble, and the gentleman from Georgia, Mr. Johnson, who are also present with us today.

You can continue. Sorry.

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[3] National Association of Counties. "The Meth Epidemic in America: The Impact of Meth on Children." July 5, 2005: p. 10. Available at http://www.naco.org/Template.cfm?Section=Meth—Action—Clearinghouse&template=/ContentManagement/ContentDisplay.cfm&ContentID=17216.

Ms. WATERS. That is all right.

We have heard these horror stories about children who are abandoned or children who are placed at great risk because they are unfortunate enough to end up in these situations. And even though it is not well-known among the Members of even Congress and perhaps the public, I know that Congressman Cardoza has a special experience with this situation of children who were at risk because of their parents having been on methamphetamine.

And I would just like to ask you if the children that you have knowledge of are safely being cared for now?

Mr. CARDOZA. Well, it varies, Ms. Waters. And thank you for your recognition.

When we got our children from the foster care system, they had been abandoned by their mother, who was a methamphetamine addict. They were in foster care, being somewhat abused for a second time, and a CASA volunteer saved our kids, a kindergarten teacher that recognized that my son was under severe stress and could see it in the classroom.

We were lucky and our children were lucky. We were lucky to get them. They are wonderful kids. They will be great adults if we don't—I often joke, if we let them live that long, they will be great adults. Like any kids, they are persnickety and get into mischief. But we love them deeply, and they are in a great situation now.

But the impact from the years that they were in a bad situation still affects their lives, even though they are 13 and 10 now. That impact continues. Even though they have got a nurturing mother and a father that take care of them and love them, there are impacts that reside inside them that affect them to this day.

I am personally aware of two children that were taken out of a meth lab about a mile from my home. When they removed these children, they were covered in red phosphorus and their teddy bears literally had to be considered hazardous materials and were taken away in Hazmat bags by men in white suits, because they were so contaminated and dangerous. The children were literally little toxins. They were taken to the hospital to be decontaminated.

And when you see those kinds of experiences, you know the effect of methamphetamine on parents causes parents to simply abandon the kids. And especially if they have been taken the drugs during pregnancy, while the drug can have an effect on the child physically, the emotional lack of attachment that the parent has, because they oftentimes abandon newborns and things, is something that early child development practitioners will tell you has a lifelong effect on this young people that were abandoned.

That is why the counties are having such trouble dealing with some of the after-effects of this, and I really appreciate your question. I am very passionate about this subject, and I know the money will be well-spent if we can direct it this way.

Ms. WATERS. Thank you very much.

Mr. SCOTT. Thank you.

Mr. Smith?

Mr. Johnson?

Mr. JOHNSON. I wish to commend you, Representative Cardoza, for this measure to extend this act, which would provide $20 million per year for children who have been adversely impacted by

their drug environments. If we don't pay now, we will certainly pay later. And $20 million compared to $97 billion is a small amount when it goes toward helping children. So you are to be commended.

I have only talked with you a couple of times since I have been in Congress, and my idea of you is of someone who is very stern and focused and that kind of thing. But to hear you and your wife have taken in foster children who were challenged gives me a different perspective on your character. So I look forward to getting to know you better and thank you so much for your service to your country in that regard.

Mr. CARDOZA. Thank you, Mr. Johnson.

Mr. SCOTT. Does the gentleman want equal time? [Laughter.]

Mr. CARDOZA. I will do some soul searching about my sternness.

The reality is there are a great deal of young people that are put—you know, 1.6 million people are affected in some way; 500,000 children are in foster care at any given time in the United States; 118,000 are up for adoption.

There is a disproportionate number of children in the African-American community vis-a-vis the population. They comprise about 15 percent of the population and 39 percent of those waiting for adoption.

We have a lot of work to do on this issue, but the counties and the locales that are dealing with this, in some cases cities, really need to help in developing special protocols. These are special kids with special needs, and I think that this money will go to developing those programs that can be used disseminated throughout the country to solve the problem.

I thank the Chairman.

Mr. SCOTT. Thank you.

If there are no other questions, thank you, Mr. Cardoza, and we will excuse you at this point.

Thank you for introducing this bill. The children you are talking about are at the highest risk of getting in trouble, and any investments we can make before they get in trouble will go a long way, as the gentleman from Georgia has indicated.

As you have heard, we have got several votes, at least eight votes. So it is going to be some time. We will get back as soon as we can, but it will be at least a half an hour before we can get back. So we will get back as soon as we can and continue with the hearing.

We are in recess.

[Recess.]

Mr. SCOTT. The Committee will come back to order.

Representative Forbes is detained but specifically asked me to continue, so we will continue with the hearing.

And I understand that the witnesses have been informed that Mr. Mitchell is on a time crunch. And we would ask him to testify at this point.

Mr. Mitchell, you are recognized for 5 minutes.

TESTIMONY OF WILLIE MITCHELL, CHAIRMAN OF THE BOARD, SAN ANTONIO FIGHTING BACK, SAN ANTONIO, TX

Mr. MITCHELL. Thank you, Mr. Chairman.

Let me say first of all, I am clearly elated to be here, and I appreciate the opportunity to come before you and your Committee to give some impact to the problem with HIV/AIDS to those who have been incarcerated and to those who are being incarcerated.

From my perspective, I have worked with the Three Rivers Federal Penal Institution in Three Rivers, Texas, and the thing that I think is so unique is that this bill that you have designed and put together, I think everything that I know, as a practitioner and out in the community, everything is being addressed.

The one thing that I know is beneficial is that those who come from those communities that really have the AIDS virus or have the potential of getting the AIDS virus and going into the penal institution, I think if tested before, that will help to serve and make sure that the finances to make sure that the people who have AIDS going in get the treatment that is necessary and reduce the problem with those who are incarcerated to where there are more people coming in with that same virus.

And for those that are inside the prison, if they are not tested to see, then it just continues to spread and it will be widely known as they come out. If they are coming out with the virus and haven't been tested, that is not good for the community either, because the community is going to have to suffer and pay for that type of testing and the medicine that is needed. So the bill will certainly help those who are incarcerated, those who are not incarcerated.

And from my perspective, I have a grant right now that is from the Center for Substance Abuse and Mental Health Service Administration, SAMHSA, and the Center for Substance Abuse Prevention, CSAP, and right now just what you are talking about we want to see being done for them, I am doing it already for the public.

So if we can do it, and SAMHSA has the need to show that it is needed and necessary for the general public, why shouldn't we do it for those who have been incarcerated? That is one of the issues that I think makes it so unique and special.

And we are doing free testing. So why wouldn't the Federal Government want to test these people before they enter the penal institution?

That is why I am so strong and I feel so good about it, is because I am there, I am in the community.

And within the penal institution you must realize that there will be some type of sexual activity going on among these men. If you don't test to make sure and then give them the information that is needed so that if I know what the possibilities are and the information is being given to me or we will looking at it, then we have a better chance of preventing it.

But if we do the laymen thing and act as though it is not going to happen and say, well, we will deal with that later, then the penal institutions have the problems with the medical part of it, and then as they come out to the public, there is another problem.

So I think the bill will serve not only the penal system, but it will serve the community to let them know that we are doing this testing to make sure that if a person has this virus, at least we will test to find out, so that we will have some indication of what is going in and what is going out.

And then I have transitional housing, where I have transitional housing for those that come out of the penal institution. So when we talk about jobs and opportunities for them, the first thing they want to know, well, do they have any ailments, do they have any sicknesses, have they been tested for this. That is the first thing the employer wants to know. So if you do that and test them before they come out, then that means that also we save again, because they may have a better opportunity to get a job.

So I am much in favor of it, and I appreciate the fact of being able to come and at least make the testimony before you, because I know that this is an important step in trying to make sure that we address this issue.

That is basically about all I have to say about it. It is just that it is something that is needed. I appreciate the fact that you all are taking the initiative to put forth this bill. And I hope that anything that we can do and say in our community will help you.

[The prepared statement of Mr. Mitchell follows:]

PREPARED STATEMENT OF WILLIE MITCHELL

In 2006, the HIV/AIDS virus pandemic reached a milestone our world hoped it never would; 25 years of existence. The HIV/AIDS virus is one that has touched lives from all backgrounds regardless of class, race, gender, or geographic location. While there are many factors which contribute to the number of men and women infected with HIV/AIDS virus, those individuals who are or have been incarcerated are not to be excluded. According to an unpublished report done by the U.S. Department of Justice in a report done in 2002 titled *Disease Profile of Texas Prison Inmates;* ". . . study shows that for a number of conditions, the prison population exhibited prevalence rates that were substantially higher than those reported for the general population."[1] Upon entry into the Texas Department of Criminal Justice (TDCJ) system for any duration of time, all inmates receive a medical and mental health examination; however it does not currently include testing for the HIV/AIDS virus.

Therefore it would only be prudent for the state to do so in order to take a proactive approach and reduce the number of individuals infected along with the potential of infecting others with the HIV/AIDS virus. ". . . infection with HIV was more common among black females than among either white or Hispanic females."[2] The need for testing before and after incarceration is not only a social injustice; however it also has the potential to be an economic injustice. Social in the sense that individuals infected with the virus who are from low income backgrounds can only create future financial responsibilities to the state in addition to the country. Economic in the sense that it costs the state thousands of dollars each year to provide health care, medications, housing, along with other welfare benefits; all at the expense of both the state and the country. The federal government cannot wait for individuals to become infected with this virus; it must act now and address the issues with a proactive mentality. The report further indicates that, "the high rates of HIV among prison populations are attributable to high-risk behaviors in which a number of criminals reportedly engage prior to incarceration. For example, 40 to 80 percent of prison inmates are reported to have used intravenous drugs." "Eleven percent of incarcerated men are reported to have had sex with a prostitute, while between two and group percent are reported to have engaged in bisexual or homosexual relationships."[3] The lack of mandatory HIV/AIDS screening process in place within the TDCJ system during the study period may likely contribute to the underestimation of the actual cases that exist. The absence of a clear understanding of the number of cases is a danger not only to the individual who is infected, the community at large, and the many correctional facility professionals whose lives are at risk if an individual does not know their status. Furthermore, "research indicates the following factors may contribute to prisoners' excess disease prior to incarceration: low socioeconomic status, poor access to health care in their home commu-

[1] *Disease Profile of Texas Prison Inmates Pg. 4–5,* Baillargeon, Jacques Ph.D., Black, Sandra A. Ph.D., Dunn, Kim M.D., and Pulvino, John P.A.

[2] Ibid Pg. 7

[3] Ibid Pg. 10

nities, and high risk behaviors. Following incarceration, a number of environmental factors including crowded living conditions, lack of temperature control, poor sanitation, and increase psychological stress may further contribute to excess disease among inmates."[4]

Testing inmates for the HIV/AIDS virus is one of many that is needed to ensure the health and wellness of the incarcerated population and correction facility professionals who serve them everyday. The Hepatitis virus is another fatal illness that is often associated with high risk populations of which many incarcerated men and women are. The report also made reference to the increase rates of the transmittal of the Hepatitis virus through risky behavior such as multiple partners, male to male sex, and intravenous drugs. Currently in the state of Texas, it is a challenge to receive testing and aftercare in the event an individual becomes infected; this virus equally deserves the attention of our state and national government.

[4] Ibid Pg. 12

ATTACHMENT

The author(s) shown below used Federal funds provided by the U.S. Department of Justice and prepared the following final report:

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THE DISEASE PROFILE OF TEXAS PRISON INMATES

194052

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Abstract

Purpose: Whereas prison inmates are reported to exhibit poorer overall health status and higher rates of health care utilization than the general population, no current information exists on the overall disease profile of the U.S. prison population. The present study examined the prevalence of major acute and chronic conditions in one of the nation's largest prison populations.

Methods: The study population consisted of 170,215 Texas Department of Criminal Justice inmates who were incarcerated between August 1997 and July 1998. Information on medical conditions and sociodemographic factors was obtained from an institution-wide medical information system.

Results: Infectious diseases (29.6 %) constituted the most prevalent major disease category among inmates. This was followed by diseases of the musculoskeletal system and connective tissue (15.3 %), diseases of the circulatory system (14.0 %), mental disorders (10.8 %), and diseases of the respiratory system (6.3 %). Among the specific conditions examined, evidence of tuberculosis infection without active pulmonary disease (20.1 %) was found to be the most prevalent condition, followed by hypertension (9.8 %), asthma (5.2 %), low back pain (5.1 %), and viral hepatitis (5.0 %).

Conclusion: The present study shows that for a number of conditions, the prison population exhibited prevalence rates that were substantially higher than those reported for the general population. Moreover, estimates for a number of diseases varied substantially according to age, race, and gender. Understanding the disease profile in US incarcerated populations will permit correctional administrators to develop more efficient health care delivery systems for prison inmates.

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Abbreviations or acronyms

Texas Department of Criminal Justice (TDCJ)

International Classification of Diseases (ICD)

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Introduction

Research indicates that prison inmates in the United States exhibit higher rates of health care utilization than the general population. [1-5] This excess has been attributed in part to prison inmates' increased risk for infectious disease [2, 6, 7] and mental disorders. [8, 9, 13] The prevalence of both tuberculosis and hepatitis, for example, are reported to be higher for prisoners than for their same-age peers in the general population. [10-11] Likewise, the incidence of AIDS and a number of other sexually transmitted diseases are reported to be substantially elevated among prisoners. [2, 6-9] Prison inmates are also reported to exhibit elevated rates of affective disorders, schizophrenic disorders, and substance abuse. [8, 9, 12, 13] Scarce information exists, however, on the many other medical conditions that underlie the high health care utilization rates of prisoners. This dearth of information has hindered the organization of effective health care delivery in prison systems. The purpose of the present investigation, therefore, was to examine the prevalence of major diseases, both infectious and chronic, in one of the nation's largest prison populations.

Methods

The cohort under study consisted of 170,215 prison inmates who were incarcerated in the Texas Department of Criminal Justice (TDCJ) system for any duration dating from August 1997 through July 1998. Texas houses one of the largest prison populations in the US [12] and together with California houses almost one-third of all US prison inmates. [12] All inmates included in the present study population have been convicted of criminal offenses. Diagnoses of all medical conditions were made by physicians or mid-level practitioners at the time of each inmate's initial evaluation and/or subsequent medical encounters, and were classified according to International Classification of Disease (ICD-10) coding system. All inmates in Texas are required to have medical and mental health examinations at the time of intake. This evaluation lasts

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approximately 60 minutes and consists of a detailed medical and mental health history, a comprehensive medical physical examination, and a number of diagnostic procedures including a rapid plasma reagin (RPR), Mantoux TB skin test, and other tests as indicated. In the present study, TB class 2 (generally defined as tuberculosis infection without evidence of active pulmonary disease) was defined as a presentation of 10 mm or more induration (5 mm if the inmate was HIV positive) from a tuberculin skin test or documented history of a positive tuberculin skin test, followed by a negative chest x-ray.

All of the aforementioned data, along with sociodemographic information, are maintained in an institution-wide medical information system. This system is routinely updated to ensure that the information is reflective of the inmates' current health status. Prevalence estimates were employed to assess the proportion of inmates with a given medical condition during the study period. The present study assessed only those medical conditions that were present during the period of investigation. Prevalence of the major ICD-10 disease categories and specific medical conditions were estimated across gender and ethnic groups. [13] As a result of the large denominators associated with the present study population, race and gender differences in prevalence were all statistically significant. Due to space limitations, however, 95 percent confidence intervals were not presented. Inmates who presented with more than one medical condition were included in the tabulation of each of the diseases with which they presented. Inmates who were not identified as white, black or Hispanic comprised less than one percent of the population, and were therefore included in the white category.

Results

Sociodemographic characteristics of the total TDCJ inmate population are presented in table 1. The vast majority of inmates were male and between 30-49 years old. Blacks constituted 44 percent of the total inmate population, while whites and Hispanics represented 30 and 26 percent, respectively. Prevalence estimates of all major

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International Classification of Disease (ICD-10) categories in the TDCJ study population are presented overall and for males and females separately in table 2. Infectious diseases comprised the most common category of health conditions in the Texas prison system. Diseases of the musculokeletal system and connective tissue were the second most common disease group overall. Interestingly, whereas this category is ranked second among males, it ranked only third among females. Diseases of the circulatory system comprised third most common disease group among males, and the fifth most common among females. Table 3 presents the prevalence of major conditions according to ethnicity. Hispanics exhibited lower overall disease rates than whites or blacks. In all of the ethnic groups, however, the top four disease categories consisted of: infectious disease, mental disorders, diseases of the circulatory system, and diseases of the musculoskeletal system and connective tissue.

Table 4 shows the number of medical conditions according to sociodemographic factors in the study population. Sixty percent of the study population exhibited at least one medical condition during the one-year study period. This proportion was higher among females than among males; and higher among whites and blacks than among Hispanics. The proportion of the study population that exhibited two or more medical conditions during the study period was higher among females than among males; and higher among whites than among blacks or Hispanics.

Table 5 presents prevalence estimates of specific diseases for the entire study population according to gender and ethnicity. The first column shows that evidence of tuberculosis (TB) infection, as defined by a positive tuberculin skin test, was the most common condition in the TDCJ, occurring in 20.1 percent of inmates. Hypertension was ranked second, followed by asthma, low back pain, viral hepatitis and affective disorders. Of the fifteen most prevalent conditions, ten were chronic conditions, two were mental disorders, and three were infectious diseases. Among male inmates, positive tuberculin skin tests were more prevalent among blacks and Hispanics than among whites.

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Similarly, hypertension, the second most prevalent disease overall, was more prevalent among blacks males than among Hispanics or whites. Affective disorders, which include major depression and dysthymia, was much more prevalent among whites than among either blacks or Hispanics. Among female inmates, positive tuberculin skin tests were more common among blacks than among Hispanics or whites. By contrast, viral hepatitis was more prevalent among white and Hispanic females, than it was among black females. As in the male population, affective disorders were much more common among whites than either Hispanics or blacks. Finally, infection with HIV was more common among black females than among either white or Hispanic females.

Table 6 presents disease prevalence among TDCJ inmates according to gender and age. Among males, a number of medical conditions exhibited stepwise increases in prevalence according to age: hypertension, low back pain, diabetes, arthritis, hernia and heart disease. In particular, hypertension and diabetes were strikingly more prevalent in the 50 and over age group than in the two younger age groups. Similar age-disease patterns among female inmates: tuberculosis class 2, affective disorder, hypertension, asthma, arthritis, diabetes, low back pain, and heart disease. Particularly noteworthy is that hypertension, arthritis, diabetes, and heart disease all exhibited dramatic increases in female inmates who were 50 and over subgroup.

DISCUSSION

The purpose of the present study was to describe the patterns of disease prevalence in the Texas Department of Criminal Justice (TDCJ) prison population. The findings show that 53.0 percent of the study population exhibited at least one medical condition during the twelve-month study period. As reported, this proportion varied substantially according to race, gender, and age. The study population also exhibited a number of interesting specific disease patterns, many of which also varied substantially according to the sociodemographic factors under study.

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Prison Disease Prevalence

Our findings support previous research that has indicated higher rates of health problems among prison inmates than the general population. [1-5] Examination of chronic conditions in the TDCJ inmate population yielded some particularly interesting findings. Hypertension was the most common chronic disease with a prevalence estimate of 9.8 percent. This estimate is remarkably consistent with that reported for the general population, reported at 10.0 percent [14] but substantially higher than that reported by Novick and colleagues in their study of New York city inmates (3 percent). [9] Among both males and females, Hispanics demonstrated a lower prevalence of hypertension than either whites or blacks. These ethnic patterns are reflective of those reported for the general population. [15] Diabetes mellitus occurred in 2.6 percent of TDCJ inmates. This estimate is approximately equal to that reported for a general US population (2.9 percent) [14], but higher than that reported for New York City prison inmates (0.6 percent). [9] In the present study, diabetes was more common among Hispanics and blacks than among whites. This pattern, present in both male and female inmates, is reflective of ethnic patterns in the general US population. [16]

Our findings show that a number of chronic conditions increased dramatically with age. In fact, among both male and female inmates, hypertension, diabetes, and arthritis all more than doubled in the 50 and over subgroup. These findings are consistent with a number of investigations [21-23] that have reported higher disease prevalence, especially for chronic conditions, among elderly inmates. As a result of longer prison sentences, restrictive prison release policies, and the aging of the general population, the U.S. prison population is aging [21]. Given elderly inmates' increased occurrence of chronic and particularly costly medical conditions [23], epidemiologic information on this segment of the prison population will be integral to proper planning of correctional health care.

Prison inmates have long been recognized as exhibiting higher rates of affective disorders, schizophrenic disorders, and substance abuse than their counterparts in the free world. [9, 12, 13, 23] Inmates are reportedly twice as likely to have a lifetime history of

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psychiatric disorder than non-incarcerated adults and are substantially more likely to have multiple psychiatric disorders. [17, 18] In the present study, mental disorders constituted the third most common major disease category among females and the fourth most common among males. In fact, two mental disorders were among the 15 most prevalent specific diseases in the study cohort. Affective disorders were the sixth most common disease, with an estimated prevalence of 3.9 percent. This finding was consistent with that reported for the general population, estimated at 3.7 percent. [19] However, in her two studies of male jail detainees, Teplin [12,13] reported prevalence estimates of 3.4 and 3.9 percent for current major depression; this classification did not include dysthymia or other affective disorders, both of which were included in the present study. Schizophrenic disorders constituted the twelfth most common disease with an estimated prevalence of 2.0 percent. This estimate was slightly higher than that reported for the general population, estimated at 1.0 percent. [20] Teplin [12, 13] reported a prevalence schizophrenia of 2.7 [12] and 2.9 [13] for male jail detainees. This estimate was slightly higher than that exhibited by TDCJ male inmates (1.9 percent).

Consistent with a number of previous studies, [6, 9] the present investigation suggests that TDCJ inmates were particularly susceptible to a number of infectious diseases. Because scarce information exists on the prevalence of infectious disease on random samples of the general population, it was difficult to determine the extent to which TDCJ inmates exhibited elevated rates of infectious disease. By far, the most prevalent medical condition exhibited by TDCJ inmates was evidence of TB infection without active pulmonary infection, present in 20.1 percent of TDCJ inmates. Inmates who are infected with TB can, as a result of immune suppression or other causative factors, develop active pulmonary TB. Therefore, all TDCJ inmates who test positive for TB but exhibit a negative chest x-ray are placed on a clinically indicated regimen of prophylactic Isoniazid therapy. The 20.1 percent prevalence of TDCJ inmates who exhibited a positive tuberculin skin test is higher than such prevalence estimates reported

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among New Mexico male prison inmates (10.3 percent) [29] and Maryland state male prison inmates (12.7 percent) [30] but slightly lower than that reported among New York State inmates (27.0 percent) [31] and Chicago inmates (22.3 percent).[6] Due to high-rates of HIV-associated immunosuppression, crowded living conditions, and often poor ventilation systems, US prisons constitute a particularly high risk environment for the rapid spread of tuberculosis.[32] In fact, prevalence of TB in prisons has risen dramatically in the 1980s and 1990s as more HIV-infected inmates have entered the prison system.[33] Moreover, following release from prison, inmates have been reported to spread tuberculosis to their home communities. [32] Obtaining accurate information on both active pulmonary TB and evidence of TB infection in prison populations, therefore, is critical if prison health care providers are to prevent and control institution-wide TB epidemics.

Viral hepatitis was the fifth most common condition among TDCJ inmates, with an estimated prevalence of 5.0 percent. This estimate is slightly lower than that reported among New York city inmates, estimated at 8 percent. [9] Braithwaite and colleagues [10] determined that the prevalence of hepatitis in prisons has been reported to range from 2.3 to 67.2 percent. HIV infection was the fifteenth most prevalent condition in the TDCJ system, estimated at 1.6 percent. For both males and females, HIV infection was substantially more prevalent among blacks than among whites or Hispanics. Research based on mandatory screening and blinded seroprevalence studies among inmates shows that HIV infection rates vary substantially from system to system.[10] While most prison systems are reported to have rates of HIV infection at 1.0 percent or below, some are reported to have rates as high as 20-26 percent. The high rates of HIV among prison populations are attributable to high-risk behaviors in which a number of criminals reportedly engage prior to incarceration. For example, 40 to 80 percent of prison inmates are reported to have used intravenous drugs. [32] Eleven percent of incarcerated men are reported to have had sex with a prostitute, while between two and four percent are reported to have engaged in bisexual or homosexual relationships. [32] A number of

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investigations have reported that HIV transmission may occur following incarceration. In fact, two studies [33, 34] have documented intraprison spread of HIV infection. It is important to note that the lack of mandatory HIV and hepatitis screening processes in place in the TDCJ system during the study period may have resulted in underestimation of both of these conditions.

A number of methodologic factors precluded direct comparison of the study population with the general population. For example, the disease diagnosis protocol employed in the present study may not be reflective of the methodology used to estimate prevalence in the general population. Moreover, the age distribution of prisoners is substantially different from that of the general population. In interpreting results it is important to consider that prison populations are, on average, younger than the general population. In fact, only 8 percent of the present study population was over the age of 50. Moreover, comparisons with previous prison inmate populations are hampered by non-parallel periods of follow-up. Clearly, this issue is less problematic in assessing persistent, chronic conditions than it is in evaluating short-term, acute conditions. A study design in which parallel methods are employed to estimate disease prevalence in both prison and general population samples would permit age-adjusted direct comparisons between incarcerated and nonincarcerated samples. It is also important to note that diagnoses of medical conditions in the present study were made by several practitioners at different prison sites. While practitioners relied on standardized institutional clinical guidelines to make all diagnoses, no system-wide data on the reliability and validity of such diagnoses was available for assessment. Consequently, prevalence information reported in this study is subject to biases generally associated with clinically obtained data. In short, while the present study provides compelling preliminary evidence that prison inmates have elevated risk for a number of diseases, the extent to which the disease burden exceeds that of the general population is not yet clear.

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Prison Disease Prevalence

Research indicates that the following factors may contribute to prisoners' excess disease prior to incarceration: low socioeconomic status [2, 10] poor access to health care in their home communities, [2] and high risk behaviors.[2] Following incarceration, a number of environmental factors including crowded living conditions, lack of temperature control, poor sanitation, and increased psychological stress [2, 10] may further contribute to excess disease among inmates. Despite the high rates of health care utilization among prison inmates, correctional medicine is substantially behind other health care fields in its understanding of the health care needs of their patient populations. [2] To organize efficient delivery of health care in prison systems, correctional administrators need detailed information on the disease patterns of their populations. To this end, it will be important for future investigations to continue to explore the disease profile of inmate populations.

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Table 1: Sociodemographic Characteristics of the TDCJ Inmate Population

Variable	Overall (n=170,215)		Males (n=155,949)		Females (n=14,268)	
	n	%	n	%	n	%
Race						
White	50,322	30	45,375	29	4,949	35
Hispanic	44,202	26	42,200	27	2,002	14
Black	75,691	44	68,374	44	7,317	51
Age						
18-29	54,995	32	51,486	33	3,508	25
30-49	102,194	60	92,074	59	10,117	71
50+	13,027	8	12,384	8	643	4

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Table 2: Prevalence of major disease categories in the TDCJ Prison system[a]

Disease	**Overall** (n=170,215)		**Males** (n=155,947)		**Females** (n=14,268)	
	Frequency	Prevalence	Frequency	Prevalence	Frequency	Prevalence
Infective and Parasitic Disease	50,336	29.6	45,144	28.9	5,288	37.0
Neoplasms	1,239	0.7	1,116	0.7	123	0.9
Endocrine, Metabolic, Nutritional and Allergic Diseases	5,569	3.3	4,996	3.2	573	4.0
Diseases of the Blood and Blood-forming Organs	838	0.5	731	0.5	107	0.8
Mental Disorders	18,368	10.8	15,539	10.0	2,828	19.8
Diseases of the Nervous System and Sense Organs	7,132	4.2	6,409	4.1	723	5.1
Diseases of the Circulatory System	23,828	14.0	22,066	14.2	1,762	12.4
Diseases of the Respiratory System	10,808	6.3	9,665	6.2	1,143	8.0
Diseases of the Digestive System	10,034	5.9	9,045	5.8	989	6.9
Diseases of the Genitourinary System	1,267	0.7	952	0.6	315	2.2
Diseases of the Skin and Subcutaenous Tissue	4,114	2.4	3,745	2.4	369	2.6
Diseases of the Musculoskeletal System and Connective Tissue	6,093	15.3	23,917	15.3	2,174	15.2
Congenital Anomalies	689	0.4	652	0.4	37	0.3

a = prevalence estimates represent the percentage of inmates with a given disease during the study period

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Table 3: Prevalence of major disease categories in the TDCJ Prison system according to race[a]

	White (n=50,322)		Hispanic (44,204)		Black (n=75,691)	
	Frequency	Prevalence	Frequency	Prevalence	Frequency	Prevalence
Infective and Parasitic Disease	11,925	23.7	12,004	27.2	26,407	34.8
Neoplasms	503	1.0	227	0.5	509	0.7
Endocrine, Metabolic, Nutritional and Allergic Diseases	1,475	2.9	1,454	3.3	2,640	3.5
Diseases of the Blood and Blood-forming Organs	139	0.3	97	0.2	602	0.8
Mental Disorders	7,888	15.7	2,644	6.0	78,361	10.4
Diseases of the Nervous System and Sense Organs	2,457	4.9	1,380	3.1	3,295	4.4
Diseases of the Circulatory System	67,241	13.4	38,301	8.7	13,274	17.5
Diseases of the Respiratory System	3,662	7.3	1,190	2.7	5,956	7.9
Diseases of the Digestive System	3,652	7.3	2,282	5.2	4,100	5.4
Diseases of the Genitourinary System	451	0.9	237	0.5	579	0.8
Diseases of the Skin and Subcutaenous Tissue	1,301	2.6	763	1.7	7,050	2.7
Diseases of the Musculoskeletal System and Connective Tissue	9,513	18.9	4,931	11.2	11,649	15.4
Congenital Anomalies	304	0.6	128	0.3	257	0.3

a = prevalence estimates represent the percentage of inmates with a given disease during the study period

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Table 4: Number of TDCJ inmates with Diagnosed Medical Conditions during the Study Period[a]

Variable	No medical conditions	1+ medical condition(s)	2 + medical conditions
Overall	39.6	60.4	31.9
Gender			
Male	40.4	59.6	30.9
Female	30.7	69.3	42.4
Race			
White	35.1	64.9	36.8
Hispanic	49.8	50.3	21.6
Black	36.5	63.4	34.6
Age			
18-29	56.3	43.7	16.0
30-49	33.6	66.3	36.7
50+	15.4	84.6	60.8

a= prevalence estimates represent the percentage of inmates with a given disease during the study period

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Table 5: 15 most prevalent diseases according to gender and ethnicity[a]

Disease	Entire cohort			White		Hispanic		Black	
	All	Males	Females	Males	Females	Males	Females	Males	Females
1. Tuberculosis (class 2)[b]	20.1	20.4	16.2	14.6	10.4	20.4	16.9	24.2	19.9
2. Hypertension	9.8	9.8	10.1	7.3	6.4	4.9	5.0	14.0	14.0
3. Asthma	5.2	5.0	7.4	5.1	8.7	1.9	3.6	6.7	7.5
4. Low Back Pain	5.1	5.3	2.6	6.2	3.1	4.4	2.4	5.2	2.2
5. Viral Hepatitis	5.0	4.6	8.5	6.2	11.6	4.2	9.5	3.8	6.1
6. Affective Disorders	3.9	3.3	10.2	6.1	15.1	1.7	7.2	2.5	7.8
7. Arthritis	3.5	3.3	4.7	4.1	5.7	2.4	4.2	3.4	5.0
8. Fractures	2.9	3.0	1.3	3.9	1.5	2.1	1.1	3.0	1.2
9. Cirrhosis	2.8	2.6	5.2	3.5	6.3	2.4	6.0	2.0	4.3
10. Diabetes Mellitus	2.6	2.6	2.8	2.0	1.7	2.8	3.3	2.8	3.3
11. Hernia	2.0	2.1	0.6	2.4	0.4	1.9	0.5	2.0	0.7
12. Schizophrenic Disorders	2.0	1.9	2.7	1.6	1.0	1.1	0.8	2.6	4.7
13. Epilepsy	1.9	1.9	2.1	2.3	2.2	1.1	1.9	2.0	1.9
14. Heart Disease	1.7	1.5	2.0	2.2	1.7	0.8	1.2	1.4	2.4
15. HIV/AIDS	1.6	1.5	2.4	1.3	1.4	0.6	1.0	2.3	3.5

a= prevalence estimates represent the percentage of inmates with a given disease during the study period
b= TB (class 2) was defined as a presentation of 10 mm or more induration from a tuberculin skin test or documented history of a positive tuberculin skin test, followed by a negative chest x-ray.

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Table 6: 15 most prevalent diseases according to gender and age

Disease	Entire cohort			18-29 years		30-49 years		50 and older	
	All	Males	Females	Males	Females	Males	Females	Males	Females
1. Tuberculosis (class 2)[b]	20.4	20.4	16.2	11.0	8.1	23.9	18.1	33.2	29.4
2. Hypertension	9.8	9.8	10.1	3.2	2.2	10.7	10.8	30.2	41.9
3. Asthma	5.2	5.0	7.4	5.5	6.7	4.7	7.4	4.5	10.2
4. Low Back Pain	5.1	5.3	2.6	2.5	0.7	6.4	2.9	9.0	6.4
5. Viral Hepatitis	5.0	4.6	8.5	1.3	3.5	6.2	10.2	6.4	9.3
6. Affective Disorders	3.9	3.3	10.2	2.7	7.6	3.6	10.9	3.3	13.7
7. Arthritis	3.5	3.3	4.7	0.9	1.4	3.7	5.4	10.8	2.2
8. Fractures	2.9	3.0	1.3	2.6	0.8	3.1	1.4	3.7	2.8
9. Cirrhosis	2.8	2.6	5.2	0.6	2.1	3.5	6.2	3.9	6.7
10. Diabetes Mellitus	2.6	2.6	2.8	0.4	0.4	2.6	3.0	11.2	11.6
11. Hernia	2.0	2.1	0.6	1.2	0.3	2.2	0.6	4.7	1.2
12. Schizophrenic Disorders	2.0	1.9	2.7	0.9	1.6	2.5	3.1	1.8	3.1
13. Epilepsy	1.9	1.9	2.1	1.3	3.9	2.1	2.1	2.1	3.9
14. Heart Disease	1.7	1.5	2.0	0.4	0.6	1.2	2.0	8.4	8.9
15. HIV/AIDS	1.6	1.5	2.4	0.7	1.8	2.1	2.7	1.1	1.6

a= prevalence estimates represent the percentage of inmates with a given disease during the study period
b= TB (class 2) was defined as a presentation of 10 mm or more induration from a tuberculin skin test or documented history of a positive tuberculin skin test, followed by a negative chest x-ray.

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Mr. SCOTT. Thank you very much, Mr. Mitchell.

Let me just ask you one quick question; we usually defer questions until the end. But in your experience and education, how do you make sure that inmates actually learn the material, particularly when you consider that it has to be presented in a culturally sensitive manner?

Mr. MITCHELL. Well, the culturally sensitive manner, I don't have a problem with that, because I think with the virus as deadly as it is, if we don't do it, then we are not serving the community. I don't think that you can make this an easy thing to say. I don't think there is a special way to do it.

I think that because they have been incarcerated and for what the problems are while you are incarcerated, I think you have to have more education in terms of educating the inmates to it and putting out or disseminating information that they can read, such as pamphlets. They have a lot of down time, where at night they could read the pamphlets about the AIDS virus and what it causes.

So I think if there is some information given to them, that they can readily read—on bulletin boards. We all know the best way to get a product sold is through advertising, so if we want to sell this product, why don't we advertise it within the penal institution? And I think that is just a good business principle, that if you want to have some results, advertise it within the penal institution so that they will know what the cause and effects are.

Mr. SCOTT. Thank you.

Ms. Waters, do you have any questions for Mr. Mitchell? He has a plane to catch. He will be leaving.

Ms. WATERS. No. I want to thank Mr. Mitchell very much. I did have an opportunity to talk with him a little bit earlier when I was here. You were over there, and I should have been over there too.

However, I do thank you for being here today, and I certainly appreciate the work that you are doing and for your particular knowledge about what is going on in our prisons.

You are there. You see the inmates. You have a sense of how information is disseminated. You have enough knowledge about this to know that they can benefit from this program that we are trying to institute to save lives and to save the lives of mates on the outside.

So I just thank you for being here today and coming from so far to share this testimony with us. Thank you.

Mr. MITCHELL. Ms. Waters, I appreciate that.

It is one thing to know that within our community, within the African-American community, this virus has escalated, and the fact of the matter is that we need to make sure that there is an awareness brought about, and if we don't do that, then the virus continues to happen. Nobody will take the fact that we need to do something.

And I think this is one step in saying that within the penal system, we are going to do something. And I think from the Federal level, it says a lot about you all as Members of the Committee who are trying to allocate money for it. The States may have a difficult time, but I think from a Federal standpoint you all are doing an exciting job in doing this.

And I would just ask all of you, go visit a Federal penal institution, and it will help you to make some good choices on what is going on there. It may be a system that we have to house people that have committed certain crimes, but they do a tremendous job in trying to rehabilitate those people and give them an opportunity for other jobs as they come out so that they can become productive citizens. It is a wonderful system, and I wish the States would adopt some of the things that we do in the Federal institutions.

Ms. WATERS. Thank you very much.

Mr. SCOTT. Thank you.

Visit the prisons is on our agenda. Mr. Forbes and I are looking for prisons to visit right now, and we expect there to be more than one. So thank you for that recommendation.

Mr. MITCHELL. Thank you, Mr. Chairman.

Mr. SCOTT. Mr. Brown, you are recognized for 5 minutes.

TESTIMONY OF DEVON BROWN, DIRECTOR, DEPARTMENT OF CORRECTIONS FOR THE DISTRICT OF COLUMBIA, WASHINGTON, DC

Mr. BROWN. Good afternoon, Mr. Chairman and Members of the Subcommittee. I am Devon Brown, director of the District of Columbia Department of Corrections.

I appear before you today as a 33-year correctional executive whose experience includes leadership at both the State and local levels within Maryland, New Jersey and the District of Columbia correctional systems. I do so in firm support of House Resolution 1943.

Having spent the entirety of my career as a public servant in the proud membership of the correctional profession, I am acutely aware of the many challenges and demands of its operations and gravity of responsibilities.

Having functioned as the director of the Montgomery County Department of Corrections and Rehabilitation in Maryland, warden of two of Maryland's maximum security institutions and as a forensic psychologist, I have faced many concerns and issues existing within prison walls but ultimately having impact upon all of society. None are more important than those addressed by H.R. 1943 as it recognizes the growing interface between public safety and public health.

This bill, like similar ones enacted throughout the country, recognizes the critical significance of diagnosing, educating and treating, where appropriate, all inmates for HIV/AIDS as they enter, reside within and leave prison gates.

The proposed legislation understands that, as we speak, over 2.2 million prisoners are currently incarcerated within our country's prisons and jails with over 600,000 of them returning to our communities each year. These individuals will be re-establishing themselves in our villages, our hamlets and neighborhoods, with many securing employment in fields requiring routine and close interaction with the public.

Of acute concern is the realization that approximately 3 to 5 percent of them will be released from confinement with HIV and AIDS, a statistic which is five times the rate of prevalence in the general population.

These individuals will return to their families, resituate themselves and resume their lives infected with a highly pernicious, destructive and contagious disease. Many will be unaware that they are the host of this acutely devastating virus, nor will they know that their disorder has the potential of being innocently passed on to unsuspecting others both within and outside of prison gates.

H.R. 1943 endeavors to promote public health for all of the country by ensuring that inmates are automatically tested for HIV and AIDS upon commitment to Federal custody, educated about the disease and treated. Moreover, they are again tested upon completing their term of incarceration.

These provisions are consistent with the Centers for Disease Control recommendations and those of several other jurisdictions, among them the District of Columbia. As a means to offset the fiscal resources necessary to implement this legislation, funding is available through SAMHSA with guidance provided by the CDC.

As correctional systems take on an increasing and more vital role in promoting the vibrancy of our communities, their efforts must include doing more to contain the spread of HIV and AIDS. Inasmuch as 90 percent of all HIV-positive cases detected in prisons reportedly involve those who have contracted the infection prior to incarceration, the proposed legislation will also play an important role in protecting the health of the brave men and women who serve the people of this country each day through their employment within correctional facilities.

By diagnosing, educating and treating the inmate population who possess the disorder, it is less likely to be spread to prison staff as well. House Resolution 1943 recognizes this necessity. Its enactment is in the best interest of our correctional systems and the public they serve.

In recognition of this reality, last June the District of Columbia Department of Corrections became the first municipal detention facility in the United States to comprehensively expand its existing inmate health care services to address the HIV pandemic by integrating automatic HIV testing into its routine medical intake operations and release procedures.

As most correctional systems test for HIV under limited, voluntary conditions, our approach in automatically testing all detainees at the front and back end of incarceration is highly congruent if not identical with the elements of H.R. 1943 and stands as indisputable evidence of the feasibility as well as success of these procedures.

Our condom distribution program, implemented during the early 1990's, was likewise one of the first initiatives of its kind in the Nation and complements our automatic HIV testing strategy by contributing to the deterrence of the disease's transmission. The condom distribution initiative began at a time when only a handful of correctional systems supported such a response to controlling HIV in correctional settings.

It is important to note that while our departmental policy strictly prohibits sexual activity among inmates, the HIV/AIDS issue is considered more insidious than the consequences resulting from inmates committing consensual sex-related infractions.

In conclusion, I leave you with these observations made in 1929 by the National Society for Penal Information, as conveyed in a publication entitled, "Health and Medical Service in American Prisons and Reformatories," by F.L. Rector. And I quote: "Viewed from whatever angle, whether social, economic, administrative or moral, it is seen that adequate provision for health supervision of the inmates of penal institutions is an obligation which the State cannot overlook without serious consequences to both the inmates and the community at large."

These resounding words are as true today as when related over 7 decades ago. As it relates to HIV/AIDS transmission, the health of our Nation shall be greatly influenced by the manner in which we address our prisons.

House Resolution 1943 affirms this truth. Recognizing the profound importance that this bill will have in furthering the health of all citizens, I enthusiastically support its passage.

Mr. Chairman, this concludes my testimony.

[The prepared statement of Mr. Brown follows:]

PREPARED STATEMENT OF DEVON BROWN

Good Morning Mr. Chairman and members of the Judiciary Committee, I am Devon Brown, Director of the District of Columbia Department of Corrections. I appear before you today as a 33-year correctional executive whose experience includes leadership at both the State and local levels within Maryland, New Jersey State, and the District of Columbia correctional systems. I do so in firm support of House Resolution 1943.

Having spent the entirety of my career as a public servant in the proud membership of the correctional profession, I am acutely aware of the many challenges and demands of its operations and gravity of responsibilities. Having functioned as the Director of the Montgomery County Department of Corrections and Rehabilitation, warden of two of Maryland's Maximum Security institutions and as a forensic psychologist, I have faced many concerns and issues existing within prison walls but ultimately having impact upon all of society. None are more important than those addressed by H.R. 1943 as it recognizes the growing interface between public safety and public health.

This bill, like similar ones enacted throughout the country, recognizes the critical significance of diagnosing, educating, and treating, where appropriate, all inmates for HIV/AIDS as they enter, reside within, and leave prison gates. The proposed legislation understands that as we speak, over 2.2 million prisoners are currently incarcerated within our country's prisons and jails with over 600,000 of them returning to our communities each year. These individuals will be re-establishing themselves in our villages, hamlets, and neighborhoods, with many securing employment in fields requiring routine and close interaction with the public. Of acute concern is the realization that approximately 4–5% of them will be released from confinement with HIV/AIDS, a statistic which is five times the rate of prevalence in the general population. These individuals will return to their families, resituate themselves and resume their lives infected with a highly pernicious, destructive, and contagious disease. Many will be unaware that they are the host of this acutely devastating virus, nor will they know that their disorder has the potential of being innocently passed on to unsuspecting others both within and outside of prison gates.

H.R. 1943 endeavors to promote public health for all of the country by ensuring that inmates are automatically tested for HIV/AIDS upon commitment to federal custody, educated about the disease and treated where warranted. Moreover, they are again tested upon completing their term of incarceration. These provisions are consistent with the Centers for Disease Control (CDC) recommendations and those of several other jurisdictions among them the District of Columbia. As a means to offset the fiscal resources necessary to implement this legislation, funding is available through the U.S. Department of Health Department with guidance provided by the CDC.

As correctional systems take on an increasing and more vital role in promoting the vibrancy of our communities, their efforts must include doing more to contain the spread of HIV/AIDS. Inasmuch as 90% of all HIV positive cases detected in prisons reportedly involve those who have contracted the infection prior to incarcer-

ation, the proposed legislation will also play an important role in protecting the health of the brave men and women who serve the people of this country each day through their employment within correctional facilities. By diagnosing, educating, and treating the inmate population who possess the disorder, it is less likely to be spread to prison staff as well. House Resolution 1943 recognizes this necessity. Its enactment is in the best interest of our correctional systems and the public they serve.

In recognition of this reality, last June the District of Columbia Department of Corrections became the first municipal detention facility in the United States to comprehensively expand its existing inmate health care services to address the HIV pandemic by integrating automatic HIV testing into its routine medical intake and release procedures. As most correctional systems test for HIV under limited, voluntary conditions, our approach in automatically testing all detainees at the front and back end of incarceration is highly congruent with the elements of H.R. 1943 and stands as indisputable evidence of the feasibility as well as success of these procedures. Our condom distribution program, implemented during the early 1990's, was likewise one of the first initiatives of its kind in the nation and complements our automatic HIV testing strategy by contributing to the deterrence of the disease's transmission. The condom distribution initiative began at a time when only a handful of correctional systems supported such a response to controlling HIV in correctional settings. It is important to note that while our departmental policy strictly prohibits sexual activity among inmates, the HIV/AIDS issue is considered more insidious than the consequences resulting from inmates committing consensual sex related infractions.

In conclusion, I leave you with these observations made in 1929 by the "National Society for Penal Information" as conveyed in a publication entitled, *Health and Medical Service in American Prisons and Reformatories,* by F.L. Rector:

> "Viewed from whatever angle, whether social, economic, administrative, or moral, it is seen that adequate provision for health supervision of the inmates of penal institutions is an obligation which the state cannot overlook without serious consequences to both the inmates and the community at large."

These resounding words are as true today as when related over 7 decades ago. As it relates to HIV/AIDS transmission, the health of our nation shall be greatly influenced by the manner in which we address our prisons. House Resolution 1943 affirms this truth. Recognizing the profound importance that this bill will have in furthering the health of all citizens, I enthusiastically support its passage.

Mr. Chairman, this concludes my testimony. I would be pleased to respond to any questions that you may have of me at this time. Thank you.

Mr. SCOTT. Thank you, Mr. Brown.

Mr. Jones?

TESTIMONY OF VINCENT JONES, EXECUTIVE DIRECTOR, CENTER FOR HEALTH JUSTICE, WEST HOLLYWOOD, CA

Mr. JONES. Good afternoon, Mr. Chairman and Members of the Committee. My name is Vincent Jones. I am the executive director of the Center for Health Justice.

The Center for Health Justice is the Nation's only nonprofit organization solely focused on HIV prevention and treatment education for incarcerated populations. Our mission is to empower people affected by HIV in incarceration to make healthier choices and to advocate for the elimination of disparities between prisoner health and public health.

More specifically, we provide treatment adherence education to positive inmates, prevention education to incarcerated women and men at high-risk for HIV infection, and supportive services to positive parolees upon release.

We are the Nation's largest provider of condoms inside correctional facilities, and run a nationwide toll-free prevention and treatment hotline for inmates. We also have an active policy and advocacy team.

The Center for Health Justice was founded in 2000 by advocates with over 20 years' experience in the field to focus treatment, advocacy and prevention efforts for the incarcerated population, an often-forgotten subset of Americans.

Our work is guided by the principle that prevention and treatment in correction facilities should be equal to that of the general public. We call this health justice.

In general, positive people in the community have access to quality medical care, medications, treatment education and advocacy and support services, and so should positive prisoners. Positive and at-risk folks in the community have access to education, condoms and hotlines. So should prisoners.

Our staff and board have examined H.R. 1943, the Stop AIDS in Prison Act, through the lens of Health Justice and decided to support this bill. We applaud Congresswoman Maxine Waters for recognizing the intersection of HIV and correctional facilities and thank her for her leadership on this very important issue.

Before I tell you why we support the Stop AIDS in Prison Act, let me share some facts.

In the United States, one in four people with HIV pass through a jail or prison each year; 26 years into the epidemic, a quarter of those with HIV are undiagnosed. Women, especially women of color, constitute an increasingly large proportion of new infections.

And this might come as a surprise to some, but over 90 percent of people in prison or jail return to their communities in a matter of months, bringing back to their communities the effects of poor HIV medical treatment and prevention efforts inside.

But there is a silver lining. The simplest and most cost-effective way to address the HIV pandemic is through education and primary care providers, but incarcerated populations generally lack formal schooling and adequate health care. Hence, in-custody programs often mark their first and only opportunity for HIV prevention and treatment education and the best teachable moment, when they are sober, contemplative and in a single-sex environment.

The Stop AIDS in Prison Act recognizes those facts and takes advantage of this public health opportunity incarceration presents without taking advantage of prisoners and their decreased capacity to decline or meaningfully consent to participation and intervention.

It also encourages routine HIV testing in a manner that mirrors testing in the general public and approaches treatment holistically and also updates the formulary rules in a manner that will enhance confidentiality and help extend the lives of Americans living with HIV.

Now for a few statistics. Controlling the epidemic begins with more people knowing their status. HIV testing upon request is the norm in the general public and should be the case inside correction facilities. We are delighted that H.R. 1943 stipulates that an inmate's request for a test cannot be used against her or him in a punitive manner. The fewer disincentives to testing that exist, the greater likelihood that an individual would choose to be tested and begin to make healthier choices upon learning their HIV status.

While we believe it is important for more people to know their status, we know that inmates are more likely to make healthier choices after learning their status if they choose to take the test themselves rather than have that choice imposed upon them. For that reason, we are happy that this bill provides a clear opt-out provision for inmates.

The bill further requires that testing be offered upon entry and release and contrasts legislation proposed from other jurisdictions requiring testing only upon exit. Testing upon entry and release is preferable because it allows an individual receiving a positive diagnosis to do so in an environment where he or she can receive required care rather than just a diagnosis upon departure.

We also like the strong pre-test and post-test counseling as it helps inmates to understand the ramifications of a positive or a negative result.

We are also pleased that this bill calls for comprehensive treatment. Not only is comprehensive treatment the goal in the general public, but it is a more effective approach to reducing reinfection and prolonging lives.

Providing for a formulary that will contain all the FDA-approved medications necessary to treat HIV and AIDS and providing for automatic renewal systems for medications and requiring that medical and pharmacy personnel provide timely and confidential access to medication are all essential to providing quality care in prison. And we are happy that these issues are addressed in the bill and reflect the authors' comprehensive understanding of the challenges of HIV care in incarcerated settings.

At the Center for Health Justice, we assist inmates in developing pre-release plans that take their health into consideration and know the effectiveness of these types of tools. We are also happy that this bill provides a similar planning.

Finally, the exposure incident provision in this bill is one in which we look forward to working with the author to improve. It could be argued that this provision makes prisoners living with HIV the subject of scrutiny rather than members of our community to be supported with increased counseling and testing and educational resources. We agree with the goal of reducing intramural HIV transmissions, including to staff, but we believe this can be done in a different manner.

In closing, I cannot thank you enough for the opportunity to provide our expertise to those whose goals are consistent with our mission. The passage of this bill will help plug a huge gap in our Nation's plan to reduce the spread of HIV and extend the lives of Americans living with the virus.

I welcome the opportunity to show any of you how our programs work in real incarcerated settings, as that can help you understand why we believe that the bill is so essential.

Thank you.

[The prepared statement of Mr. Jones follows:]

PREPARED STATEMENT OF VINCENT JONES

Good morning. My name is Vincent Jones. I am the Executive Director of the Center for Health Justice, an organization based in Los Angeles. The Center for Health Justice empowers people affected by HIV and incarceration to make healthier

choices and advocates for the elimination of disparities between prisoner health and public health.

More specifically, Center for Health Justice provides treatment adherence education to HIV+ inmates, HIV prevention education to incarcerated women and men at high-risk for HIV infection, and supportive services to HIV+ parolees upon release. We are also the nation's largest provider of condoms inside correctional facilities, and provide prisoners access to condoms in the Los Angeles and San Francisco County Jail systems. Finally we run a nationwide HIV prevention hotline that prisoners may call collect while incarcerated.

The Center for Health Justice was founded in 2000 by HIV advocates with over 20 years experience in the field to focus HIV treatment advocacy and prevention efforts on incarcerated populations, an often forgotten subset of the HIV community. But ignoring this population is the detriment of us all.

Here are the facts: In the US one in four people with HIV pass through a jail or prison each year; 26 years into the epidemic a quarter of those with HIV are undiagnosed. Women, especially women of color, constitute an increasingly large proportion of new infections. And this might come to a surprise to some but over 90% of people in prison or jail return to their communities in a short period of time, bringing back to their communities the effects of poor HIV medical treatment and prevention efforts inside.

The fundamental tenet of our organization is the principle that HIV prevention and treatment in correctional facilities should be equal to that of the general public. We call this health justice. In general, HIV+ folks in the community have access to quality medical care, HIV medications, treatment education and advocacy and support services: HIV+ prisoners should also. HIV+ and at-risk folks in the community have access to prevention education, condoms and HIV hotlines that provide information to reduce the risk of transmission: HIV+ and at-risk prisoners should to.

Applying principle of Health Justice to the real world is not only the right thing to do but it is also good policy.

Today, I am here to tell you that our staff and board have examined HR 1943, the STOP AIDS in Prison Act of 2007 through the lens of Health Justice and decided to support this legislation. We applaud Congresswoman Maxine Waters for recognizing the intersection of HIV and correctional facilities and thank her for her leadership on this very important issue.

As you know the purpose of the bill is to stop the spread of HIV and AIDS among prisoners, to protect staff from HIV infection, to provide comprehensive medical treatment to prisoners who are living with HIV, to promote HIV awareness and prevention among prisoners, to encourage prisoners to take responsibility for their own health and to reduce the transmission of HIV in prison.

We like the fact that many elements of this legislation conforms with existing standards and practices employed outside of correctional facilities. More specifically:

- **Testing and Counseling upon intake** is consistent with the provision of testing to individuals who are not incarcerated. The strong pre and post test counseling component of the legislation is critical because it helps inmates understand the potential ramifications of a positive OR a negative result. In either instance, it is incumbent upon them to make healthier choices and appropriate counseling and education makes that more likely.
- **Improved HIV Awareness through Education** is critical. The simplest and most cost-effective way to address the HIV epidemic is through education and primary care providers, but incarcerated populations generally lack formal schooling and adequate healthcare. Hence, in-custody programs often mark their first and only opportunity for HIV prevention education and in the best teachable moment: when constituents are sober, contemplative, and in single sex environments. In our experience while education is available to some portion of prisoners at some times in some facilities, all programs could benefit from increased access by community service providers and health departments and prisoner peer educators to provide HIV education. We particularly support the provision of educational materials to be available at intervals during incarceration including at orientation, in medical clinics at regular educational programs and prior to release. In our experience education, particularly about a sensitive topic as HIV, is best reinforced frequently and provided repeatedly to individuals who at various points during their lives and incarceration may be more open to receiving such information.
- Controlling the HIV epidemic begins with more people knowing their HIV status. **HIV Testing upon request** is the norm in the general public and should be the case inside correctional facilities as well. We are delighted that

the legislation stipulates that an inmate request for an HIV test can not be used against her or him in a punitive manner. The few obstacles to testing that exist the greater likelihood that an individual will choose to be test and begin to make healthier choices upon learning their HIV status.

- The encouragement of HIV testing of pregnant women is also critical and is the norm in the general population. We know that we can stop the transmission of HIV from a mother to her child if the appropriate treatment is given at the right time.
- By doing HIV prevention and treatment education in correctional facilities for the past seven years, we know that HIV is often one a myriad of issues that our clients face. For this reason, we apply a holistic approach to treatment. We are pleased that this bill calls for comprehensive treatment as well. Not only is comprehensive HIV treatment the goal in the general public but it is a more effective approach to reducing re-infection and prolonging lives. The confidential counseling and voluntary partner notification aspects of this legislation are important too because they help to create an environment in which HIV positive inmates will seek out and adhere to treatment.
- Providing for a formulary that will contain all of the FDA-approved medication necessary to treat HIV/AIDS is essential. The science around HIV is constantly evolving and the disease affects people differently. One drug that does the trick for one person may not work at all for another. The provision of automatic renewal systems for medication is also essential and we're glad it's included in this bill. It is not uncommon for inmates to go without medications for weeks because their prescription expired after three months—but access to a physician to renew them took more than that time. We were able to resolve this issue with the Sheriff's Department of Los Angeles County, and we are happy to see that this specific issue was addressed in this bill. It reflects the author's comprehensive understanding of the challenges of HIV care in an incarcerated setting.
- Requiring that medical and pharmacy personnel provide timely and confidential access to medications similarly reflects that the author of the legislation understands that in correctional settings it is difficult to provide medications in a way that protects confidentiality. In our experience, HIV+ prisoners' confidentiality is often violated when medications are distributed to folks in long lines and without a way to conceal the type of medication being distributed. And as you know, one's HIV positive status is a highly protected status in terms of confidentiality law in the general public and should be in incarcerated settings due to the many real negative implications that can and do result from being HIV positive in prison or jail.
- We assist inmates in developing pre-release plans that take their health into consideration and know the effectiveness of these types of tools. We are happy that this bill provides for similar planning especially. Many inmates often lack access to adequate health care but can be helped to surmount the obstacle with the proper planning
- To our knowledge, no population is required to take an HIV test. We are happy that this bill provides a clear opt-out provision for inmates. While we believe it is important for more people to know their status, we know that inmates are more likely to make healthier choices after learning their status if they choose to take the test themselves.
- The bill further requires that testing be offered upon entry and release, in contrast to legislation proposed in various other jurisdictions requiring testing only upon exit. Testing upon entry and release is preferable because it allows an individual receiving a positive diagnosis to do so in an environment where he or she can receive required care, rather than just a diagnosis upon departure.
- The exposure incident provision in the bill is one which we look forward to working with the author to improve. It could be argued that this provision making prisoners living with HIV the subject of scrutiny rather than members of our community to be supported with increased counseling and testing and educational resources. We agree with the goal of reducing intra-mural HIV transmission including to staff but we believe this could be done in a different manner.

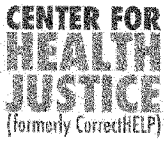
IN CONCLUSION

We are pleased that the Congress of the United States has taken official notice of the issue of HIV among the incarcerated. We support efforts to increase HIV testing in a manner that mirrors HIV testing in the community, takes advantage of the public health opportunity incarceration presents without taking advantage of prisoners and their decreased capacity to decline or meaningfully consent to participation in interventions.

Thank you for the opportunity to provide our expertise to those whose goals are consistent with our mission: to empower those affected by HIV and incarceration to make healthier choices.

Thank you.

ATTACHMENT



THE FACTS: In the United States,

- One in four persons with HIV passes through a jail or prison each year.
- 25 years into the HIV epidemic, a quarter of those infected with the virus are undiagnosed.
- Women, especially women of color, constitute an increasingly large share of new HIV infections.
- 90% of people in prison or jail are released in a matter of months
- A minority of jails and prisons allow prisoners access to condoms despite the fact that condoms are 98% effective in reducing the spread of HIV and 40-60% of inmates admit to sexual contact.

Every client that Center for Health Justice empowers to make healthier choices is reducing the likelihood of spreading HIV to their sexual partners behind bars or back in their communities. Their work to help incarcerated women, who are often single mothers, to reach their full potential has an extra benefit in that their children gain from the greater stability that CHJ helps them to maintain in their lives.

OUR MISSION:

Founded in 2000, the mission of Center for Health Justice is to empower people affected by incarceration and HIV to make healthier choices and to advocate for the elimination of disparities between prisoner health and public health.

WHAT WE DO:

We provide

- treatment adherence education to HIV positive inmates;
- HIV prevention education to incarcerated women and men at high risk for HIV infection;
- supportive services to former clients and HIV positive parolees upon release;
- condoms to inmates in LA and San Francisco counties via the nation's largest program of its kind; and
- a nation-wide, toll-free HIV treatment and prevention hotline for prisoners.

We advocate for

- the elimination of disparities between prisoner health and public health;
- legislation in the CA Legislature and at the Federal level to allow prisoners access to condoms; and
- increased HIV testing in correctional facilities in a manner that encourages people to engage in less risky behavior, disclose their HIV status to their sexual partners, and utilize services to help them to lead a healthier life regardless of their HIV status.

WHY WE DO WHAT WE DO:

By targeting incarcerated people who are living with HIV, or who are at risk for infection, Center for Health Justice is closing a major gap in our nation's plan to reduce the spread of HIV and extend the lives of people living with the virus.

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Ms. WATERS. Thank you.
Mr. SCOTT. Thank you.
Mr. Fornaci?

TESTIMONY OF PHILIP FORNACI, DIRECTOR, D.C. PRISONERS' PROJECT, WASHINGTON LAWYERS' COMMITTEE FOR CIVIL RIGHTS AND URBAN AFFAIRS, WASHINGTON, DC

Mr. FORNACI. Good afternoon. Thank you. My name is Phillip Fornaci. I am director of the D.C. Prisoners' Project at the Washington Lawyers' Committee for Civil Rights.

In that capacity, we work with folks who are incarcerated here in D.C. And as probably most of you are familiar, in D.C., all folks who are convicted of felonies are sent into the Federal Bureau of Prisons. So we work very closely with folks who are held in the Federal Bureau of Prisons.

I wanted to thank the Chairman for having this hearing and to especially thank Congresswoman Maxine Waters for her leadership on this bill. It is a very important step in curbing the spread of HIV, which has decimated so many communities in this country.

We believe that testing combined with effective AIDS education efforts can help to prevent new HIV infections. This is really where we are going.

About a dozen years ago, I used to run the largest legal organization in D.C. that was geared toward protecting people against discrimination based on HIV. A dozen years ago, things were a little bit different. It was very common to have landlords who would not rent to someone with HIV, employers who would not hire someone, doctors who would not even treat someone with HIV. And a lot of that has changed, in part because there has been such a massive public education effort that has gone on over the years and the awareness has grown.

But I think we need to remember that in jails and prisons, it is different. They have not had that exposure, generally speaking, to those kinds of educational efforts. It has not reached them or in any case has not been received. It is not been clear I think to a lot of prisoners how HIV is spread, how it affects people who have it. And discrimination is rampant in the world of folks who are incarcerated, in a world that is marked by violence and desperation.

We had a case a few years ago that we actually just settled last year involving someone in a jail facility who, because he had some dispute with a corrections officer, that corrections officer posted his medical records on a bulletin board that was in a common area of the jail. That inmate was subjected to physical violence, his bed was burned, and faced harassment for the rest of his stay in jail.

So we want to be aware that those kinds of things do happen, and they will happen again in the future. We want to try to prevent it, but this is the culture into which we are dropping this bill, and I think it is important that we understand that.

Some comments on the legislation specifically.

We commend the idea of comprehensive HIV education and the testing protocol, and particularly we would also like to commend the inclusion of the opt-out provision. Testing in itself will do nothing unless people are willing to do something with the test results. We can't force people to get tested and say, "Ha, ha, you are posi-

tive," and expect for a result to come out of it. It needs to be a voluntary process, as Mr. Jones has already testified, to make that effective.

So I would urge you to certainly preserve the voluntary nature of the testing program, which is so crucial, and consider adding a written informed consent that is some kind of a sign-off for the individual prisoner to say, "Yes, I have been told I can opt out of it; I have decided to get tested," or, "No, I have not."

We just want to make sure that there is no coercion in this whole process, which is very, very likely to happen without some kind of a formalistic process of informed consent.

I have one concern with regard to the bill, and it is not so much concern about the bill but the environment in which we are bringing it into, is the confidentiality provisions. They could potentially be strengthened in the bill. And I wanted to give a few suggestions, and you may do with them what you may. They are in my written testimony. I will elaborate slightly.

One is that we want to require that no non-medical staff have access to medical records. This is a basic premise, and it is generally the rule in most penal institutions but not always, and very often it happens that people have non-medical staff have access to medical records. When they do, it causes a problem.

The other thing is there need to be swift and certain consequences, including potential job dismissal, for staff who allow confidential medical information, including information about HIV, to be released to another prisoner. This is where problems result, when the information becomes widely known and people become known as HIV-positive within a prison setting. It will lead to violence, undoubtedly.

We also want to ensure that there is adequate staffing patterns so that people are protected from violence, which again we know is more common than we would like to think in these facilities. And there will be more of it when we are dropping in a situation where many, many people will be tested for HIV and many people who didn't know they were positive were find out they are positive.

Finally, I want to raise the issue of the Prison Litigation Reform Act. Actually it creates a little bit of a barrier to enforcing the confidentiality provisions of this bill. If, for example, the instance that I brought up earlier of a person whose medical records are posted on the wall, there would be no remedy for that person because of the Prison Litigation reform Act. Because it did not cause a physical injury to them despite that it caused much humiliation and pain and suffering, they would not be entitled to any kind of litigation as a result of that confidentiality breach.

Finally, I just want to make one statement with regard to the HIV testing on re-entry, which is a great idea and I commend you for including that in the bill. I would again, though, specifically include language that I have put in my written testimony, basically that a refusal to take an HIV test will not affect the program placement or the person's eligibility for a halfway house placement. And there is a very strong possibility of discrimination against people who decide they don't want to be tested for whatever reason and they need to get into a halfway house.

We had an incident a few years ago, we had a case where one of our clients was to be released on parole, and it became known to the parole authorities that she was HIV-positive. She actually told them because she had taken coursework in how to live with your HIV diagnosis. She was denied parole. We had to bring actually a habeas corpus suit in that situation to win her release, in part because people didn't understand HIV in the parole process.

So I just wanted to raise some cautionary remarks. But again, I want to commend this Committee and particular Congresswoman Waters for bringing this.

Thank you very much.

[The prepared statement of Mr. Fornaci follows:]

PREPARED STATEMENT OF PHILIP FORNACI

Thank you for this opportunity to provide testimony on H.R. 1943, the "Stop AIDS in Prison Act 0f 2007." In particular, I would like to thank Representative Maxine Waters for her outstanding leadership on this issue, as well as the important roles played by Congressman Conyers, Congressman Smith, Congressman Scott, Congressman Forbes, Congresswoman Lee, and Congresswoman Christensen as co-sponsors.

My name is Philip Fornaci. I am Director of the D.C. Prisoners' Project, a section of the Washington Lawyers' Committee for Civil Rights & Urban Affairs. Our organization represents D.C. prisoners held both locally in D.C. jail facilities as well as those held in the federal Bureau of Prisons (BOP), where those convicted of felonies in D.C. are sent. We advocate for appropriate medical care, protection from violence, and access to basic constitutional rights.

Although D.C. prisoners are a small percentage of the overall BOP population, more than 7,000 D.C. prisoners are spread throughout 99 separate BOP institutions, and our organization receives correspondence from individuals living in as many as 70 different facilities every year. Because we focus heavily on health care issues in the BOP, we have a great deal of experience with regard to medical care at a wide range of facilities. Additionally, because D.C. prisoners have a higher-than-average prevalence of HIV infection than other prisoners in the BOP, we have a broad perspective on issues facing people with HIV in these facilities. I appreciate the opportunity to comment on this legislation.

The most significant aspect of the Stop AIDS in Prison Act is simply that it provides official recognition of the AIDS epidemic within the federal Bureau of Prisons (BOP). Because most prisoners in the BOP will eventually leave prison, BOP policies and procedures can have a strong impact on public health efforts to limit the spread of HIV outside of prison. Effective AIDS education programs, policies that encourage and support responsible behavior, and comprehensive medical treatment for people in BOP custody are therefore extremely important for all Americans.

HIV TESTING

The centerpiece of the Stop AIDS in Prison Act is its mandate for routine HIV testing in all BOP facilities in the context of pre- and post-test counseling. I commend the bill's sponsors for recognizing that "routine HIV testing" requires provisions to allow people to "opt out" of HIV testing if they choose to do so, while also giving prisoners an opportunity to receive this important information about their health.

The opt-out provision is particularly important because, consistent with the goals of the legislation, it does not simply coerce prisoners into learning their HIV status. It recognizes that prisoners need to choose to be tested for the goals of the legislation to be achieved. Effective HIV prevention requires HIV education, along with testing, so that people can change their behaviors. The prisoner must enter the process voluntarily, be willing to learn about how to protect himself and others from infection, and use that information when he is released. A more coercive approach that does not allow a prisoner to decline testing is unlikely to be effective in achieving the educational purposes behind testing. HIV testing on its own does nothing to prevent the spread of HIV. What happens after testing is crucial.

Recommendation: Written Informed Consent. To preserve the viability of the opt-out provision, and to ensure that all prisoners recognize that they have the ability to refuse testing, it is extremely important that the bill be amended to include provisions for written informed consent. Currently, there are no controls in place

that will ensure that prisoners have free choice to exercise their opt-out right, and there is significant room for coercion. Remedying this need not be complicated. In order to ensure that prisoners are aware that they have the right to be tested, and the right to refuse to be tested, the BOP can design a simple form to that effect, which would remain in the prisoner's medical file. It would also ensure that, rather than simply telling prisoners that they have a free choice around testing, there are actual procedures in place documenting a prisoner's exercise of that choice.

HIV TREATMENT

Another important aspect of the bill is the requirement that prisoners testing positive for HIV receive comprehensive HIV treatment. Although the BOP is required to provide constitutionally-mandated levels of medical care, it is not always delivered in every BOP facility. We frequently receive reports from men and women who have been denied consistent HIV treatment while in the BOP, with frequent treatment interruptions. Some BOP facilities tend to provide only the most minimal treatment for HIV, changing medications in favor of the least-expensive treatments, regardless of their effectiveness. (This is particularly a problem in privately-owned facilities that contract with the BOP.) Other facilities have chaotic health care delivery systems that result in prisoners missing treatments or receiving the wrong medicines.

It is important to recognize that treatment for HIV also requires that facilities provide adequate levels of general health care. People with HIV often also have hypertension, diabetes, or hepatitis. "Comprehensive medical treatment to inmates who are living with HIV/AIDS" (section 2(b)(1)) must also include treatment for non-HIV conditions for people who also have HIV.

It is my hope that, with enactment of this legislation, the BOP will take this legislative mandate seriously, effectively monitoring its facilities to ensure that every prisoner's serious medical needs are being met. At this point, no such effective monitoring process is in place.

CONFIDENTIALITY CONCERNS

The bill contains language aimed at protecting the confidentiality of HIV-related medical information (section 3(7)), but this language is unfortunately inadequate for the important task at hand. Although stigma and prejudice associated with HIV infection have decreased to some extent in the broader society over the last twenty years, people with HIV still suffer from job and housing discrimination as a result of their HIV status. Despite many years of public education, huge segments of the U.S. population still retain false information about HIV and about the people who live with it. Unfortunately, HIV is not treated like other diseases.

Within the walls of any BOP prison, however, the situation is far worse. HIV is not treated like diabetes or hypertension. People with HIV in jails and prisons across the U.S. are isolated and singled out for violent treatment. Outmoded beliefs about how HIV transmission occurs, as well as false stereotypes about people infected with HIV, are commonplace. It becomes fodder for homophobic attacks and physical violence. Ignorance about HIV runs rampant not only among prisoners but among correctional and even medical staff as well. In the prison setting, where violence (including sexual assault) is ever-present, persons with HIV must keep their HIV status private for their own protection. Identifying as a diabetic or even someone with mental illness does not place people at risk of violence; identifying as HIV-positive may cost a prisoner his life.

One example may be instructive. Our organization represented a man who, for reasons that remain unknown, had apparently gotten into a dispute with a correctional officer. That officer posted the man's HIV medical records on a bulletin board in a common area in the facility. As a result, our client was threatened repeatedly through anonymous notes and, when he was moved to another facility, the threats continued and his bed was burned. Although he survived, he lived the rest of his sentence in fear of further attacks, knowing that both staff and prisoners were potential assailants.

However, unlike in our case, where we were able to bring litigation under local law, the federal Prison Litigation Reform Act (PLRA) will prevent any BOP prisoner whose confidentiality has been breached from enforcing this provision of the bill. There is no way for a prisoner to enforce the confidentiality provisions of this bill, nor is there any way to recover damages for the terror, mental anguish, and threats that would result from a confidentiality breach.

Recommendation: Strengthen the confidentiality provisions of this bill. As in the case described here, corrections staff themselves sometimes use HIV information to manipulate and harass prisoners, just as some staff commonly use infor-

mation about a prisoner's sexual orientation or alleged status as a "snitch" to enforce a code of behavior. Simply educating staff about the importance of confidentiality will do little to deter such actions. In the context of this bill, where thousands of people with HIV will be identified, it is imperative that the BOP adopt strict procedures to protect prisoners potentially stigmatized by their HIV status. Specifically, enhanced confidentiality protections should include:

- A requirement that no non-medical staff have access to confidential prisoner medical information. There is no security-based reason why a corrections office would need to know any confidential medical information, whether HIV status, a mental illness diagnosis, or cancer.
- The guarantee of swift and certain consequences, including job dismissal, for staff who allow confidential medical information (including information about HIV status) to be released to another prisoner.
- Adequate staffing patterns and transparent institutional rules protecting prisoners against violence from other prisoners, regardless of the cause of the violence.
- Include under this bill an exemption from the PLRA's physical injury and exhaustion of administrative remedies requirements to allow prisoners to file individual lawsuits to enforce this provision when corrections staff fail to protect their confidential medical information.

HIV TESTING AND PAROLE

The requirement that prisoners be tested prior to release is a useful opportunity, and probably the most appropriate time for HIV testing. However, individuals may have their own reasons for not wanting to be tested while incarcerated and wish to exercise their opt-out rights.

A few years ago, our organization represented a woman whose parole was denied because parole authorities found out she was HIV-positive. They discovered this because the woman revealed this fact herself, citing as proof of her educational achievements that she had completed a course in "Dealing with Your HIV Diagnosis." The parole authorities, expressing a level of ignorance not uncommon in some parts of the broader community, decided that she would be a risk to the community. We had to file a *habeas corpus* petition to secure her release on parole, which was successful largely because the case generated some media attention.

There are many other reasons why prisoners may not want to be tested prior to release, both practical and psychological. Their rights to refuse should not be taken lightly.

Recommendation: Explicitly endorse the right to opt-out of testing prior to reentry. Although the bill refers back to the opt-out provision, that provision does not address issues like release to halfway house or other pre-release issues. Section 3(9) should also add language similar to: "However, the inmate's refusal shall not be considered a violation of prison rules, result in disciplinary action, *or affect program placement, including eligibility for halfway house placement.*

Thank you for this opportunity to provide comments on this important piece of legislation. I am available to answer any questions you may have.

Mr. SCOTT. Thank you.

Admiral Kendig?

TESTIMONY OF REAR ADMIRAL NEWTON E. KENDIG, M.D., ASSISTANT DIRECTOR, HEALTH SERVICES DIVISION, FEDERAL BUREAU OF PRISONS, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Admiral KENDIG. Good afternoon, Chairman Scott, Ranking Member Forbes and Members of the Subcommittee. Thank you for the opportunity to discuss the Bureau of Prisons' Infectious Disease Management Programs and the Stop AIDS in Prison Act of 2007.

My name is Newton Kendig, and I serve as the medical director for the Federal Bureau of Prisons. Prior to my current position, I served as the Bureau of Prisons' chief of infectious diseases. Previously I was medical director for the Maryland Department of Cor-

rection and Public Safety and, prior to that, infectious disease fellow at Johns Hopkins University.

I am board-certified in infectious diseases and internal medicine. I am also on faculty at Johns Hopkins University, where I provide care to patients with HIV infections and AIDS in a clinic at the university hospital.

I believe the Stop AIDS in Prison Act of 2007 addresses an issue that is of great significance and importance to all of us who work in corrections and particularly to physicians who provide care to patients who are infected with HIV.

Bureau of Prisons has a comprehensive infectious disease management program that has been remarkably effective in diagnosing and treating inmate patients with HIV infections as well as controlling the spread of HIV within the Federal prison system.

The prevalence of HIV in the BOP's inmate population has been between 0.9 percent and 1 percent, based on multiple surveillance testing. Currently the prevalence of diagnosed HIV infection is 0.9 percent.

Acquisition of HIV infection among inmates in the Bureau of Prisons is exceedingly rare. In a 1999 admission cohort, 4,826 inmates without HIV infection were retested several times over a 2-year period, with only one conversion.

All sentenced inmates in the Bureau of Prisons receive a physical examination within 14 days and a preventative health assessment within 6 months of arrival at an institution. The assessment includes screening for signs and symptoms of HIV infection. HIV testing is conducted for all inmates with risk factors for infection and when otherwise clinically indicated.

Inmates are reassessed at least every 3 years through their incarceration as part of our preventive health care program.

Inmates are also subject to health care assessments during routine and non-routine physical examinations and during chronic care appointments. These visits provide ongoing opportunities for HIV testing throughout incarceration, including testing prior to release.

With our infectious disease management program, the Bureau of Prisons has the following general categories of inmates for the presence HIV: inmates who volunteer at any time, when testing is clinically indicated, following a blood exposure event and during surveillance testing conducted randomly or serially.

We are aware of the newly issued guidelines by the Centers for Disease Control and Prevention that recommend community standards be changed to include HIV screening as a part of routine clinical care in all health care settings. We have concerns, however, with the requirement in this bill to test all Federal inmates upon release, even in the absence of clinical indications.

The Bureau of Prisons believes this testing requirement is not consistent with practical medical judgment for the Federal inmate population. Our available incident data and clinical experience indicate that Federal inmates are rarely contracting HIV infection while incarcerated in the BOP.

We have been extremely successful in controlling HIV transmission within our facilities through a combination of inmate edu-

cation, a medically practical testing program and prevention of the behaviors linked to the transmission of HIV infection.

We are concerned that the use of health care staff to test all inmates upon release will take away from the time these staff spend on other critical health care services. We need to ensure that important public health measures, such as securing post-release access and necessary medical care are provided to inmates.

The BOP believes we should not risk shifting limited resources away from important post-release health care needs.

Chairman Scott, this concludes my formal statement. And again, thank you for the opportunity to comment.

[The prepared statement of Admiral Kendig follows:]

PREPARED STATEMENT OF NEWTON E. KENDIG

STATEMENT

OF

NEWTON E. KENDIG, M.D.
MEDICAL DIRECTOR
FEDERAL BUREAU OF PRISONS

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM,
AND HOMELAND SECURITY

COMMITTEE ON THE JUDICIARY
UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON
H.R. 1943, THE STOP AIDS IN PRISON ACT OF 2007

PRESENTED ON

MAY 22, 2007

Statement of Newton E. Kendig, M.D.
Medical Director, Federal Bureau of Prisons
Before the
Subcommittee on Crime, Terrorism, and Homeland Security
of the
Committee on the Judiciary
United States House of Representatives
May 22, 2007

Good Afternoon Chairman Scott, Ranking Member Forbes, and Members of the Subcommittee. I appreciate the opportunity to appear before you today to discuss the Bureau of Prisons' infectious disease management programs and the Stop AIDS in Prison Act of 2007.

My name is Newton Kendig, and I serve as the Medical Director for the Federal Bureau of Prisons (BOP). I also serve as the BOP's Assistant Director of the Health Services Division and am responsible for the healthcare programs, occupational safety programs, environmental health programs, and food service operations in the Bureau of Prisons.

Prior to my current position, I served as the BOP's Chief of Infectious Disease Programs, Medical Director for the Maryland Department of Corrections, and Infectious Disease Fellow at Johns Hopkins University. I am board certified in infectious diseases and internal medicine. I am an attending physician at Johns Hopkins University, where I provide care to patients with HIV infection and AIDS in the infectious disease clinic at the University hospital.

I believe the Stop AIDS in Prison Act of 2007 addresses an issue that is of great significance and importance to all of us who work in corrections and particularly to physicians who provide care to patients who are infected with HIV.

We in the BOP have been concerned with effectively managing HIV and AIDS within our institutions for many years. The BOP has a comprehensive Infectious Disease Management program that has been remarkably effective in controlling the spread of HIV in the Federal prison system. The prevalence of HIV in the BOP's inmate population has been between 0.9 percent and 1.0 percent based on multiple surveillance testings. Currently, the prevalence of diagnosed HIV infection is 0.9 percent. Acquisition of HIV infection among inmates in the BOP is exceedingly rare. In a 1999 admission cohort, 4,826 inmates without HIV infection were tested repeatedly for 2 years, with only 1 seroconversion.

The BOP's program includes appropriate testing and counseling of inmates for HIV and other sexually-transmitted diseases, as well as comprehensive education, prevention, testing, and treatment of all infectious diseases.

All sentenced inmates in the BOP receive a physical examination within 14 days and a preventive health assessment within 6 months of arrival at an institution. The assessment includes screening for signs and symptoms of HIV. HIV testing is conducted for all

inmates with risk factors for infection and whenever otherwise clinically indicated. Inmates are reassessed at least every 3 years throughout their incarceration as part of the BOP's preventive healthcare program. These are comprehensive healthcare assessments that evaluate inmates for all medical conditions for which they may be at risk.

Inmates are also subject to health care assessments during routine and non-routine physical examinations and chronic care clinic visits that can occur at any time during an inmate's incarceration based on the inmate's medical needs.

The assessments and screenings that our agency conducts during healthcare encounters are one important part of the BOP's efforts at managing HIV in the inmate population. Within our Infectious Disease Management program, the BOP tests the following categories of inmates for the presence of the HIV:

1. Inmates who volunteer;
2. When testing is clinically indicated or if risk factors are present;
3. Following a blood exposure event; and
4. Surveillance testing, which can include randomly or serially testing.

The Stop AIDS in Prison Act of 2007 incorporates many aspects of the BOP's current policies and practices; and it goes further by

requiring testing of all inmates upon admission and release, while allowing inmates to opt out if they so choose.

While such testing is costly, in terms of both the tests themselves and staff time, we recognize the basis for mandating the tests upon admission. We are aware of the newly-issued guidelines by the Centers for Disease Control and Prevention that recommend the community standard be changed to include HIV screening as a part of routine clinical care in all healthcare settings. We do have concerns, however, with the requirement in the bill to additionally test all Federal inmates upon release, even in the absence of clinical indications. BOP believes the testing requirement is not consistent with practical medical judgment for the Federal inmate population. Our available sero-incidence data and clinical experience indicate that Federal inmates are not readily contracting HIV infection while incarcerated in the BOP.

The inmate education component of our Infectious Disease Management program provides inmates with the information they need to avoid the behaviors that transmit HIV. Our inmate management practices control drug use (to include intravenous drug use) and aggression (to include sexual aggression) in our institutions. And our HIV testing program allows inmates to volunteer to be tested and requires testing when it is clinically indicated, including prior to release. We have been extremely successful in controlling HIV transmission within our facilities

through the combination of inmate education, a medically-practical testing program, and prevention of the behaviors linked to the transmission of HIV.

We are concerned that the use of health care staff to test all inmates upon release will take away from the time these staff spend on more critical health care services. We need to ensure that critical public health measures, such as securing post-release access to necessary medical treatment services are provided to inmates. The BOP believes we should not risk shifting limited resources away from important post-release public health issues. However, the BOP will continue to monitor this issue so that medical resources are allocated appropriately.

Chairman Scott, this concludes my formal statement. I would be pleased to answer any questions you or other Members of the Subcommittee may have.

Mr. SCOTT. Thank you.

Did you want to start?

Ms. WATERS. Thank you very much.

First, Mr. Chairman, I would like to thank all of our panelists who are here today sharing such valuable information with us. Just sitting here listening to you, I have learned an awful lot. And I do have several questions.

Mr. Brown, given the fact that you guys are leaders in testing inmates, what is the reaction of the inmates to the idea that they are being tested for HIV/AIDS? Is it done as part of a comprehensive examination when they come in, for example? How do you do it?

Mr. BROWN. First of all, the inmates are very receptive to it, very receptive to it. We do have the opt-out provision, as your bill calls for.

Ms. WATERS. Yes.

Mr. BROWN. Those that choose to opt out usually do it because they already know their HIV status. It is part of our routine medical screening, just as we test for tuberculosis or venereal disease, we test for HIV. And as I said, there is the opt-out provision.

Ms. WATERS. Mr. Brown, we have built-in confidentiality protections in the bill. Have you had a problem with people being exposed and being harmed in any way, similar to what has been described today?

Mr. BROWN. Well, what was described was something that happened reportedly years before the initiation of this program. No, we have not had not one single case where there has been a breach of confidentiality. As Mr. Fornaci points out, if that should happen there will be swift consequences to anyone that is guilty of that violation.

Ms. WATERS. Do you have anyone other that medical personnel that is handling medical records?

Mr. BROWN. No, only medical personnel.

Ms. WATERS. Okay.

Dr. Kendig, what is the incubation period for the HIV infection that leads to AIDS? How long does it take?

Admiral KENDIG. From the time of infection to the progression to AIDS on average is 10 years without antiretroviral therapy, on average.

Ms. WATERS. So given that you don't do routine testing, that it is only testing when it is indicated, or if there is an incident where there could have been transmission and you are trying to protect the workers there, is it possible that you could have inmates who could serve 5 or 6 years in prison and their HIV/AIDS status cannot have been detected by anybody?

Admiral KENDIG. Certainly it is possible.

I do want to emphasize, though, that we are very concerned about identifying all infected inmates upon entry to our system. Last year we tested well over 24,000 inmates.

Our clinical practice guidelines make it very clear to our clinicians they should have an extremely low threshold for testing. And so if there is any indication at all that there are risk factors for HIV acquisition, we test those inmates upon entry and we repeat-

edly go back then, because we think it is critical to get them treatment.

Ms. WATERS. Well, let us be clear. Let us be clear, because we don't want to be confused. You do not have routine testing for all inmates coming into the system?

Admiral KENDIG. Correct.

Ms. WATERS. It is only done if it is indicated, or you mentioned something about a kind of surveillance or something like that. But you don't have routine HIV/AIDS testing for inmates entering or exiting prison. Is that correct?

Admiral KENDIG. If by "routine" you mean we offer testing to every inmate, no. But we do also in addition to the testing categories you mentioned, we have testing upon request, inmate request, at any time.

Ms. WATERS. But again, we are clear, you don't have it routinely for all inmates entering or exiting. And there is this incubation period that you just described, which it is not unreasonable to believe someone could serve time in prison, 2, 3, 4, 5, 6 years, and not be detected. Is that possible?

Admiral KENDIG. It is possible.

I would just mention, with all respect, that it is also possible with opt-out. Our testing that is risk-based is mandatory. With an opt-out provision, there is also the potential that inmates that have injection drug use histories or other high-risk behaviors would also not be detected.

Ms. WATERS. Based on the question that I asked Mr. Brown about the reaction of inmates to the knowledge that they have testing available, it seems that what I am hearing is that most of the inmates want to know whether or not they are infected and they would welcome treatment and would be better positioned when they leave to manage their infection and not to infect others.

Would you agree with that?

Admiral KENDIG. I would. And that, ma'am, would certainly be our hope. We do show a videotape to all of our inmates currently where former Bureau of Prison inmates, both genders, all races, talk about their experience with HIV infection and encourage our inmates to be tested. And with this bill, we would continue to approach this with peer oriented education.

Ms. WATERS. What percentage of your inmates are actually tested? What percentage of the people ask to be tested?

Admiral KENDIG. I don't have the answer to that question.

Ms. WATERS. Describe your surveillance testing to me.

Admiral KENDIG. We have two types of surveillance testing that are permitted through our policy and rules language.

One is random testing, and that is to assess the prevalence, so it is broad-based, where we test across the Bureau of Prisons, to determine our prevalence.

Ms. WATERS. How often is that done?

Admiral KENDIG. It is done periodically.

Ms. WATERS. But no set——

Admiral KENDIG. No.

Ms. WATERS. And when was the last time?

Admiral KENDIG. In 1999.

Ms. WATERS. In 1999?

Admiral KENDIG. Yes.

Ms. WATERS. This is 2007?

Admiral KENDIG. Yes.

Ms. WATERS. That is a long time.

Admiral KENDIG. It is.

Ms. WATERS. I would like to thank Mr. Jones for coming from my hometown. And I would like to thank you for your testimony.

I am particularly interested in how you assist inmates who are exiting to be able to continue and maintain care.

Mr. JONES. We help them by putting together a pre-release health plan, and it addresses a number of issues in their lives, because oftentimes for these clients HIV is a small part of what they have to deal with. Oftentimes, they are homeless, unemployed, so on and so forth. So we help them to address all of the issues going on in their life as well as HIV.

And if they are positive, currently in L.A. County or in most of California, there is a transitional case management program. So if you are positive, you get linked on care on the outside. You get linked to a doctor, to housing in some cases.

Our programs focus people who don't know their status or have not been tested positive. We try to make sure that they stay negative, if they are negative.

Ms. WATERS. And do you have some suggestions for us? In our bill we talked about on exit the counseling, 30-day supply of medicine and referral or follow-up. Do you have some way that you can suggest we should strengthen that?

Mr. JONES. I think that it is great that you definitely include that in there, because the link from incarceration to being released is very critical, and if people are just kind of put out there into the community with no support, then it is a missed opportunity, especially because for most of the population they don't get any public health messages. So I think the fact that you are giving them the medication and the counseling, that is great.

Perhaps some education could happen for parole officers. In our experience, we have found that some parole officers don't know how to deal with that type of information. And sometimes they use it against them. And so if we can help to strengthen the support of parole officers to support those inmates, that can be helpful.

Ms. WATERS. Thank you very much.

Mr. SCOTT. Thank you.

Mr. Forbes?

Mr. FORBES. Thank you, Mr. Chairman.

I would like to echo Congresswoman Waters in thanking you all for being here, especially for your patience in putting up with us having to go back and forth today.

I support this bill and am a cosponsor of the bill, but I do want to ask some questions that I think are important for us to try to understand.

Mr. Jones, just a quick question for you, because I only have a few minutes. Did I understand you to say that you felt prisoners should have a right to have condoms?

Mr. JONES. Correct.

Mr. FORBES. Admiral, let me ask you a couple of questions too.

On this risk-based assessment, you have two population groups. One is the group of people that you would determine to have a risk assessment that would lend themselves to be testing positive for HIV. And then the other set would be obviously individuals that do not fall in that category.

As to those who have a higher risk factor, your testing right now is actually greater than the testing that would be in this bill since there is an opt-out factor. Is that fair to say?

Admiral KENDIG. I am not sure. And I agree, I don't know whether or not we will identify more inmates or fewer inmates. They are two different strategies and it is——

Mr. FORBES. I am just talking about for the risk-assessed group, that one group.

Admiral KENDIG. I think because it is mandatory we are more sure that we will be able to——

Mr. FORBES. Is there anyway you could argue that a mandatory, where you are testing everybody, would be less likely to pick it up than one with an opt-out provision?

In other words, it looks like to me, if I am testing everybody, I have got a greater net to pick up everybody than if I had a provision where I am allowing people to opt out. Am I missing something on that?

Admiral KENDIG. Correct. Correct.

Mr. SCOTT. Can they opt out now?

Mr. FORBES. I think the admiral said there is no opt-out provision for that set of people with risk assessments.

Admiral KENDIG. Correct.

Mr. FORBES. As for that other population group, the ones that you don't do the risk assessment, how much more likely are they to have HIV than the general population outside of prison?

Admiral KENDIG. First of all, I just want to clarify, everyone does get a risk assessment, regardless of their criminal history, their medical history, they get asked questions upon incarceration, and that is repeated during preventative health visits.

We have an incredibly diverse population in the Bureau of Prisons and we have a subset of inmates who really are at very, very low risk for HIV, and that has been our strategy, because of that, to go through risk-based sting. But I can't really quantify that for you.

Mr. FORBES. This isn't a trick question. I am just trying to get an answer.

You bring the entire population in, in the prisons, and you do your risk assessment for everybody as they come in.

Admiral KENDIG. Correct.

Mr. FORBES. There is a group of people that you identify and say they have a higher risk factor for having HIV than the other group. Is that correct?

Admiral KENDIG. Correct.

Mr. FORBES. As to those individuals in that set, you have mandatory testing that they cannot opt out of?

Admiral KENDIG. Correct.

Mr. FORBES. So as to that set, you have got 100 percent testing. As to the other group, the group that you did not feel met that criteria for having a higher risk assessment, how much more likely

would that group be to have HIV than the general population outside of the prison?

Admiral KENDIG. I think it would be fairly comparable. Again, we do have diverse subsets.

Mr. FORBES. I understand that. But it would be fairly comparable?

Admiral KENDIG. Yes.

Mr. FORBES. In fact, it might even be lower because outside you are going to have some people who if you did an assessment you would say they have a high risk factor for having HIV.

My point is, we don't give testing to people outside the prison for HIV on a regular basis, do we?

Admiral KENDIG. Well, the Centers for Disease Control new guidelines recommend routine care in all health care settings in this country if the prevalence is less than .1 percent.

Mr. FORBES. What about other illnesses?

Because I think one of our concerns is this—and this is a leading question. I am not saying this is what she was asking, but I heard Congresswoman Waters, maybe you just raised the question, that in a 10-year period of time somebody could go from HIV to AIDS, and I think one of our concerns is we would hate to have somebody in prison in that period of time, granted.

But there are a lot of other illnesses that I would be equally concerned about. I am thinking about colon cancer, prostate cancer, lung cancer, pancreatic cancer, all of which if you miss you may have a smaller window than 10 years. Would that be correct?

Admiral KENDIG. Correct.

Mr. FORBES. Are you doing any testing on any of those illnesses?

Admiral KENDIG. It is part of our preventative health care program. We have age-based, but this is all, again, risk-based criteria. We follow the U.S. Preventative Task Force guidelines for the most part on when to screen for chronic illnesses, like diabetes and hypertension, for cancers such as cervical cancer, breast cancer, and for any chronic infectious diseases.

So we do have published specific guidance on when to screen for all of these different infections and it is all risk-based.

Mr. FORBES. Mr. Brown, are you doing testing that is the same kind of testing on all of your inmate population that you do on HIV? Do you do that for the other illnesses, such as colon cancer, prostate cancer, pancreatic cancer, all of the ones that would have, actually, a lower window than 10 years before we may be in a terminal situation from those?

Mr. BROWN. Keep in mind, we operate a municipal detention center, not a prison. But my response is the same as the doctors. There is a risk-based criteria that we use in making those type of assessments. They are done, but there is certain criteria.

Mr. FORBES. Risk-based?

Mr. BROWN. Yes, sir.

Mr. FORBES. So HIV is the only one that you do that is not risk-based?

Mr. BROWN. No, sir.

Mr. FORBES. Oh, I am sorry.

Mr. BROWN. No, sir. In addition to HIV, when people come in our system we test for tuberculosis, we test for venereal disease. There

is a serious of contagious diseases that all prison systems, including the Bureau, would test for if it met the ACA, the American Correction Association standards.

So it is not just HIV. That is the exception, actually.

Mr. FORBES. I understand.

Last question that I would just ask, Admiral, you and Mr. Brown both, what do you have in terms of tangible evidence from individuals that you have tested, you have found that they have tested positive, how did that get us a better result? I mean, what behavioral patterns did you see change in them? How were we able to help them, treating them and those particular findings?

Could both of you just address that for us?

Mr. BROWN. Keep in mind that our testing results have indicated approximately 3 percent of our intake of 19,000 that come through our walls each year test positive for HIV.

Now, it is not just a matter of giving them pamphlets, it is not just a matter of showing a videotape. We constantly, just as you would go to your physician and while you are waiting you might see a series of health related videos on the TV, we have that.

The good congresswoman asked my colleague here what in addition would we ask to be done to improve the bill. Keep in mind, the average inmate reads at less than an 8th-grade reading level. It is not a matter of a pamphlet. You have got to bring groups in that prison and educate them constantly, not one time but constantly, keep this at the front burner, and that is what we do at the District of Columbia.

Mr. FORBES. And Admiral?

Admiral KENDIG. First of all, I hope I have shared my concern and my support for identifying people that are living with HIV infection. Unlike 10 or 15 years ago, we can provide life-saving intervention, so that is first key and paramount.

But secondly, from a prevention and infection control standpoint, it is an opportunity to counsel the inmates about safe activities as far as blood exposures with cellmates that they need to avoid and obviously participation in prohibiting behaviors such as tattooing, injection drug use or sexual contact with other inmates that could transmit the virus to others. And then also pre-release, as far as going back to live with their families and the important measures they need to take to protect their loved ones.

Mr. FORBES. Thank you all.

Thank you, Mr. Chairman.

Mr. SCOTT. Thank you.

We are going to try to complete the questioning so we don't have to keep you another half-hour.

Do you have questions, any questions?

Mr. COBLE. I was just going to apologize for my not being here, Mr. Chairman.

I want to thank the admiral for the very cooperative exchange I have had with the BOP staff. Convey my best to Harley.

I will hold my questions for later, Mr. Chairman.

Mr. SCOTT. We are not coming back.

Mr. FORBES. Now is later. [Laughter.]

Mr. Fornaci, can you say a little about the consent form you had mentioned?

Mr. FORNACI. Yes. I believe that is even the procedure that is used at the DCJ with their HIV testing. And it basically says, "Yes, I have been told that I can opt out, and I have decided not to opt out."

Mr. FORBES. How does that differ from what is in the bill?

Mr. FORNACI. Because the bill basically says we will give information, a written piece of paper that says that you can opt out. It doesn't necessarily mean anyone is ever reading it. It doesn't mean that anyone has ever acted on it. It something you stick in the person's file saying, "Yes, I know about it," and it is a little measure of control.

Mr. FORBES. And, Dr. Kendig, what services are available after someone is released from prison that tested positive?

Admiral KENDIG. Well, the Bureau of Prison's philosophy is if possible to have all inmates go to halfway houses, as a part of reentry, so we can facilitate their transition to the community services. And so optimally we would be linking inmates to HIV services through the halfway house program.

If they are a direct release, then we put together a transition care plan with their case manager and work with the social workers, particularly at our medical centers and some of our other facilities where we house large numbers of HIV-infected inmates to help with that transition plan.

Mr. FORBES. If someone tests positive, do you consider that in their placement in prisons?

Admiral KENDIG. Yes. We, several years ago, implemented a medical classification system in the Bureau of prisons, so we now actually designate inmates not just based on security needs, but based on their medical needs. We have some prisons in very remote parts of the country. We have had this occur, where we have had doctors in remote parts of the country in the community who say I have never taken care of an AIDS patient in my career.

Because of that, we are strategically designating inmates with HIV infection throughout the Bureau of Prisons——

Mr. FORBES. But that is for medical treatment, not to segregate them from the population?

Admiral KENDIG. Correct, it is for medical treatment and it is throughout our system, but there are a few remotely located prisons where we would not house HIV patients for——

Mr. FORBES. We just have a few seconds.

Ms. Waters, do you have another question?

Ms. WATERS. Yes, I wanted to be clear about what the admiral said about mandatory testing in response to Mr. Forbes' question.

When you say "mandatory," is that really mandatory? I am told that if the inmate refuses the test, that he or she is written up for refusal to obey an order. And only in the event of an exposure incident involving a guard is an inmate forced to be tested.

Admiral KENDIG. Correct. We do not do forcible testing.

Ms. WATERS. I think it is important for you to have that cleared up because I think the way you were asked the question and the way it was answered, you were led to believe that in this testing procedure, that it was mandatory.

Mr. SCOTT. That there was no opt-out.

Ms. WATERS. There was no opt-out.

Mr. FORBES. That is what I thought it was.

Admiral KENDIG. Well, I mean, it is different than opt-out. We don't tell the inmates they have an opportunity to opt out. We say it is mandatory for the sake of your health and also for prevention purposes.

Ms. WATERS. But if they choose to opt out, that is what I am describing, they can opt out?

Admiral KENDIG. With sanctions, yes.

Ms. WATERS. Well, the sanction is to be written up for refusal to obey an order.

Admiral KENDIG. Yes.

Ms. WATERS. Is that correct?

Admiral KENDIG. Yes.

Mr. FORBES. What is the sanction for that?

Admiral KENDIG. It would depend on the specific case, and they would go through a disciplinary hearing process.

Mr. FORBES. Did you indicate you tested 24,000 inmates?

Admiral KENDIG. Yes, sir.

Mr. FORBES. How many tested positive?

Admiral KENDIG. Two and one-tenth percent.

Mr. FORBES. Where did we get .1 percent from?

Admiral KENDIG. That is our diagnosed prevalence, if you take our diagnosed number of inmates and divide it by our denominator. Two and one-tenth percent is when we do risk-based testing, we identify about twice as many individuals compared to our baseline prevalence.

Mr. FORBES. Any other questions?

We want to thank you for your testimony. This has been very helpful. I would like to thank the witnesses for their testimony.

Members may have additional written questions which we will forward to you, and answer as promptly as you can in order that they may be part of the record.

Without objection, the hearing record will remain open for 1 week for submission of additional materials.

Further, without objection, the Committee stands adjourned.

[Whereupon, at 4:05 p.m., the Subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

I

110TH CONGRESS
1ST SESSION

H. R. 1199

To extend the grant program for drug-endangered children.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 27, 2007

Mr. CARDOZA (for himself, Mr. LARSEN of Washington, and Ms. HOOLEY) introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To extend the grant program for drug-endangered children.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Drug Endangered Children Act of 2007".

SEC. 2. DRUG-ENDANGERED CHILDREN GRANT PROGRAM EXTENDED.

Section 755(c) of the USA PATRIOT Improvement and Reauthorization Act of 2005 (42 U.S.C. 3797cc–2(c))

1 is amended by striking "fiscal years 2006 and 2007" and
2 inserting "fiscal years 2008 and 2009".

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I

110TH CONGRESS
1ST SESSION

H. R. 1943

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

IN THE HOUSE OF REPRESENTATIVES

APRIL 19, 2007

Ms. WATERS (for herself, Mr. CONYERS, Mr. SMITH of Texas, Mr. SCOTT of Virginia, Mr. FORBES, Ms. LEE, and Mrs. CHRISTENSEN) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Stop AIDS in Prison Act of 2007".

SEC. 2. COMPREHENSIVE HIV/AIDS POLICY.

(a) IN GENERAL.—The Bureau of Prisons (hereinafter in this Act referred to as the "Bureau") shall develop a comprehensive policy to provide HIV testing, treatment,

1 and prevention for inmates within the correctional setting
2 and upon reentry.
3 (b) PURPOSE.—The purposes of this policy shall be
4 as follows:
5 (1) To stop the spread of HIV/AIDS among in-
6 mates.
7 (2) To protect prison guards and other per-
8 sonnel from HIV/AIDS infection.
9 (3) To provide comprehensive medical treat-
10 ment to inmates who are living with HIV/AIDS.
11 (4) To promote HIV/AIDS awareness and pre-
12 vention among inmates.
13 (5) To encourage inmates to take personal re-
14 sponsibility for their health.
15 (6) To reduce the risk that inmates will trans-
16 mit HIV/AIDS to other persons in the community
17 following their release from prison.
18 (c) CONSULTATION.—The Bureau shall consult with
19 appropriate officials of the Department of Health and
20 Human Services, the Office of National Drug Control Pol-
21 icy, and the Centers for Disease Control regarding the de-
22 velopment of this policy.
23 (d) TIME LIMIT.—The Bureau shall draft appro-
24 priate regulations to implement this policy not later than
25 1 year after the date of the enactment of this Act.

SEC. 3. REQUIREMENTS FOR POLICY.

The policy created under section 2 shall do the following:

(1) TESTING AND COUNSELING UPON INTAKE.—

(A) Medical personnel shall provide routine HIV testing to all inmates as a part of a comprehensive medical examination immediately following admission to a facility. (Medical personnel need not provide routine HIV testing to an inmate who is transferred to a facility from another facility if the inmate's medical records are transferred with the inmate and indicate that the inmate has been tested previously.)

(B) To all inmates admitted to a facility prior to the effective date of this policy, medical personnel shall provide routine HIV testing within no more than 6 months. HIV testing for these inmates may be performed in conjunction with other health services provided to these inmates by medical personnel.

(C) All HIV tests under this paragraph shall comply with paragraph (9).

(2) PRE-TEST AND POST-TEST COUNSELING.—Medical personnel shall provide confidential pre-test and post-test counseling to all inmates who are test-

1 ed for HIV. Counseling may be included with other
2 general health counseling provided to inmates by
3 medical personnel.
4 (3) HIV/AIDS PREVENTION EDUCATION.—
5 (A) Medical personnel shall improve HIV/
6 AIDS awareness through frequent educational
7 programs for all inmates. HIV/AIDS edu-
8 cational programs may be provided by commu-
9 nity based organizations, local health depart-
10 ments, and inmate peer educators. These HIV/
11 AIDS educational programs shall include infor-
12 mation on modes of transmission, including
13 transmission through tattooing, sexual contact,
14 and intravenous drug use; prevention methods;
15 treatment; and disease progression. HIV/AIDS
16 educational programs shall be culturally sen-
17 sitive, conducted in a variety of languages, and
18 present scientifically accurate information in a
19 clear and understandable manner.
20 (B) HIV/AIDS educational materials shall
21 be made available to all inmates at orientation,
22 at health care clinics, at regular educational
23 programs, and prior to release. Both written
24 and audio-visual materials shall be made avail-
25 able to all inmates. These materials shall be

1 culturally sensitive, written for low literacy lev-
2 els, and available in a variety of languages.
3 (4) HIV TESTING UPON REQUEST.—
4 (A) Medical personnel shall allow inmates
5 to obtain HIV tests upon request once per year
6 or whenever an inmate has a reason to believe
7 the inmate may have been exposed to HIV.
8 Medical personnel shall, both orally and in writ-
9 ing, inform inmates, during orientation and pe-
10 riodically throughout incarceration, of their
11 right to obtain HIV tests.
12 (B) Medical personnel shall encourage in-
13 mates to request HIV tests if the inmate is sex-
14 ually active, has been raped, uses intravenous
15 drugs, receives a tattoo, or if the inmate is con-
16 cerned that the inmate may have been exposed
17 to HIV/AIDS.
18 (C) An inmate's request for an HIV test
19 shall not be considered an indication that the
20 inmate has put him/herself at risk of infection
21 and/or committed a violation of prison rules.
22 (5) HIV TESTING OF PREGNANT WOMAN.—
23 (A) Medical personnel shall provide routine
24 HIV testing to all inmates who become preg-
25 nant.

1 (B) All HIV tests under this paragraph
2 shall comply with paragraph (9).
3 (6) COMPREHENSIVE TREATMENT.—
4 (A) Medical personnel shall provide all in-
5 mates who test positive for HIV—
6 (i) timely, comprehensive medical
7 treatment;
8 (ii) confidential counseling on man-
9 aging their medical condition and pre-
10 venting its transmission to other persons;
11 and
12 (iii) voluntary partner notification
13 services.
14 (B) Medical care provided under this para-
15 graph shall be consistent with current Depart-
16 ment of Health and Human Services guidelines
17 and standard medical practice. Medical per-
18 sonnel shall discuss treatment options, the im-
19 portance of adherence to antiretroviral therapy,
20 and the side effects of medications with inmates
21 receiving treatment.
22 (C) Medical and pharmacy personnel shall
23 ensure that the facility formulary contains all
24 Food and Drug Administration-approved medi-
25 cations necessary to provide comprehensive

1 treatment for inmates living with HIV/AIDS,
2 and that the facility maintains adequate sup-
3 plies of such medications to meet inmates' med-
4 ical needs. Medical and pharmacy personnel
5 shall also develop and implement automatic re-
6 newal systems for these medications to prevent
7 interruptions in care.
8 (D) Correctional staff and medical and
9 pharmacy personnel shall develop and imple-
10 ment distribution procedures to ensure timely
11 and confidential access to medications.
12 (7) PROTECTION OF CONFIDENTIALITY.—
13 (A) Medical personnel shall develop and
14 implement procedures to ensure the confiden-
15 tiality of inmate tests, diagnoses, and treat-
16 ment. Medical personnel and correctional staff
17 shall receive regular training on the implemen-
18 tation of these procedures. Penalties for viola-
19 tions of inmate confidentiality by medical per-
20 sonnel or correctional staff shall be specified
21 and strictly enforced.
22 (B) HIV testing, counseling, and treat-
23 ment shall be provided in a confidential setting
24 where other routine health services are provided
25 and in a manner that allows the inmate to re-

1 quest and obtain these services as routine med-
2 ical services.
3 (8) TESTING, COUNSELING, AND REFERRAL
4 PRIOR TO REENTRY.—
5 (A) Medical personnel shall provide routine
6 HIV testing to all inmates no more than 3
7 months prior to their release and reentry into
8 the community. (Inmates who are already
9 known to be infected need not be tested again.)
10 This requirement may be waived if an inmate's
11 release occurs without sufficient notice to the
12 Bureau to allow medical personnel to perform a
13 routine HIV test and notify the inmate of the
14 results.
15 (B) All HIV tests under this paragraph
16 shall comply with paragraph (9).
17 (C) To all inmates who test positive for
18 HIV and all inmates who already are known to
19 have HIV/AIDS, medical personnel shall pro-
20 vide—
21 (i) confidential prerelease counseling
22 on managing their medical condition in the
23 community, accessing appropriate treat-
24 ment and services in the community, and
25 preventing the transmission of their condi-

1 tion to family members and other persons
2 in the community;
3 (ii) referrals to appropriate health
4 care providers and social service agencies
5 in the community that meet the inmate's
6 individual needs, including voluntary part-
7 ner notification services and prevention
8 counseling services for people living with
9 HIV/AIDS; and
10 (iii) a 30-day supply of any medically
11 necessary medications the inmate is cur-
12 rently receiving.
13 (9) OPT-OUT PROVISION.—Inmates shall have
14 the right to refuse routine HIV testing. Inmates
15 shall be informed both orally and in writing of this
16 right. Oral and written disclosure of this right may
17 be included with other general health information
18 and counseling provided to inmates by medical per-
19 sonnel. If an inmate refuses a routine test for HIV,
20 medical personnel shall make a note of the inmate's
21 refusal in the inmate's confidential medical records.
22 However, the inmate's refusal shall not be consid-
23 ered a violation of prison rules or result in discipli-
24 nary action.

1 (10) EXPOSURE INCIDENT TESTING.—The Bu-
2 reau may perform HIV testing of an inmate under
3 section 4014 of title 18, United States Code. HIV
4 testing of an inmate who is involved in an exposure
5 incident is not "routine HIV testing" for the pur-
6 poses of paragraph (9) and does not require the in-
7 mate's consent. Medical personnel shall document
8 the reason for exposure incident testing in the in-
9 mate's confidential medical records.
10 (11) TIMELY NOTIFICATION OF TEST RE-
11 SULTS.—Medical personnel shall provide timely noti-
12 fication to inmates of the results of HIV tests.
13 **SEC. 4. CHANGES IN EXISTING LAW.**
14 (a) SCREENING IN GENERAL.—Section 4014(a) of
15 title 18, United States Code, is amended—
16 (1) by striking "for a period of 6 months or
17 more";
18 (2) by striking ", as appropriate,"; and
19 (3) by striking "if such individual is determined
20 to be at risk for infection with such virus in accord-
21 ance with the guidelines issued by the Bureau of
22 Prisons relating to infectious disease management"
23 and inserting "unless the individual declines. The
24 Attorney General shall also cause such individual to

be so tested before release unless the individual declines.".

(b) INADMISSIBILITY OF HIV TEST RESULTS IN CIVIL AND CRIMINAL PROCEEDINGS.—Section 4014(d) of title 18, United States Code, is amended by inserting "or under the Stop AIDS in Prison Act of 2007" after "under this section".

(c) SCREENING AS PART OF ROUTINE SCREENING.—Section 4014(e) of title 18, United States Code, is amended by adding at the end the following: "Such rules shall also provide that the initial test under this section be performed as part of the routine health screening conducted at intake.".

SEC. 5. REPORTING REQUIREMENTS.

(a) REPORT ON HEPATITIS AND OTHER DISEASES.—Not later than 1 year after the date of the enactment of this Act, the Bureau shall provide a report to the Congress on Bureau policies and procedures to provide testing, treatment, and prevention education programs for Hepatitis and other diseases transmitted through sexual activity and intravenous drug use. The Bureau shall consult with appropriate officials of the Department of Health and Human Services, the Office of National Drug Control Policy, and the Centers for Disease Control regarding the development of this report.

1 (b) ANNUAL REPORTS.—

2 (1) GENERALLY.—Not later than 2 years after
3 the date of the enactment of this Act, and then an-
4 nually thereafter, the Bureau shall report to Con-
5 gress on the incidence among inmates of diseases
6 transmitted through sexual activity and intravenous
7 drug use.

8 (2) MATTERS PERTAINING TO VARIOUS DIS-
9 EASES.—Reports under paragraph (1) shall dis-
10 cuss—

11 (A) the incidence among inmates of HIV/
12 AIDS, Hepatitis, and other diseases trans-
13 mitted through sexual activity and intravenous
14 drug use; and

15 (B) updates on Bureau testing, treatment,
16 and prevention education programs for these
17 diseases.

18 (3) MATTERS PERTAINING TO HIV/AIDS
19 ONLY.—Reports under paragraph (1) shall also in-
20 clude—

21 (A) the number of inmates who tested
22 positive for HIV upon intake;

23 (B) the number of inmates who tested
24 positive prior to reentry;

(C) the number of inmates who were not tested prior to reentry because they were released without sufficient notice;

(D) the number of inmates who opted-out of taking the test;

(E) the number of inmates who were tested following exposure incidents; and

(F) the number of inmates under treatment for HIV/AIDS.

(4) CONSULTATION.—The Bureau shall consult with appropriate officials of the Department of Health and Human Services, the Office of National Drug Control Policy, and the Centers for Disease Control regarding the development of reports under paragraph (1).

SEC. 6. APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out this Act.

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I

110TH CONGRESS
1ST SESSION

H. R. 545

To amend the Omnibus Crime Control and Safe Streets Act of 1968 to clarify that territories and Indian tribes are eligible to receive grants for confronting the use of methamphetamine.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 17, 2007

Mr. UDALL of New Mexico (for himself and Mr. KILDEE) introduced the following bill; which was referred to the Committee on the Judiciary, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Omnibus Crime Control and Safe Streets Act of 1968 to clarify that territories and Indian tribes are eligible to receive grants for confronting the use of methamphetamine.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Native American Methamphetamine Enforcement and Treatment Act of 2007".

SEC. 2. NATIVE AMERICAN PARTICIPATION IN METHAMPHETAMINE GRANTS.

(a) IN GENERAL.—Section 2996(a) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797cc(a)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by inserting ", territories, and Indian tribes (as defined in section 2704)" after "to assist States"; and

(B) in subparagraph (B), by striking "and local" and inserting ", territorial, Tribal, and local";

(2) in paragraph (2), by inserting ", territories, and Indian tribes" after "make grants to States"; and

(3) in paragraph (3)(C), by inserting ", Tribal," after "support State".

(b) GRANT PROGRAMS FOR DRUG ENDANGERED CHILDREN.—Section 755(a) of the USA PATRIOT Improvement and Reauthorization Act of 2005 (42 U.S.C. 3797cc–2(a)) is amended by inserting ", territories, and Indian tribes (as defined in section 2704 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797d))" after "make grants to States".

(c) GRANT PROGRAMS TO ADDRESS METHAMPHETAMINE USE BY PREGNANT AND PARENTING WOMEN OFFENDERS.—Section 756 of the USA PATRIOT Improvement and Reauthorization Act of 2005 (42 U.S.C. 3797cc–3) is amended—

(1) in subsection (a)(2), by inserting ", territorial, or Tribal" after "State";

(2) in subsection (b)—

(A) in paragraph (1)—

(i) by inserting ", territorial, or Tribal" after "State"; and

(ii) by striking "and/or" and inserting "or";

(B) in paragraph (2)—

(i) by inserting ", territory, Indian tribe," after "agency of the State"; and

(ii) by inserting ", territory, Indian tribe," after "criminal laws of that State"; and

(C) by adding at the end the following:

"(3) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given the term in section 2704 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797d)).."; and

(3) in subsection (c)—

(A) in paragraph (3), by striking "Indian Tribes" and inserting "Indian tribes"; and

(B) in paragraph (4)—

(i) in the matter preceding subparagraph (A)—

(I) by striking "State's services" and inserting "services of the State, territory, or Indian tribe"; and

(II) by striking "and/or" and inserting "or";

(ii) in subparagraph (A), by striking "State";

(iii) in subparagraph (C), by inserting ", Indian tribes," after "involved counties"; and

(iv) in subparagraph (D), by inserting ", tribal" after "Federal, State".

○

PREPARED STATEMENT OF THE HONORABLE MAXINE WATERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND MEMBER, SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

I would like to thank Chairman Bobby Scott and Ranking Member Randy Forbes for organizing this hearing on H.R. 1943, The "Stop AIDS in Prison Act," which I introduced last month. I would also like to thank both of them, as well as Judiciary Committee Chairman John Conyers and Ranking Member Lamar Smith, for all of their recommendations and assistance in drafting this bill.

HIV/AIDS IN AMERICA

Twenty-five years after AIDS was discovered, the AIDS virus continues to spread. About 1.7 million Americans have been infected by HIV since the beginning of the epidemic, and there are 1.2 million Americans living with HIV/AIDS today. Every year, there are 40,000 new HIV infections and 17,000 new AIDS-related deaths in the United States.

HIV/AIDS is spreading especially rapidly among women and racial minorities. In 1985, women accounted for a mere 8% of new AIDS cases; by 2005 they accounted for 27%. In 1985, Hispanic Americans accounted for only 15% of new AIDS cases; by 2005 they accounted for 25%. In 1985, African Americans accounted for a quarter of new AIDS cases; by 2005 they accounted for half. African American women account for an astonishing 67% of new AIDS cases among women, and over 70% of new AIDS cases overall are found among people of color.

HIV/AIDS IN AMERICAN PRISONS

HIV/AIDS is also spreading in our nation's jails and prisons. In 2005, the Department of Justice reported that the rate of confirmed AIDS cases in prisons was three times higher than in the general population. The Department of Justice also reported that 2.0% of State prison inmates and 1.1% of Federal prison inmates were known to be living with HIV/AIDS in 2003.

However, the actual rate of HIV infection in our nation's prisons is unknown because prison officials do not consistently test prisoners for HIV. There is little knowledge about the lifestyles of those who enter our nation's prisons, and there is usually no official acknowledgement that sexual activity—whether consensual or otherwise—is taking place in prisons. The only way to determine whether HIV is being spread among prisoners is to begin routine testing. Furthermore, if prison inmates are exposed to HIV in prison and then complete their sentences and return to society without knowing their HIV status, they could infect their spouse or other persons in their community.

While we don't know the rate of HIV infection in Federal prisons, we do know that racial minorities have high incarceration rates. According to Department of Justice statistics, 40% of Federal prison inmates in 2003 were black and 32% were Hispanic. So if prisoners leave prison with HIV/AIDS and don't know it, the virus will continue to spread among minority communities.

THE IMPORTANCE OF HIV SCREENING

HIV screening is essential to stop the spread of AIDS. About one quarter of the people living with HIV/AIDS in the United States do not know they are infected. The Centers for Disease Control and Prevention (CDC) reports that many infected persons decrease behaviors that transmit the AIDS virus to sex or needle-sharing partners once they find out about their infection. The CDC theorizes that sexually transmitted HIV infections could be reduced by more than 30% per year if all HIV-infected persons found out about their infection and changed their behavior in a manner comparable to those who already know of their infection. When people know their HIV status, they are more likely to act responsibly—to protect their partners and themselves.

On September 21, 2006, the CDC published new guidelines for HIV screening in health care settings. These guidelines recommend routine HIV screening for all patients between the ages of 13 and 64, regardless of risk factors, under an "opt-out approach," in which patients are notified that an HIV test will be included in their routine health care and they can refuse to take the test. However, separate written consent for the HIV test is not required. Instead, consent for an HIV test can be included in the general consent for medical care.

The CDC's new guidelines are an expansion of the CDC's guidelines for HIV screening of pregnant women, which were issued in 2001. The 2001 guidelines recommended routine HIV screening for all pregnant women using an opt-out approach. The 2001 guidelines led to a dramatic 95% decline in perinatal AIDS cases.

DESCRIPTION OF THE LEGISLATION

The "Stop AIDS in Prison Act" would require the Federal Bureau of Prisons to develop a comprehensive policy to provide HIV testing, treatment and prevention for inmates in Federal prisons. This bill requires the Federal Bureau of Prisons to test all Federal prison inmates for HIV upon entering prison and again prior to release from prison, unless the inmate opts-out of taking the test. The bill also requires HIV/AIDS prevention education for all inmates and comprehensive treatment for those inmates who test positive for HIV. This bill has 28 cosponsors and bipartisan support.

CRITICISM OF THE LEGISLATION

The legislation I introduced may be considered controversial by some people. There is a large and diverse group of stakeholders involved in HIV/AIDS policy debates, including HIV/AIDS advocacy organizations, gay and lesbian organizations, civil rights groups, churches and religious groups, the medical community, and even the entertainment industry. Everyone involved in these policy debates shares the same goal: the prevention and eradication of HIV and AIDS, but not everyone agrees on the most effective ways to accomplish this goal.

One common concern that has been expressed about the "Stop AIDS in Prison Act" is that the bill does not require the Bureau of Prisons to obtain separate written consent from prisoners prior to an HIV test. I believe that requiring separate written consent as a pre-condition for an HIV test would defeat one of the main purposes of the bill, namely to help prisoners find out if they have HIV. Prisoners already have the right to obtain an HIV test upon request if they believe they are at risk. My bill would enable prisoners who do not know they are at risk to find out if they are infected.

My bill does give inmates the right to "opt-out" or refuse routine HIV testing, and it requires the Bureau of Prisons to inform inmates both orally and in writing of this right. The claim that separate written consent should be required for HIV tests within Federal prisons is especially ironic, given the fact that the Bureau of Prisons' current procedures do not allow prisoners to opt-out of an HIV test. Prisoners who refuse an HIV test are written up for refusal to obey an order and could face disciplinary action. Under the bill, prisoners could refuse an HIV test without fear of disciplinary action. Nevertheless, I would be pleased to work with concerned individuals to ensure that the opt-out language is effective at protecting prisoners' rights.

SUPPORT FOR THE LEGISLATION

I am honored that several prominent HIV/AIDS advocacy organizations are supporting the "Stop AIDS in Prison Act." These include AIDS Action, The AIDS Institute, the National Minority AIDS Council, and the AIDS Healthcare Foundation. The bill also has been endorsed by the Los Angeles County Board of Supervisors. I request unanimous consent to submit letters and statements of support for inclusion in the hearing record.

CONCLUSION

I firmly believe that the "Stop AIDS in Prison Act" will help stop the spread of HIV/AIDS among prison inmates, encourage them to take personal responsibility for their health, and reduce the risk that they will transmit HIV/AIDS to other persons in the community following their release from prison. I look forward to hearing the testimony of the witnesses on how this legislation would contribute to our nation's efforts to stop the spread of AIDS and provide effective, compassionate care to people who are living with HIV.

WASHINGTON LEGISLATIVE OFFICE
Caroline Fredrickson
Director

915 15th Street, NW Washington, D.C. 20005

(202) 544-1681 Fax (202) 546-0738

May 18, 2007

The Honorable Robert C. Scott
Chair, Subcommittee on Crime, Terrorism, and Homeland Security
House Judiciary Committee
Washington, D.C. 20515

Re: H.R. 1943, the Stop AIDS in Prison Act of 2007, which lacks important protections for Persons with HIV/AIDS.

Dear Chairman Scott,

On behalf of the American Civil Liberties Union, a non-partisan organization with hundreds of thousands of activists and members and 53 affiliates nationwide, we write to express our serious concerns about H.R.1943, the Stop AIDS in Prison Act of 2007 ("Stop AIDS in Prison Act") and encourage you not to move forward with a mark up of the bill until these concerns are addressed. The ACLU strongly supports efforts to make routine HIV testing and effective HIV/AIDS programming available in federal prisons. While this legislation attempts to establish a routine testing systems for incarcerated persons in the Federal Bureau of Prisons, it actually could result in prisoners being tested involuntarily and test results not being kept confidential.

The Bill Does Not Specify Which Inmates Are Tested and Could Severely Endanger the Health of Short-Term Prisoners and their Partners

The bill does not specify which inmates are subject to its testing provisions, and could end up endangering the health of short-term prisoners and their partners. When Congress enacted the Corrections Officers Health and Safety Act of 1998, 18 U.S.C.A. 4014, it limited its provisions to persons "sentenced to incarceration for a period of 6 months or more." By contrast, the new bill deletes the six-months sentence provision from the Corrections Officers Health and Safety Act and then creates an entirely new additional testing scheme without specifying to whom it applies.

As a result, the bill would impose on the Bureau of Prisons testing, counseling, and treatment requirements on presumably all persons in its custody, which could include persons under arrest but not charged, persons charged but not sentenced, persons serving sentences as short as a few days, federal prisoners incarcerated in state facilities, and state prisoners incarcerated in federal facilities. In addition to the obvious impact on BOP medical services, the lack of specification on who must be

tested will mean that HIV prevention and treatment resources will not be focused on those most in need of help.

The bill could also have a severe impact on public health. The legislation requires the routine testing of all inmates and pharmaceutical care--including a 30-day post-release supply of pharmaceuticals--to anyone testing HIV-positive. The ACLU urges the Subcommittee to obtain the advice of public health officials on the public health impact of providing short-term pharmaceuticals to short-term inmates. Our understanding of current HIV medicine is that, placing an HIV-positive person on short-term use of pharmaceuticals creates a significant risk of the person developing drug-resistant HIV, which may be passed on to a partner. The potentially enormous public health consequences of short-term use of pharmaceuticals was one of the reasons that Congress limited the provisions of the Corrections Officers Health and Safety Act of 1998 to persons serving federal sentences of at least six months.

"Rontine" Testing That Does Not Require Written Informed Consent Could Result in Prisoners Being Tested Involuntarily.

Written informed consent represents an important aspect of patient autonomy. The only method to ensure that "routine" testing can be informed and consensual is by providing prisoners an opportunity to give written consent to testing. Written informed consent is even more important in light of the growing prison population and the prevalence of HIV/AIDS within the prison system.

Written informed consent also ensures prisoners are informed of the limits to their medical privacy. Obtaining written consent before administering a HIV test encourages a patient to ask questions and to have a dialogue with his or her health provider about the nature of HIV/AIDS, how the disease was transmitted, and how to effectively avoid acquiring the disease. In addition without a signed informed consent form, it is difficult for medical personnel to prove that a patient actually consented to HIV testing.

The Legislation Does Not Adequately Protect Confidentiality of Test Results.

The legislation's confidentiality provisions are not strong enough and at a minimum, the privacy provisions of the Corrections Officers Health and Safety Act, 18 USC 4014(e), should be included in the bill. Individuals who test positive for HIV while incarcerated face additional negative consequences that merit increased confidentiality. HIV-positive prisoners whose status is not kept confidential may face discrimination and threats from guards and other prisoners, may be segregated from other prisoners and may be denied access to prison and jail jobs and activities. Many proponents of mandatory testing underestimate the stigma and harms that continue to afflict the HIV-positive population. A 2005 study of HIV screening in the Annals of Internal Medicine described the persistence of stigma and discrimination experienced by people who are HIV-positive:

> Positive HIV test results are associated with important harms, including fears of rejection, abandonment, verbal abuse and physical assault. A substantial proportion of Americans (20% to 25%) continue to agree with stigmatizing

statements about HIV. Four percent of 142 patients recently diagnosed with HIV infection reported losing a job because of their status, 1% had been asked to move, and 1% had been assaulted.

A 2006 Kaiser Family Foundation Survey of Americans on HIV/AIDS concluded that a great deal of misinformation still exists about HIV/AIDS. The study found 37% of Americans believe that HIV is transmissible through a kiss; 22% believe that it is transmissible by sharing a drinking glass, and 16% believe that it is transmissible by touching a toilet seat.

Moreover, getting an HIV test is not the same as getting a cholesterol test. When a patient finds out that he or she is HIV positive, it is a life-altering event, as HIV treatment generally requires a commitment to a life-long and complicated treatment regime. Moreover, families and friends unfortunately are sometimes unsupportive when a patient learns that he or she is HIV positive. Thus having robust confidentiality provisions that protects the privacy of prisoners who are HIV positive is vital to their safety and well-being.

Requiring Testing after "Exposure Incidents" Undermines the Concept of Routine HIV/AIDS Testing.

The current proposed legislation, which authorizes forcible testing when an inmate is involved in an exposure incident, undermines the entire concept of routine testing. This provision of the bill is inconsistent with the Centers for Disease Control and Prevention (CDC) September 2006 Guidelines[1], which emphasize that all HIV testing must be voluntary. The CDC does not recommend administering HIV tests against the person's will.

The World Health Organization has concluded that mandatory testing policies are often inefficient uses of prison resources, diverting funding and staff from other, more effective prevention efforts.[2] Other requirements of H.R. 1943 such as pre-test counseling, education about HIV transmission and risk reduction, and counseling about the consequences of a positive test result are essential for ensuring that prisoners will understand their health care treatment options. Institutional consequences often result from a positive HIV test result, such as segregation in some states, loss of access to programs, visitation, and jobs. Instituting mandatory HIV testing after a possible exposure incident could deter prisoners from coming forward for needed health services.

Other Provisions of the Bill Endanger Health or Confidentiality

Previous sections of this letter highlight the most significant problems with the bill. However, there are other problems that should be corrected before being reported out of Subcommittee, including:

---

[1] CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings (September 2006).

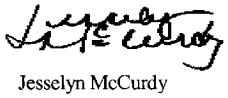
[2] World Health Organization, *HIV in Prisons, 2001*, at 53.

In paragraph 3(1)(A), it is unclear whether the provision requires all inmates to receive a comprehensive medical examination that includes an optional HIV test, or whether it merely requires an HIV test to be offered if there happens to be a comprehensive medical examination. Paragraphs 3(3)(A) and 3(3)(B) should both include a requirement that the programs or materials be "fully consistent with CDC HIV preventions guidelines" and "present scientifically accurate information in a clear and understandable manner" (which does not appear in 3(3)(B)).

Subsection 4(a) should be revised to strike 18 USCA 4014(a) in its entirety. The new bill sets up an entirely new testing scheme for all inmates and should fully replace the entry testing provisions. The revisions made in subsection 4(a) will mean that inmates in BOP custody would be subject to entry HIV tests under both the 1998 law and this new bill.

Any legislative change to the HIV testing policy must maintain the important patient protections that safeguard individual liberty and autonomy. **Although we have serious concerns with this legislation in its current form, we look forward to working with you to improve the bill and provide additional protections for HIV positive prisoners.**

Sincerely,



Caroline Fredrickson
Director

Jesselyn McCurdy
Legislative Counsel

NEWS RELEASE

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AIDS Action Council Vows to Work with Congress Toward Passing Stop AIDS in Prison Act of 2007

WASHINGTON, May 22, 2007 – AIDS Action Council underscored its support of the Stop AIDS in Prison Act of 2007 today at a hearing of the Crime, Terrorism and Homeland Security Subcommittee of the House Judiciary Committee. The bill filed by Rep. Maxine Waters (D-CA) in April would provide routine non-mandatory (opt out) HIV counseling and testing at entry and release from federal prisons and allow inmates to request an HIV test while ensuring that they would not be penalized by prison officials for making that request. AIDS Action vowed to work with Congress toward passage of the bill on behalf of its diverse nationwide membership of community-based HIV/AIDS service providers and public health departments.

The rate of confirmed AIDS cases is three times higher among prison inmates than in the U.S. general population, according to the U.S. Department of Justice Bureau of Justice Statistics Bulletin most recently revised on March 1, 2007, including data through 2004, the most recently compiled data.

"This important bill recognizes and addresses the HIV epidemic within federal prisons and the public health threat it poses to our nation," said Rebecca Haag, Executive Director, AIDS Action Council. "This bill, which seeks to stop the spread of HIV in prisons and the community through counseling, testing and treatment of inmates, is an essential piece of legislation. It will help prevent new infections as well as ensure treatment for a large number of people currently living with HIV by protecting prisoners' rights and ensuring that best practices in HIV testing and treatment are followed," she added.

AIDS Action commits to maintain its work with legislators to prioritize the needs of people living with HIV by making life-saving drugs, medical treatment, and essential support services available to all who are HIV infected, and to highlight the importance of HIV prevention. More than 250,000 people in the U.S. know they are infected with HIV but do not have access to HIV care, and an additional 250,000 – 300,000 people in the U.S. are infected with HIV but are unaware of their positive status.

"As many as 1.2 million people are living with HIV/AIDS in the United States; we can best help them by making sure they receive quality care and treatment, including people who are incarcerated," Haag said.

AIDS Action strives to end the HIV epidemic by advancing public policies that prevent new infections, provide care for people living with HIV, and support the search for a cure. AIDS Action serves as the national voice for AIDS service organizations, health departments, and a diverse network of community-based organizations across the U.S. that provides services for people living with or affected by HIV infection.

THE AIDS INSTITUTE

For Immediate Release: 4.19.07

National Office - Washington, DC: 202-835-8373
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Media Contact: Jamila Taylor, (202) 835-8373, **JTaylor@theaidsinstitute.org**

THE AIDS INSTITUTE COMMENDS CONGRESSWOMAN MAXINE WATERS FOR THE *STOP AIDS IN PRISONS ACT OF 2007*

In 2004, the U.S. Department of Justice reported that HIV/AIDS prevalence among U.S. prisoners was three times that of the general population. HIV transmission in prisons has gone virtually unaddressed by federal lawmakers until recent years. Congresswoman Maxine Waters will introduce a bipartisan bill that includes the partnership of other senior members of the House Judiciary Committee. Current cosponsors include Representatives John Conyers (D-MI), Lamar Smith (R-TX), Robert C. Scott (D-VA), and Randy Forbes (R-VA).

The *Stop AIDS in Prisons Act of 2007* will provide routine, opt-out HIV testing to all inmates with pre and post-test counseling. All inmates who test positive for HIV/AIDS will receive comprehensive medical treatment. Another important component of the legislation is the provision that inmates may request an HIV test without being penalized for a violation of prison rules. Due to the fact that minorities are overrepresented in the prison population and are disproportionately affected by HIV/AIDS, this bill will help to eradicate the spread of transmission among this population.

###

For more information and to become involved in AIDS advocacy work, please contact
The AIDS Institute at: (202) 835-8373, or by email at: Info@theaidsinstitute.org or www.TheAIDSInstitute.org
The AIDS Institute is a national nonprofit agency that promotes action for social change through public policy research, advocacy and education.

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Congresswoman Maxine Waters Tackles HIV/AIDS Is Proposed Legislation

Congresw

By Dennis J. Freeman

First Published: 4/23/2007

Page 1 c

[Email This Article To a Friend]

LOS ANGELES -- Congresswoman **Maxine Waters** said she wants in companies to cover the cost of HIV testing and testing for federal priso they arrive and when they leave the penal institutions.

"We will ensure that your confidentiality is respected," said Waters, D-("What we're saying is...just offer it. Just do it. We believe that when yo kind of testing, not only will you catch HIV/AIDS, but you can get peopl the kinds of medicines that they need in order to have long and healthy

Waters said she realizes the bills are among the most controversial tha drafted related to HIV testing and funding for HIV/AIDS clients.

The insurance bill (H.R. 822) would require insurance companies to pa testing in the same way they cover the cost of diabetes testing.

H.R. 1943, the Stop AIDS in Prison Act of 2007, calls for mandatory HI testing for all inmates arriving and exiting a federal correctional facility. others introduced a similar bill (H.R. 6038, Stop AIDS in Prison Act of 2 fall.

Waters efforts are a response to the growing impact HIV/AIDS is havin

minority communities. According to the Centers for Disease Control an Prevention, African Americans account for half of all new HIV/AIDS cas and ethnic minorities comprise 69 percent of new cases, according to t data released by the CDC. According to the Bureau of Justice Statistic Americans made up 41 percent of all inmates in the prison system at th 2004.

"Congresswoman Waters always has been an unapologetic advocate f AIDS in black communities," said **Phill Wilson**, executive director of th AIDS Institute. "AIDS in America today is a black disease. Current func and HIV policies are not keeping up with the reality of AIDS in Black Ar Black AIDS Institute supports Congresswoman Waters' call for additior for HIV awareness, prevention and treatment; we welcome her leaders ways to think about HIV policies in the United States."

By enacting this bill, Waters said she hopes that the spread of HIV/AID inmates will be curbed. The congresswoman added that the bill would comprehensive and timely medical treatment to those incarcerated. It's designed to promote HIV/AIDS awareness and prevention, she said.

Although some state prisons require routine HIV testing among inmate provide treatment access, federal prisons currently do not, according tc *HealthBeat*.

Original cosponsors of the Stop AIDS in Prison Act include Rep. **John** Mich., Chairman of the House Judiciary Committee; Rep. **Lamar S. Sn** Texas, Ranking Member of the House Judiciary Committee; Rep. **Rob** D-Va., Chairman of the Judiciary Subcommittee on Crime, Terrorism, a Homeland Security, which has jurisdiction over federal prisons; and Re **Forbes, R-Va.**, Ranking Member of that subcommittee. Waters is also Congress for an additional $610 million for the Minority AIDS Initiative separate proposal.

Dennis J. Freeman is a freelance writer and the Black AIDS Institute's public relations specialist.
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HIV/AIDS and African Americans

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Fact Sheet: HIV/AIDS among African Americans

View PDF

January 2007

In the United States, the HIV/AIDS epidemic is a health crisis for African Americans. At all stages of HIV/AIDS—from infection with HIV to death with AIDS—blacks (including African Americans) are disproportionately affected compared with members of other races and ethnicities [1, 2].

STATISTICS

HIV/AIDS in 2005

- According to the 2000 census, blacks make up approximately 13% of the US population. However, in 2005, blacks accounted for 18,51[illegible] (49%) of the estimated 38,096 new HIV/AIDS diagnoses in the United States in the 33 states with long-term, confidential name-based HIV reporting [2].*
- Of all black men living with HIV/AIDS, the primary transmission category was sexual contact with other men, followed by injection drug use and high-risk heterosexual contact [2].
- Of all black women living with HIV/AIDS, the primary transmission category was high-risk heterosexual contact, followed by injection drug use [2].
- Of the estimated 141 infants perinatally infected with HIV, 91 (65%) were black (CDC, HIV/AIDS Reporting System, unpublished data, December 2006).
- Of the estimated 18,849 people under the age of 25 whose diagnosis of HIV/AIDS was made during 2001–2004 in the 33 states with HIV reporting, 11,554 (61%) were black [3].

*See the box (before the References section) labeled Understanding HIV and AIDS Data for a list of the 33 states.

Race/ethnicity of persons (including children) with HIV/AIDS diagnosed during 2005

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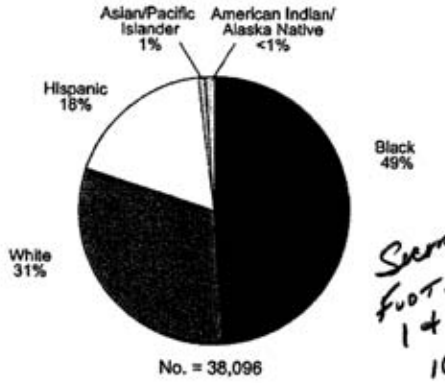

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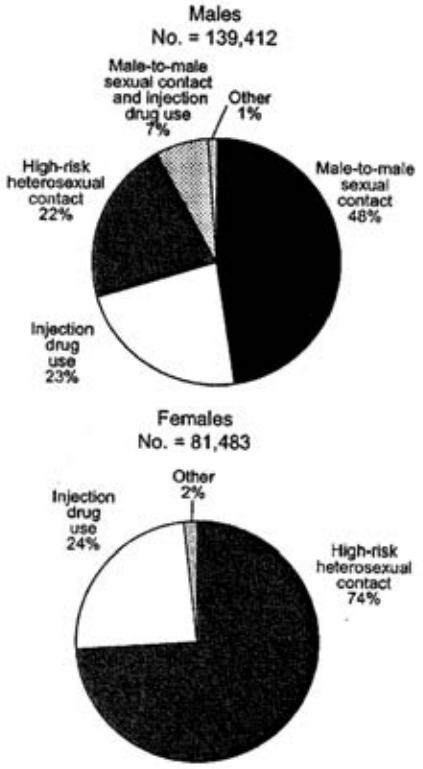
Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

Transmission categories for black adults and adolescents living with HIV/AIDS at the end of 2005



Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

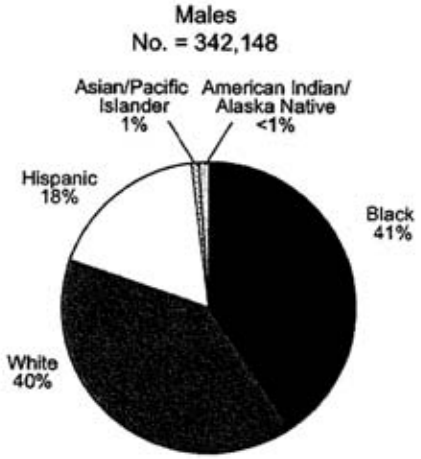
AIDS in 2005

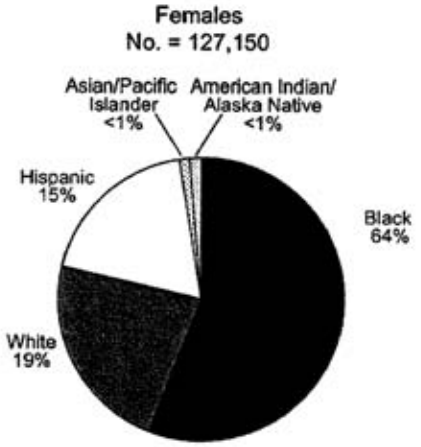
- Blacks accounted for 22,030 (50%) of the estimated 44,198 AIDS cases diagnosed in the 50 states and the District of Columbia [2].
- The rate of AIDS diagnoses for black adults and adolescents was 10 times the rate for whites and nearly 3 times the rate for Hispanics. The rate of AIDS diagnoses for black women was nearly 24 times the rate for white women. The rate of AIDS diagnoses for black men was 8 times the rate for white men [2].
- The 188,077 blacks living with AIDS in the 50 states and

the District of Columbia accounted for 44% of the 425,910 people in the United States living with AIDS [2].

- Of the 58 US children (younger than 13 years of age) who had a new AIDS diagnosis, 39 were black [2].
- Since the beginning of the epidemic, blacks have accounted for 399,637 (42%) of the estimated 956,666 AIDS cases diagnosed in the 50 states and the District of Columbia [2].
- From the beginning of the epidemic through December 2005, an estimated 211,559 blacks with AIDS died [2].
- Of persons whose diagnosis of AIDS had been made during 1997–2004, a smaller proportion of blacks (66%) were alive after 9 years compared with American Indians and Alaska Natives (67%), Hispanics (74%), whites (75%), and Asians and Pacific Islanders (81%) [2].

Race/ethnicity of adults and adolescents living with HIV/AIDS, 2005





Note. Based on data from 33 states with long-term, confidential name-based HIV reporting.

RISK FACTORS AND BARRIERS TO PREVENTION

Race and ethnicity, by themselves, are not risk factors for HIV infection. Even though HIV testing rates are higher for blacks than for

members of other races and ethnicities [4], rates of undetected or late diagnosis of HIV infection are high for black men who have sex with men (MSM) [5].

Blacks are also more likely to face challenges associated with risk factors for HIV infection, including the following.

Sexual Risk Factors

Black women are most likely to be infected with HIV as a result of sex with men who are infected with HIV [2]. They may not be aware of their male partners' possible risk factors for HIV infection, such as unprotected sex with multiple partners, bisexuality, or injection drug use [6, 7]. Sexual contact is also the main risk factor for black men. Male-to-male sexual contact was the primary risk factor for 48% of black men with HIV/AIDS at the end of 2006, and high-risk heterosexual contact was the primary risk factor for 22% [2].

Substance Use

Injection drug use is the second leading cause of HIV infection both for black men and women [2]. In addition to being at risk from sharing needles, casual and chronic substance users are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol [8]. Drug use can also affect treatment success. A recent study of HIV-infected women found that women who used drugs, compared with women who did not, were less likely to take their antiretroviral medicines exactly as prescribed [9].

Lack of Awareness of HIV Serostatus

Not knowing one's HIV serostatus is risky for black men and women. In a recent study of MSM in 5 cities participating in CDC's National HIV Behavioral Surveillance System, 46% of the black MSM were HIV-positive, compared with 21% of the white MSM and 17% of the Hispanic MSM. The study also showed that of participating black MSM who tested positive for HIV, 67% were unaware of their infection; of participating Hispanic MSM who tested positive for HIV, 48% were unaware of their infection; of participating white MSM who tested positive for HIV, 18% were unaware of their infection; and of participating multiracial/other MSM who tested positive for HIV, 50% were unaware of their infection [10]. Persons who are infected with HIV but don't know it cannot benefit from life-saving therapies or protect their partners from becoming infected with HIV.

Sexually Transmitted Diseases

The highest rates of sexually transmitted diseases (STDs) are those for blacks. In 2005, blacks were about 18 times as likely as whites to have gonorrhea and about 5 times as likely to have syphilis [11]. Partly because of physical changes caused by STDs, including genital lesions that can serve as an entry point for HIV, the presence of certain STDs can increase one's chances of contracting HIV infection 3- to 5-fold. Similarly, a person who has both HIV infection and certain STDs has a greater chance of spreading HIV to others [12]. A recent CDC literature review showed that high rates of HIV infection for black MSM may be partly attributable to a high prevalence of STDs that facilitate HIV transmission [5].

Homophobia and Concealment of Homosexual Behavior

Homophobia and stigma can cause some black MSM to identify

themselves as heterosexual or not to disclose their sexual orientation [13, 14]. Indeed, black MSM are more likely than other MSM not to identify themselves as gay [5]. The absence of self-identification or the absence of disclosure presents challenges to prevention programs. However, data suggest that these men are not at greater risk for HIV infection than are black MSM who identify themselves as gay [14, 15]. The findings of these studies do not mean that black MSM who do not identify themselves as gay or who do not disclose their sexual orientation do not engage in risky behaviors, but the findings do suggest that these men are not engaging in higher levels of risky behavior than are other black MSM.

Socioeconomic Issues

Socioeconomic issues and other social and structural influences affect the rates of HIV infection among blacks [16]. In 1999, nearly 1 in 4 blacks were living in poverty [17]. Studies have found an association between higher AIDS incidence and lower income [18]. The socioeconomic problems associated with poverty, including limited access to high-quality health care, housing, and HIV prevention education, may directly or indirectly increase the risk factors for HIV infection.

PREVENTION

In the United States, the annual number of new HIV infections has decreased from a peak of more than 150,000 in the mid-1980s and has stabilized since the late 1990s at approximately 40,000. Populations of minority races and ethnicities are disproportionately affected by the HIV epidemic. To reduce further the incidence of HIV, CDC announced the Advancing HIV Prevention (AHP) initiative in 2003. This initiative comprises 4 strategies: making HIV testing a routine part of medical care, implementing new models for diagnosing HIV infections outside medical settings, preventing new infections by working with HIV-infected persons and their partners, and further decreasing perinatal HIV transmission.

CDC has also established the African American HIV/AIDS Work Group to focus on the urgent issue of HIV/AIDS in African Americans. The work group developed a comprehensive response to guide CDC's efforts to increase and strengthen HIV/AIDS prevention and intervention activities directed toward African Americans. Already, CDC is engaged in a wide range of activities to involve community leaders in the African American community and to decrease the incidence of HIV/AIDS in blacks.

For example, CDC

- Funds demonstration projects evaluating rapid HIV testing in historically black colleges and universities as well as projects to improve the effectiveness of HIV testing among black women and MSM.
- Conducts epidemiologic research focused on blacks, including
    - Brothers y Hermanos, a study of black and Latino MSM conducted in Los Angeles, New York, and Philadelphia that aims to identify and understand risk-promoting and risk-reducing sexual behaviors.
    - Women's Study, a study of black and Hispanic women in the southeastern United States that examines relationship dynamics, and the cultural, psychosocial, and behavior factors associated with

prevention for people living with HIV, teaches communication skills in negotiating safer sex, and reinforces the benefits of consistent condom use. WILLOW also teaches women how to recognize healthy and unhealthy relationships, discusses the effect of abusive partners on safer sex, and provides information about local shelters for women in abusive relationships.

CDC also supports research to create new interventions for African Americans and to test interventions that have proven successful with other populations for use with African Americans. Additionally, CDC funds agencies through ADAPT (Adopting and Demonstrating the Adaptation of Prevention Techniques) to adapt and evaluate effective interventions for use in communities of color.

In addition, CDC

- Provides intramural training for researchers who are members of minority races and ethnicities through a program called Research Fellowships on HIV Prevention in Communities of Color.
- Established the extramural Minority HIV/AIDS Research Initiative (MARI) in 2002 to create partnerships between CDC epidemiologists and researchers who are members of minority races and ethnicities and who work in communities of color. MARI funds epidemiologic and preventive studies of HIV in communities of color and encourages the career development of young investigators. CDC invests $2 million per year in the program and since 2003 has funded 13 junior investigators at 12 sites across the country [19].

Understanding HIV and AIDS Data

AIDS surveillance: Through a uniform system, CDC receives reports of AIDS cases from all US states and territories. Since the beginning of the epidemic, these data have been used to monitor trends because they are representative of all areas. The data are statistically adjusted for reporting delays and for the redistribution of cases initially reported without risk factors. As treatment has become more available, trends in new AIDS diagnoses no longer accurately represent trends in new HIV infections; these data now represent persons who are tested late in the course of HIV infection, who have limited access to care, or in whom treatment has failed.

HIV surveillance: Monitoring trends in the HIV epidemic today requires collecting information on HIV cases that have not progressed to AIDS. Areas with confidential name-based HIV infection reporting requirements use the same uniform system for data collection on HIV cases as for AIDS cases. A total of 33 states (Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming) have collected these data for at least 5 years, providing sufficient data to monitor HIV trends and to estimate risk behaviors for HIV infection.

HIV/AIDS: **This term is used to refer to 3 categories of diagnoses collectively: (1) a diagnosis of HIV infection (not AIDS), (2) a diagnosis of HIV infection and a later diagnosis of AIDS, and (3) concurrent diagnoses of HIV infection and AIDS.**

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Key Facts at a Glance

Key Facts at a Glance
Demographic trends in jail populations

To the chart based on these data | Download spreadsheet version

Jail populations by race and ethnicity, 1990-2005

	Number of jail inmates (one-day) count		
Year	White non-Hispanic	Black non-Hispanic	Hispanic of any race
1990	169,400	172,300	58,000
1991	175,300	185,100	60,600
1992	178,300	196,300	64,500
1993	180,700	203,200	69,400
1994	191,800	215,300	75,500
1995	206,600	224,100	75,700
1996	215,700	213,100	80,900
1997	230,300	237,900	88,900
1998	244,900	244,000	91,800
1999	249,900	251,800	93,800
2000	260,500	256,300	94,100
2001	271,700	256,200	93,000
2002	291,800	264,900	98,000
2003	301,200	271,000	106,600
2004	317,400	275,400	108,300
2005	331,000	290,500	111,900

Source: Bureau of Justice Statistics Correctional Surveys (The National Probation Data Survey, National Prisoner Statistics, Survey of Jails, Census of Jail Inmates, and The National Parole Data Survey) as presented in **Correctional Populations in the United States, 1997,** and **Prison and Jail Inmates at Midyear, 2005**.

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House votes today on grants for meth addicts' kids

By MICHAEL DOYLE
MODESTO BEE WASHINGTON BUREAU

WASHINGTON — The children of Central Valley meth addicts this week are learning politics the hard way.

The lessons are being showcased today as the House votes on whether to add $20 million for programs serving "drug-endangered children." Rep. Dennis Cardoza, D-Merced, is seeking the money as part of a big Justice Department funding bill.

"These kids that come out of these kinds of homes really need to be kept together," Cardoza said.

"That takes resources. If you don't intervene, they're going to end up in gangs, they're going to end up on the streets."

To pay for the grants, Cardoza had to propose cuts elsewhere. He targeted the Census Bureau and general administrative overhead.

Other amendments, too, attempt to divert money from the Census Bureau to diverse priorities. The Census Bureau, though, has allies. The authors of big funding bills, moreover, often are loath to tinker with their handiwork.

"We've made hard choices on how to spend scarce resources," said Rep. Frank Wolf, the Virginia Republican who chairs the House subcommittee that funds the Justice Department.

Here's one lesson: If Cardoza wins the vote today, he will have bargaining leverage with the Senate. If he loses, he says, "part of the strategy" is that lawmakers might be more willing next year to provide the money rather than casting another vote against helping children.

A second lesson deals with the meaning of real money.

Earlier this year, Congress renewed broad antiterrorism legislation dubbed the USA Patriot Act. Lawmakers included unrelated measures to fight methamphetamine, providing $20 million annually for "drug endangered children" programs.

But the Patriot Act's drug endangered children provision, just a few sentences in an 86-page bill, was not a promise of money.

Instead, it authorized that the money be spent. It takes separate action, through an annual appropriations bill, for real money to be provided.

Situations are desperate

"The need is tremendous, absolutely tremendous," Merced County social worker Cathy Clark said Tuesday. "We'll go out to homes, and the place is filthy, the kids are filthy, and there is no food. With meth, the drive to get the drug just drives everything else out."

Clark works with Merced's anti-drug task force, which exposes her to horrific scenes. Last year, she recalled, drug agents burst into a Los Banos garage and ordered the meth-smoking adults to get down on the floor. Dutifully, a 2-year-old boy mimicked the men around him; he lay down on the floor and placed his hands behind his back.

"This little boy was traumatized," Clark said. "He was scared to death."

A problem in many areas

In the past five years, three out of four California counties reported an increase in the number of children removed from their families because of meth, a National Association of Counties survey shows. An estimated 1.4 million Americans regularly use the illegal stimulant, another national survey found.

The relationship between parental drug use and child abuse and neglect is "extremely complex," Nancy Young, director of the Irvine-based Children and Family Futures, cautioned in a Senate hearing earlier this year.

Nationwide, Young noted, the "relatively rapid increase" in meth use has not been associated with increased child abuse reports.

Still, anecdotal evidence piles up.

In Merced County, Clark said she typically sees about 65 families a year through her work with the drug task force; 90 percent of these, she said, involve meth.

Bee Washington Bureau reporter Michael Doyle can be reached at 202-383-0006, or mdoyle@mcclatchydc.com.

March 26, 2007

Help Children Affected By Drug Abuse

Co-sponsor H.R. 1199 – The Drug Endangered Children Act of 2007

Dear Colleague:

We urge you to join us in helping children living in homes in which methamphetamine or other drugs are used or manufactured. One of the most troubling results of the meth epidemic has been its impact on children. According to the Drug Enforcement Administration (DEA), over 15,000 children were found at meth labs from 2000 to 2004. This problem is hardly limited to methamphetamine. A recent Health and Human Services study found that over 1.6 million children live in a home where at least one parent abuses illicit drugs, including meth, cocaine, heroin, and prescription medicines.

Child welfare agencies and law enforcement are stretched to the breaking point in many areas across the country because of this enormous challenge. Drug abuse harms children by contributing to domestic violence, abuse, and neglect. According to a survey released last year by the National Association of Counties, 69% of responding officials from county social service agencies indicate that their counties have had to provide additional special training for their welfare system workers and have had to develop new and special protocols for workers to address the special needs of children displaced by parental drug use.

That is why we have introduced H.R. 1199, which authorizes $20 million for the Drug Endangered Children grant program for FY 2008 and FY 2009. The Drug Endangered Children grant program provides grants to improve coordination between the state and local agencies that provide assistance to drug endangered children and aid the transition of these children to safe residential environments. This program was authorized in the USA PATRIOT Improvement and Reauthorization Act of 2005 (P.L. 109-177) at $20 million, but unfortunately that authorization has expired.

We strongly encourage you to co-sponsor the Drug Endangered Children Act of 2007. If you have any questions or would like to co-sponsor please contact Ben Correa in Congressman Cardoza's office at 6-4560 or ben.correa@mail.house.gov.

Sincerely,

Dennis A. Cardoza Member of Congress	Rick Larsen Member of Congress	Darlene Hooley Member of Congress

Patriot Act Authorizing Language

SEC. 755. GRANTS FOR PROGRAMS FOR DRUG-ENDANGERED CHILDREN.

(a) In General- The Attorney General shall make grants to States for the purpose of carrying out programs to provide comprehensive services to aid children who are living in a home in which methamphetamine or other controlled substances are unlawfully manufactured, distributed, dispensed, or used.
(b) Certain Requirements- The Attorney General shall ensure that the services carried out with grants under subsection (a) include the following:

(1) Coordination among law enforcement agencies, prosecutors, child protective services, social services, health care services, and any other services determined to be appropriate by the Attorney General to provide assistance regarding the problems of children described in subsection (a).
(2) Transition of children from toxic or drug-endangering environments to appropriate residential environments.

(c) Authorization of Appropriations- For the purpose of carrying out this section, there are authorized to be appropriated $20,000,000 for each of the fiscal years 2006 and 2007. Amounts appropriated under the preceding sentence shall remain available until expended.

The National; Character Laboratory, inc.a character or moral ;health association,and a tax-exmpt non-private foundation, under Secs. 501(c) and 509 (a)(2)I.I.R.C.and the Public Affairs Committee (PAC) N CL's model city project, unincorporated, both at 4635 Leeds Ave.,El Paso,. TX 79903-1211 (915) 562-5046, fax 562 3110 e.mail ajstuartjr@aol. com web site www.moral health ,org. A.J. Stuart, Jr.Col. AUS, Ret. Pres. NCL Inc. & Chmn PAC, Martha Franco, NCLInc. Trustee and Secy-treas. PAC Sherwood Kaiup, M..D. trustee NCLInc. & Robert Stone, ist Sgt , USA Ret.,vice-pres. NCL, Inc. & vice-chmn. PAC

Mr.Bobby Vassar Majority Chief Counsel 5-21-07
House Sub- committee on Crime, Terrorism, and Homeland Security
fax 225-3672

Dear Mr.Vassar

The attached copy of our condensed proposed Character Corrections Act is submitted for your evaluation and comment.

Since his bill is based upon character theory which has never been taught, we explained the very peculiar circumstances in the original proposed Character Corrections Act, copy also enclosed.

We have been using modern character corrections in El Paso since November, and the program is popular with the adult probationers and their teacher. It is being expanded locally as fast as resources permit.

We have asked our Rep. Sylvestre Reyes (staff person, Ms. Taylor Bentsen) to ask Rep. Sheila Jackson Lee to sponsor the bill,and we have contacted Mr. Ted Hutchinson in Rep.Lee;s office.

The bottom line here is 350 billion dollars a year savings in the cost of crime,plus a dramatic reduction in drug abuse, and even some reduction in the divorce rate.

We can furnish a great deal more backup information if desired,i.e. a summary of a 55 page recidivism report, and a written summary of a one hour t v documentary, etc.

Please let us know your reactions.

Sincerely,

A.J. (Alex) Stuart,Jr. Col.AUS,Ret.Pres. CL,Inc. & Chmn .Pub . Affairs Cmte.
Incls.

This bill also provides for the continuing development and use of improved character corrections programs for offenders.

Replacing conventional corrections with character corrections and early release for those successfully completing a character corrections program is a major change in policy,

The main advantage of character corrections is that it reduces recidivism and thus crime by about three quarters, or from about 96% to only 23%.

We expect that state and local corrections systems which make the change, as is being done in EL Paso,Texas, will start by conducting pilot programs. This would provide time to train judges and others involved in the criminal justice system to learn how to identify the very few who are probably not capable of taking character corrections successfully. It would also provide time, for others in the system especially teachers,to learn how to conduct the character corrections programs; One way to obtain the teachers is to re-train existing teachers or probation officers into character corrections teachers.

Prior experience in Albany, Georgia from 1970-80 indicated that at least 90% of offenders can succeed in character corrections, and that it is wise to release the offenders after completing character corrections successfully.

It will also be necessary to make other changes, such as those needed in the state or local criminal codes so as. to permit early release of offenders after successfully completing the cheracter corrections program.

It will also take time and effort to inform the public regarding character corrections, and convincing them that early release of those successfully completing character corrections is safe, justified, and wise

. The news media shold inform the public ,that character corrections is a very desirable change in corrections, which reduces recidivism and crime by three quarters,,and that early release should be a part of the program.in character corrections..

. Then the churches and other family or civic oriented organizations should teach the public more about simple character theory and corrections,,,so that the changes needed will be cheerfully accepted by all..,

Since character corrections reduces crime by three quarters and thus the number of jobs for criminologisrts, we can expect the criminologists to attempt to delay the program.

Character corrections also reduces the demand for drugs by three quarters, thus dramatically reducing the incomes of drug dealers The dealers can be expected to try to bribe dishonest public officials involved,as apparently happened in Georgia, ,or to even arrange for fatal accidents for the honest ones,as has happened so frequently in Mexico;

SEC. 3 CONVENTIONAL AND CHARACTER CORRECTIONS COMPARED

.Since psychiatry is legally in charge of mental health, including moral health, and the Diagnostic and Statistical Manual (DSM) of psychiatry is the ultimate written legal authority on all matters concerning mental and moral health, academia teaches according to the DSM,.

Research by the National Character Laboratory, Inc;.has found that starting in about 1950, psychiatry abandoned morality and,even removing the term "character" from the new edition of the DSM published in 1958, So character has not existed in academia.since 1958.

.Robert Coles,M.D.,.a famous child psychiatrist,and later an honorary life member of NCL,Inc., wrote an article published in a prominent newspaper in the early 1970's complaining that psychiatry had abandoned morality.

Also in the early 1970's , the president of NCL,Inc.,Col.A.J. Stuart, Jr.AUS, Ret. spoke on the telephone with Herbert Pardes,M.D.,then president of the American Psychiatric Association,, Stuart asked Dr. Pardes if the Association would endorse teaching character education in the schools. Dr. Pardes said no, and then explained the reason.. He said "Nobody knows right from wrong."

The official position of psychiatry on character (in a 1980's letter to the National Character Laboratory,Inc.) is that character is only a subjective concept like beauty. They maintain this position in spite of the fact that character was clearly defined as six different attitudes In the PRAIRIE CITY research reported back in 1960. .

NCL Inc's. explanation for this peculiar behavior by most leading psychiatrists is that the

theory. and designed to improve the character of the offender.

SEC 4 RESULTS OF PRIOR CHARACTER CORRECTIONS PROGRAMS

A type of Character corrections was used under judge Asa Kelley in Albany,GA from 1970- 80, and those who succeeded in the program were released from probation or confinement.

A very thorough recidivism study was conducted. The control group of about half of 1,500 offenders who had taken conventional corrections, had a recidivism rate of 96%, compared to only 23% for the experimental group, which had taken character corrections.The recidivism rate for character corrections was only 18% for the last year of the program.

There was also evidence that the use of drugs had declined dramatically, and even the divorce rate dropped.

SEC 5 A CURRENT CHARACTER CORRECTIONS PROGRAM

The president of NCL,Inc. wrote a two month program on character corrections similar to the Georgia program, but based up.on modern character theory in 2006. We plan to market the program soon.

The West Texas Division of Supervision and Corrections started using the course with two pilot classes on character corrections in El Paso, TX with high risk adult probationers from Nov. 7, 2006 to Jan. 23, 2007 and then completed instruction for 90 more on May 9th, 2007. The program is being expanded locally. The probationers involved and the teacher spoke highly of the course at the graduation exercises.

SEC 6 ACCEPTABLE CHARACTER CORRECTIONS PROGRAMS

Any character corrections type program based program modern character theory is acceptable.

SEC 7 FEDERAL FUNDS FOR CORRECTIONS

State and local corrections agencies must replace conventional corrections with character corrections in order to receive federal funds.

This feature takes effect two years after this bill becomes law, in order to provide enough time for the states to revise their criminal codes to permit early release of those who successfully complete character corrections, to provide time for the development and testing of new character corrections programs, and to inform the public about modern character theory and its use in character corrections and the justification for early release. ,

The National Character Laboratory,Inc.a character or moral health association, and a tax-exempt non-private foundation under Secs; 501(c) and 509(a)(2) I.R.C., and the Crime Prevention Committee,(CPC), NCL's model city project, unincorporated, both at 4635 Leeds Ave,El Paso,TX 79903-1211 (915)562-5046, fax 562-3110, e-mail, ajstuartjr@aol.com, web site www.moral health. org A.J Stuart,Jr,Col.AUS, Ret. Pres,NCL & Chmn.CPC; Martha Franco, NCL trustee and Secy-treas CPC;Sherwood. Kaip,trustee,NCL, Robert Stone,1st Sgt;Ret.,Vice-Pres.NCL & vice-Chmn,CPC.

The Crime Prevention Committee submits the following draft bill on character corrections, Feb. 19,2007..

HR___

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

SEC 1 SHORT TITLE

This bill may be cited as the Character Corrections Act of 2007.

SEC 2. PURPOSE

Under present conditions a very high proportion of our black youth and to a lesser extent hispanic youth are unemployed and involved in drug abuse and crime. Character corrections has a record of alleviating these conditions. When used in Albany,GA for ten years,it reduced recidivism from 96% to only 23% over a ten year period and in the final year of the program the recidivism rate was only 18%...

Almost all present corrections programs are based upon the false environmental theory of human behavior and hence produce high recidivism and crime rates., The false environmental theory was introduced by Fabian socialists in the 1960-70 time frame instead of modern character theory,published in 1960. One reason was that the Fabians are trying to convert us to socialism by perverting our society morally, down to the point were we would accept socialism.

The Fabians managed to convince then president George H;.W.Bush to endorse one world (socialist) government..He said in a major speech to Congress, which we heard,that "We must have a one world government." We were shocked to hear this because we knew that joining the UN as subordinate part was the Fabian socialist goal at that time....

Now our present president George W. Bush is secretly converting us to a socialist government in the form of the so called, Security and Prosperity Partnership (SPP) which would consolidate Mexico., the United States,and Canada into a socialist conglomerate. Thus he would largely destroy our nation and our Constitution, which he swore to defend. (See "The Great Deceit" by Veritas,1964, 354 pages for basic information on the Fabian socialist conspiracy up until 1964.. For information on (SPP), see "North American Union Fact Sheet", from the American Policy Center, as well as several other independent sources.....,

Also,in the 1950's,, psychiatry, which is legally in charge of mental health , including moral health,decided to take away from God the supreme authority in moral health.,and assumed that power itself.. It then actually abandonded morality!

.. Psychiatry even removed the term "character" from its manual in the1958 edition. Doing this eliminated character disorders such as homosexuality. (The homosexual has simply learned the wrong attitude towards sex,and can be converted to heterosexual in many cases.) They have a character disorder,and should be classifed as such instead of "normal.".

. Further, when the new character theory was published in1960, only two years after the word "character" had been removed from psychiatry, psychiatry rejected the new theory by ignoring it,and thus prevented the new theory from being taught, or used in corrections...

This bill requires replacing conventional corrections programs with character corrections. It also calls for the related prompt release of offenders from confinement, probation, or parole upon successful completion of a character corrections program. This major policy change is discussed later.

the wrong attitude towards sex,and attitudes are character.. So homosexuality is a character disorder. But since character had been eliminated, the psychiatrists could not longer recognize character disorders. so they reclassified homosexuality as normal, with disasterous results to our whole society... This bad decision empowered the homosexuals to invade the schools, churches, and even the military as normal, leading to all sorts of educational, social,.religious, and legal problems.

The PRAIRIE CITY basic research program on character originated under Robert F. Peck, Ph.D and other psychologists and some sociologists in the University of Chicago, just after WWII.. The primary objective was to discover if character really exists,and if so what it is,and how it develops, and so that we can tell how it can be changed..

The program observed a group of children from first through tenth grades, their parents and teachers,,and was eminently successful, It discovered that character is a collection of six attitudes or traits,,which they carefully defined.

The PRAIRIE CTY research thus produced the first modern character theory,and many think that the researchers,should have received a Nobel prize., Instead, psychiatry,apparently, to be consistent with their no morality policy, ignored and thus rejected the complete new character theory from PRAIRIE CITY,.

Then the rest of academia followed psychiatry instead of adopting the new theory..

The National Character Laboratory,Inc has endeavored to get academia to accept and teach the character theory, but academia apparently defers to psychiatry and still refuses to teach it.

However,now that character corrections has actually been re-started in El Paso, Texas, academia willl have teach the character theory,in order to explain why character corrections works so much better than conventiuonal corrections. ..

The National Strategy to Reduce Crime,published in 1973 in response to the tripling of the national crime rate between 1965 and 1971,, said on page 1 of Volume 1 that crime is caused by the false social1ist promoted environmental theory, and ignores character completely. This explains why the strategy was a failure in reducing crime rates.

NCL Inc.and its Model City project,the Crime Prevention Committee in El Paso, Texas, have endeavored to produce a good plan for reducing crime, and improving moral health nationally and globally, including proposing and promoting legislation such as this..Our plan is published in "Moral Health" by A; J;. Stuart, Jr. now in its second edition. The plan is kept current by means of memoranda called "Character Planning" now in their 437th edition.;

Present conventional corrections programs cover a wide variety of subjects,except character. The FBI national crime rates were stable at about 1,500 per 100,000 until 1965. But then the rate suddenly tripled to 4,600 by 1971, and is still almost 4,000. , Our recidivism rates are thus in the 96% range,and our national crime rate has decreased from 4600 in 1971 to 3,899 at last report. The rate has been decreasing recently by about 2% a year..

.NCLInc's present explanation for this dramatic increase in crime from 1965-1971 is that psychiatry is largely at fault for rejecting morality.,This rejection was accepted by far too many people,especially in academia, who then perverted some of our college youth, especially regarding sexual promiscuity and drug abuse, which too often lead to crime.

Also, the Fabian socialist conspiracy was discovered, researched,extensively,and reported in "The Great Deceit" in1964. The research, covered four years of scholarly work under Archibald B. Roosevelt, a son of Teddy, and his Veritas Foundation..

The Roosevelt research confirmed t he existence of a Fabian socialist conspiracy in this country It consists of powerful evil people, mostly in academia, whose goal is to convert us to a socialist form of government, no matter what the cost

The Fabians chose as their main method perverting our whole society morally, down to the point where we would accept socialism. As mentioned previuosly the Fabians were able to convince a president of the United States to endorse their plan for converting us to socialism by having us join the socialist UN,and now his son is converting us into th socialist American Union..

Since Roosevelt's research was published in 1964, revealing the truth about the Fabian Socialist conspiracy, this may have triggered a violent reaction by the Fabians

within academia, as a means of detracting attention away from Roosevelt's discoveries.In any event, our national crime rates started its dramatic increase the next year,in 1965,and continued for six years,until1971...

One valuable outcome of the Albany,Georgia character corrections program in1970-80 was a 1980 hour long documentary describing the program titled "Delinquency and Crime-Is the A Soluton?" The video features a typical ex-offender. He said that when he was a youth, he lacked the character to hold down any job, and therefore turned to crime and prison as a way of life.

The average offender soon discovers that he can cope with prison life, so when released he commits another more serious crime, in order to get back in, and to have more prestige. ..This explains the very high (96%) recidivism rate with conventional corrections found in a thorough recidivism study in Albany Georgia covering 1,500 offenders in the period 1970-80.

Half had taken conventional corrections, and the other half character corrections under Judge Asa Kelley and Attorney Dan MacDougald, Jr.;..

The recidivism study found an average recidivism rate of only 23% for ten years for those who had taken character corrections, and the rate dropped to only 18% the last year.

Almost all of the offenders appearing before Judge Asa Kelley were assigned to take character corrections. Judge Kelley used the MMPI psychological test to help decide what to do with each offender. The MMPI was also used during the character corrections program,to help insure success with each offender.

However,the MMPI is a very extensive complicated test designed to help psychiatrists determine exactly what type of metal illness a person has,,and is difficult to interpret and expensive..

.. Since most offenders do not have any form of mental illness,the corrections authorities in EL Paso decided against using the test, and use a character scale and personal interview instead..

In Georgia,only those few who were afflicted with extreme cases of deviant behavior were sent to state prison. Judge Kelley was proud of the fact that keeping so many offenders in the local system had saved the state a lot of money in the prisons.

Mr ;MacDougald told Stuart that the real reason the county discontinued the program in 1980 was that it had reduced the demand for drugs so much that the local drug dealers had prevailed upon the county government to cancel the program "to save money". Actually canceling the program resulted in a large increase in local crime and in the size of the jail population.

We know that Mexico has a great drug problem, and primarily because of the huge demand for drugs in this country. Thus using character corrections here would help reduce the number of drug abusers, and would also help Mexico, by dramatically reducing the demand for drugs..

Modern character theory includes a clear definition of the term,character, originally consisting of 6 traits,or attitudes, NCL,Inc; has,for various good reasons. increased this number to ten over the past 46 years.,

Character theory is now starting to be put into use with character corrections. This began Nov;7th, 2006 when two successful small pilot programs using high risk probationers atarted, and graduated Jan.23rd,2007..

Now the program is expanding locally. We are planning to include the local jail and juvenile probation in the neer future. as well as spreading characterw corrections to the other about 100 other local corrections systems in Texas, and into the state prisons..

The course being used now was written by Stuart..and is the first we know of based upon modern character theory. It also uses the best available methods of teaching people to love instead of hating others.

We encourage others to write other and hopefully better programs,, but still consistent with modern character theory.This is a new field,and the present course if the first one based on modern character theory,. The Georgia program is based on a similar theory, and it may be possible to arrange to use the Georgia program by contacting one of Dan MacDougald'Jr's two attorney sons, in Atlanta, GA. One is Harry, the other is Dan. MacDougald III.. Harry is at (404) 352 4067... ..

So as to make it available to the public, a complete description of, Stuart's course will be

included the appendix of the new third edition of his book "Moral Health.". This will be available in the near future,we hope;. The present second edition of the book is now available to order from any book store, Amazon.com, or 800 434 1579.

.. The about two month program is based upon modern the modern character theory described above and is,supplemented by various other secular methods helpful for teaching offenders to love others. The key word is love.. (We use secular methods in the programs, partly,to avoid law suits, but also because they are faster and thus less expensive than the spiritual programs with which we are familiar.

In the early 1990's NCLInc. finally convinced the Federal Bureau of Prisons to develop its own character corrections type program of 20 classroom hours called "Living Free." However, then a new management came in who did not understand character corrections or approve of the program, so it was never properly implemented and has been discontinued.

Sec. 4 ACCEPTABLE CHARACTER CORRECTIONS PROGRAMS.

In general,any character corrections program consistent with modern character theory from, PRAIRIE CITY and NCL,Inc. is acceptable.. States or local corrections organizations are encouraged to develop their own versions of character corrections, or to use either Stuart's curriculum, or the slightly modified one used in El Paso... In order to avoid possible law suits by homosexuals,,El Paso decided to eliminate any reference to homosexuals in the program. This is not a major change since either program should work on homosexuals the same as on heterosexuals,. and only about 1-2% of the population are homosexuals anyhow. Another acceptable program is the one used in Albany,GA from1970-80. Contact Mr.Harry MacDougald an sttoney in Albany, GA for information

NCL,Inc.includes homosexuality in character theory because. homosexuals are persons who have learned the wrong attitude towards sex,and therefore have a character disorder.. With proper treatment, most of these people can be either converted into heterosexuals,or at least have their promiscuous behavior reduced, and thus lengthen their lives.

With further experience in treatment and more research the treatment may be further improved. Since the official position of psychiatry and hence academia is that here is no such thing as character and that homosexuality is normal,,there has been no federally supported research on homosexuality for many years.

NCL'er Dr.Joseph Nicholosi who specializes in treating homosexuals, and his wife have written a book on how to prevent children from becoming homosexuals.

Effective character corrections type programs for misdemeanants are available from the National Curriculum Training Instititue,(NCTI) POB 60905,Phoenix,AZ 85082 1 800 622 1644. Request a copy of the NCTI catalog. The programs are primarily for misdemeanants, and reduce recidivism from around 50% to only about 5%.

Sec. 5 RESEARCH

The last major research project on character of which we are aware is PRAIRIE CITY,conducted for ten years just after WWII, in a small town west of Chicago,by a team of 8-10 psychologists and sociologists from the University of Chicago. They conducted a longitudinal basic research project on 34 youth from grades 1-10 to discover what character is and to learn all about character development.

Robert F..Peck was the principal author of the final report, lifled "The Psychology of Character Development" by R.F.Peck, R.J.Havighurst,et al.1960. Peck needed five years to complete analyzing the data and writing the report.,finally completed when he was with the University of Texas at Austin.

Since NCL,Inc was organized in 1971,it has endeavored to keep the research on the theory current . We have added four new assumed character traits,for various reasons, subject to confirmation by a replication of the original research.

NCL,Inc. publishes a Character Discipline"in which it includes all information available on character and closely related subjects, such as human relations and the family..

Sec.6 AUTHORIZATION OF APROPRIATIONS

There are authorized to be appropriated $10,000,000 in fiscal 2008 for a replication of the

original Prairie City research under modern conditions. (The original research was a multi-million dollar research program over a 15 year period.)

There are authorized to be appropriated for other character research programs $15,000,000.

These programs would include such things as character corrections, drug treatment and other character related research, which covers a wide field of character related forms of deviant behavior, including how to prevent or treat homosexuality..

Sec 7 WITHHOLDING FEDERAL FUNDS

State and local corrections systems which fail to use character corrections will be denied federal funds..