Program Brief

Accept or Decline? Deciding Factors in a Voluntary HIV Testing Program for Probationers and Parolees

John E. Denton
Bronwen Lichtenstein, PhD*

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HIV testing for communities at risk was a key recommendation of the National HIV/AIDS Strategy during the Obama Administration. These vulnerable groups include probationers and parolees under community supervision. According to the Bureau of Justice Statistics (2017), 4,708,100 U.S. adults or 1 in 52 adults were under community supervision at the end of 2014, with the large majority being male and a disproportionate number being non-White. An approximate distinction between the two types is that probationers are low-level offenders who are sentenced directly to community supervision, while parolees have served prison time for felony crimes and are released to community supervision on a conditional basis. Both types of convicted offender are at risk of HIV infection. Prison release is often hazardous for parolees because of the temptation to fall back into activities involving drug use and unprotected sex (Green et al., 2013). Probationers have similar risks but lack information about HIV prevention strategies compared to the parolees who take prevention classes while incarcerated (Barber & Lichtenstein, 2015). Despite the well-documented risks of both groups, supervised offenders are largely neglected in terms of HIV education and testing efforts (Gordon et al., 2016). This is a noteworthy omission in view of the almost five million adult supervised offenders in the United States.

This brief presents the results of an onsite program for voluntary HIV education, testing, and linkage to care at a probation and parole office in Alabama (hereafter "parole office"). The program was designed to provide HIV services to a neglected population in the Deep South and took place on three scheduled reporting days each month. The program was piloted in 2015 and fully implemented in 2016 through a partnership involving the parole office, an AIDS Service Agency, and the second author. As required by state authorities, we offered opt-in HIV testing at the parole office. We also ensured that participants were aware that HIV testing was not required for reporting purposes. Initial contact with the program was facilitated by trained student assistants who, as HIV education advocates and testing "champions," approached individual supervisees in the waiting area of the parole office on reporting days. If this initial approach elicited interest, then a more detailed discussion of HIV facts and figures followed, ending with the question "Would you like to be tested for HIV?" and an offer of a $10 gift card for testing. By using this stepwise method, we were able to test 569 probationers and parolees or 25%

*John Denton is a prevention advocate and testing champion for the Pro-Test Program for HIV education, testing, and linkage to care at the Tuscaloosa County Probation and Parole Office, Tuscaloosa, Alabama. Mr. Denton is also a premedical student and medical scribe, University Medical Center, The University of Alabama, Tuscaloosa, Alabama, USA. Bronwen Lichtenstein, PhD, is a Professor, Department of Criminology and Criminal Justice, The University of Alabama, Tuscaloosa, Alabama, USA. Dr. Lichtenstein is also a Research Fellow, Rural Center for AIDS/STD Research, Indiana University, Bloomington, Indiana, USA. (*Correspondence to: blichten@ua.edu).*

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of the 2,276 offenders who reported to the parole office during our site visits. This brief describes frequently stated reasons for accepting or refusing free HIV testing in a correctional setting and the interplay between the parole office environment and uptake of HIV testing services. Our analysis of these responses can be used to guide the provision of HIV services to vulnerable people in correctional and other settings in which opt-out testing is not an option.

Opt-In and Opt-Out HIV Testing of Vulnerable Populations

Routine HIV testing is recommended in clinical settings in the United States (Centers for Disease Control and Prevention [CDC], 2017). A salient question for practitioners is how to optimize routine screening of vulnerable people on a voluntary basis, particularly in large institutions such as hospitals and prisons. Voluntary uptake is highly dependent on location and the method that is used to facilitate it. Testing can be as high as 60%-62% in residential drug treatment programs, especially when facilitated by nurse advocates (Simeone et al., 2017). Voluntary testing in nonresidential drug treatment programs is significantly lower. Uptake in hospital emergency departments ranges from 24% to 91%, depending on whether or not opt-in or opt-out methods are deployed (Christopoulos et al., 2012). With the opt-in method, patients must actively consent to being tested, while opt-out requires patients to decline routine testing, perhaps by refusing to sign a consent form. An ethical challenge for the opt-out method in the criminal justice system is that many people are unaware of their right to decline, as indicated when 38% of prisoners in seven U.S. uptake prisons believed that HIV testing was mandatory (Rosen et al., 2015). Because HIV testing is a life-saving measure, and opt-out testing consistently yields higher uptake and thus better life-saving potential than the opt-in method, the CDC recommends opt-out testing in all health care settings (Rosen et al., 2015). In our own case, opt-in testing was the only possibility, so we had to devise other strategies in order to optimize uptake.

Two questions relate to the feasibility of HIV testing programs at the parole office. First, can an opt-in program work effectively in a correctional setting in which offenders report for supervision for a brief time each month? This window-of-opportunity testing can be compared to prisons, hospitals, and residential drug programs where being "inside," and thus subject to institutional authority and processes, can facilitate uptake more efficiently. Second, can an opt-in program with several layers of protection for offenders (e.g., active consent, confidentiality procedures, and separation from parole functions) be self-sustaining, or are incentives needed in order to improve uptake? In a recent intervention trial, probationers and parolees were offered $20 incentives and the study achieved a 55% success rate (Gordon et al., 2013). Because our program is the first of its kind to have onsite HIV services as a regular fixture, we will answer these questions as they relate to the challenges of HIV testing at the parole office, where offenders are free to refuse HIV testing but compelled to comply with supervision and/or drug testing, and where they spend brief, often anxious brief periods of time before returning to community life. We will also discuss the role of HIV prevention education and incentives in promoting uptake, and the way forward in providing tailored services for this key population at risk of HIV infection.

Methods

Data Collection and Analysis

The design and methods of this 2-year-old program are described in detail elsewhere (Lichtenstein, Barber, and the West Alabama AIDS Outreach Partnership Group, 2016). In brief, the program offers an HIV training component for parole officers, has a 3-day-per-month schedule in which we offer HIV services during the mandated reporting period for probation or parole, and includes a referral component in which newly diagnosed offenders are linked to HIV care at a community health clinic. For evaluation purposes, we also collect data on HIV testing uptake, record all yes/no responses for testing, and keep a log of all verbal responses to the question of why testing is accepted or declined. For the analysis, we dichotomized these data into yes/no categories, created sub-categories for each type