Screening of Prisoners for HIV: Public Health, Legal, and Ethical Implications

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INTRODUCTION

More than most other fields, public health law is constantly in flux. Levels of disease wane and ebb in varying segments of society. Knowledge of etiologic agents and modes of exposure mount. New treatment options are developed. Evaluations of prevention and control methods accumulate. The social milieu in which diseases exist changes. In short, what was certain five or ten years ago may be outdated today.

This paper addresses a topic that was vigorously debated in the last decade, but has largely dropped from the legal discourse: programs to screen prisoners for HIV. This lack of attention is unfortunate, because, at the end

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of the first decade of the 21st century, the AIDS epidemic has changed in important ways from that of the 1980s and 1990s; increasingly, the disease is affecting a more representative cross-section of society, treatment options have improved, and stigma has decreased. Simultaneously, the proportion of people who live with undiagnosed HIV/AIDS is still high, and the rate of HIV among incarcerated populations is between two and four percent, which rivals the prevalence in many sub-Saharan African countries. Of greatest significance, though, programs which were newly proposed 10 or 15 years ago have now been conducted for a long enough time to generate strong outcomes data, as well as to have endured legal and ethical challenges; this data and the results of these challenges can and should inform current policy.

This paper calls for the routine, opt-out screening of all incarcerated people. This recommendation is based in the proposition that all public health policies must be effective, as demonstrated by valid scientific evidence; legal; and ethical. Unlike on-demand or opt-in screening, only opt-out and mandatory screening consistently achieve high rates of testing uptake. High rate of case identification permits the greatest number of inmates possible to enter treatment at the earliest point in the course of their disease that antiretroviral therapy is indicated. This substantially improves treatment outcomes and reduces the rate at which resistance to antivirals develops. Furthermore, earlier and more complete treatment can significantly reduce the amount of transmission within the prison setting, and screening can provide a point in time to initiate prevention services for inmates who test either positive or negative. Since a high proportion of Americans with HIV pass through a correctional institution in any given year, and many are released after a fairly short stay in a jail or prison, treatment and prevention services which are dependant on case identification can also help to reduce transmission in the general public. In order to be effective, screening must be integrated with appropriate medical care and prevention services, and these services must be set up in such a way as to continue after release. While there are challenges to implementing such programs, several states have demonstrated that they can be conducted successfully.

While both opt-out and mandatory screening can achieve high rates of testing uptake, serious legal and ethical problems face mandatory testing initiatives. Such programs have been challenged on a variety of legal theories, including that they violate the prohibition on unreasonable searches and seizures, that they constitute and infringement on the free exercise of religion, that they constitute cruel and unusual punishment, and that they deny equal protection of the laws. In most instances, these claims fail. However, poorly crafted mandatory screening policies have failed to pass the constitutional standards for legal searches and seizures and have occasionally been found to violate the right to religious freedom. On the other hand, routine, opt-out screening is universally upheld under all four legal theories.

Additionally, there are serious concerns about whether mandatory screening is ethical. Public health policies should be the least restrictive op-
tion that can achieve an important public health goal. Nonconsensual public health policies should only be implemented when either justified by a claim of desert or when the policy is so broadly applied as to ensure that the democratic process is equitably weighing the costs and benefits of a program; the nonconsensual nature of a policy must also generate a public health benefit which could not be obtained through a consensual policy. Because inmates as a class have not committed acts which cause them to deserve to be submitted to HIV testing without their consent, and because mandatory screening of prisoners falls inequitably on a politically disenfranchised group, compulsory prisoner screening is unethical. At the same time, programs that are less efficacious than opt-out screening do not adequately facilitate the important public health goals of facilitating treatment and preventing transmission among the vulnerable prisoner population. In short, opt-out screening best balances the public health gains from effective case identification programs against legitimate ethical and legal concerns.

This thesis systematically is set out in the next four parts of this paper. Part II of this paper is an overview of HIV/AIDS in the American prisoner population and the relationship between prisons and the epidemic in the United States general population. It also evaluates screening programs in prisons and jails from a public health standpoint. Part III evaluates legal challenges to HIV screening among inmates, and it pays particular attention to whether the courts’ holdings are based in good health science. Part IV evaluates screening programs normatively, assessing the ethical implications of the various screening strategies.

I. PUBLIC HEALTH EVALUATION OF PRISONER SCREENING PROGRAMS

A. Epidemiology of HIV/AIDS in American Prisons and the General Population

At the end of 2005—the most recent year for which data is available—approximately 1.2 million Americans were living with an HIV infection, and

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1. This paper focuses fairly narrowly on prison screening programs. For those who wish a broader discussion of legal rights of prisoners with HIV or other infectious diseases, the *Jailhouse Lawyer’s Manual*, particularly chapter 25 entitled “Aids, Hepatitis, and Tuberculosis in Prisons,” is an excellent resource, and it provides highly practical advice for attorneys and inmates. See generally *COLUMB. HUMAN RIGHTS LAW REVIEW, A JAILHOUSE LAWYER’S MANUAL* 707-27 (7th ed., 2007). It is freely available online at http://hr.razummedia.com/ejlm.php.

the disease had claimed more than 550,000 lives in the United States alone.\(^3\) Although the rate of new infections and AIDS diagnoses has remained fairly constant for the last several years,\(^4\) the number of people living with an infection has steadily increased.\(^5\) This is primarily because improved treatment sharply reduced the rate of death from AIDS after about 1997\(^6\) and has led to increasingly long survival times after an AIDS diagnosis.\(^7\)

The most common modes of HIV transmission are—in order of associated cases—male-to-male sexual contact, heterosexual contact, and injection drug use.\(^8\) Transmission from infected mother to newborn is infrequent in the United States, with fewer than 70 cases in the United States in 2005.\(^9\) Other modes of transmission, such as receipt of infected blood or blood products or occupational exposure, have been largely eliminated.\(^10\)

The prevalence of HIV/AIDS is about five times higher among jail and prison populations than the general public,\(^11\) with credible estimates suggesting that between two\(^12\) and four percent\(^13\) of incarcerated individuals are HIV positive. The level of infection is even higher in New York, where eight percent of inmates are HIV positive.\(^14\) While the prevalence is elevated for both sexes, women in prisons have a disproportionately increased level of HIV infection compared to men, possibly because crimes for which women are incarcerated are more likely to entail a risk of transmission.\(^15\) In three states—


\(^4\) Id. at 10.

\(^5\) Id. at 18.

\(^6\) Nancy F. Crum et al., Comparisons of Causes of Death and Mortality Rates among HIV-infected Persons: Analysis of the Pre-, Early, and Late HAART (Highly Active Antiretroviral Therapy) Eras, 41 J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES 194, 195 (2006).


\(^8\) Id. at 10.

\(^9\) Id. at 13.

\(^10\) Id. at 10.


\(^12\) Id. at 421.


\(^15\) Spaulding et al., supra note 13, at 306-07. The reason for the disproportionate increase in infection of incarcerated women compared to incarcerated men is not completely clear. It may be in part due to the high proportion of female inmates who are incarcerated for drug crimes or prostitution (or with a history of these), both of which entail a high risk of infection. See Frederick L. Altice et al., Correlates of HIV Infection among Incarcerated Women: Implications for Improving Detection of HIV Infection, 82 J. URBAN HEALTH 312, 322 (2005).
Nevada, New York, and Rhode Island—more than 10 percent of female prisoners are infected with HIV.\textsuperscript{16}

Increased prison prevalence is due in part to increased risk behaviors prior to incarceration, including elevated rates of sexual partners, injection drug use, and commercial sexual transactions.\textsuperscript{17} Additionally, some of the disproportionate HIV burden in prisons is due to the demographics of the incarcerated population. The proportion of black and Hispanic men who are incarcerated is six and two-and-a-half times higher than whites, respectively;\textsuperscript{18} blacks comprise approximately 42 percent of state and federal prisoners.\textsuperscript{19} Because minorities are disproportionately infected with HIV in United States,\textsuperscript{20} as are men, who are also over-represented in prison populations,\textsuperscript{21} some of the elevated prevalence among prisoners reflects lopsided imprisonment of minority males.

B. What is the Role of Screening for HIV in Prisons?

Screening for HIV has utility to the extent that it can accurately identify new cases and facilitate treatment and prevention efforts.\textsuperscript{22} It is important to note that there is not great public health utility from screening and other surveillance activities alone; rather, screening is valuable to the extent that it enables or improves other legitimate medical and public health efforts. Three arguable public health justifications for mandatory prisoner screening will be considered in turn: medical interventions to aid the prisoner tested, within-prison public health, and extramural public health. The line between these categories is not bright. To some extent, all three depend on the other; for example, reducing transmission within prisons may also limit transmission in the general public by decreasing the number of people released from prison with HIV. Nonetheless, the concepts are conceptually distinct enough to be evaluated separately.

The threshold inquiry is whether prison screening programs can accurately identify people who did not previously know that they were infected. Screening has little value if it is not accurate, or if it does not identify new cases. There is evidence that a sizable proportion of HIV positive prisoners

\begin{itemize}
  \item Weinbaum et al., supra note 14, at S43.
  \item Burchell et al., Voluntary HIV Testing among Inmates: Sociodemographic, Behavioral Risk, and Attitudinal Correlates, 32 J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES 534, 536-37 (2003).
  \item Id. at 7.
  \item CDC HIV/AIDS Surveillance Report, supra note 3, at 6.
  \item Bureau of Justice Statistics, supra note 18, at 8.
\end{itemize}
do not know their HIV status. Furthermore, despite assertions of the inaccuracy of screening programs, screening is quite accurate in the prison setting, due to the relatively high prevalence of infection. Newly available rapid oral tests are highly accurate at differentiating HIV positive and negative people, and return results in a matter of minutes. The likelihood that a person who tests positive on a screening test does, in fact, have the condition, is a function of both the accuracy with which the test identifies people who are positive (its sensitivity) and negative (its specificity) and the proportion of the population subject to screening who are positive. Assuming a normal prison prevalence of three percent, one would expect that 97 percent of positive tests are true positives, and that essentially all negative tests are true negatives. In a higher prevalence prison population, such as New York, where eight percent of prisoners are HIV positive, about 99 percent of positive tests—with the initial rapid test alone—would be true positives. However, positive results on a rapid test are followed up by an even more accurate Western blot or immunofluorescent assay confirmatory test, which essentially eliminates false positive test results. Thus, if guidelines requiring confirmatory testing are followed, there should not be much concern about the risk of false positive results.

Effective screening can improve patients’ treatment. An HIV diagnosis is the first step toward care; people who are diagnosed late in their disease are at an increased risk of serious illness and death. Additionally, they are more likely to be resistant to front-line therapies, which increase both the risk of treatment failure and the cost of their drug regimen. Some have raised legitimate concerns that the high level of illnesses concurrent with HIV in the

26. For more on how to calculate positive and negative predictive values, see LEON GORDIS, EPIDEMIOLOGY (3d ed. 2004). The likelihood that a positive test is a true positive—that is, that the person does, in fact, have HIV—is highly dependent on the prevalence in the population screened. This can be seen intuitively. Consider a completely random test that returns a positive result 50 percent of the time. If 100 percent of the tested population has HIV, all positives on this completely random test would be true positives. On the other hand, in a population with no HIV, all positives would be false.
27. Weinbaum et al., supra note 14, at S43.
31. Id. at S4-S5.
prison population, such as chronic forms of hepatitis, as well as tuberculosis, substance addiction, and mental illness may complicate treatment. For example, estimates of the proportion of HIV positive prisoners co-infected with hepatitis C are as high as 70 to 80 percent, and liver disease from chronic hepatitis complicates HIV treatment by worsening drug toxicities. Nonetheless, there is good evidence that treating prisoners with highly active antiretroviral therapy (HAART) is feasible and that strong treatment outcomes can be expected. Indeed, successful prisoner treatment programs have been implemented in several jurisdictions, such as Connecticut, which employs HIV specialists at its prisons. Additionally, for those patients whose clinical picture does not necessitate antiretroviral therapy, other care, such as prophylaxis against *Pneumocystis carinii* pneumonia and treatment of active or latent tuberculosis is still strongly beneficial. There are significant barriers to implementation of HIV treatment programs in prisons, but these are due to an unacceptable lack of political will, failures to employ trained professionals in the prison system, and efforts to cut costs at the expense of prisoner health, not inherent inability to treat HIV positive prisoners.

Furthermore, screening programs facilitate efforts to reduce transmission of HIV within prisons. The same risk behaviors that lead to HIV transmission outside of correctional facilities occur within them. Rates of risk behaviors are difficult to estimate in prison settings, but the existence of consensual sexual behavior, sexual victimization, injection drug use, and amateur

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32. Weinbaum et al., *supra* note 14, at 843.
38. Springer & Altice, *supra* note 34, at 166.
39. Current treatment guidelines state that HAART is indicated if a patient’s CD4 count falls below 350 or upon acquisition of an AIDS defining illness, as well as in certain other circumstances. HAART may be indicated for some patients with CD4 counts above 350, depending on a variety of clinical considerations. Department of Health & Human Services, *Guidelines for the use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents*, 20 (2008), available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.
tattooing are well-documented.\footnote{43} For injection drug use, prison may be especially risky, as stringent restrictions on needle acquisition may lead to the reuse and sharing of contaminated needles.\footnote{44} Additionally, access to condoms and other risk-reduction methods is infrequent in many prisons.\footnote{45}

The extent to which within-prison HIV transmission occurs is controversial, but there is strong evidence that it exists. The Centers for Disease Control and Prevention evaluated evidence of transmission within the Georgia prison system between 1992 and 2005, and identified 88 prisoners who were seronegative on entry into the prison system but positive at later testing.\footnote{46} Forty-one of these prisoners were found to have seroconverted in the last year and a half of the study period.\footnote{47} If this study captured all cases of HIV transmission during imprisonment in the study period, it would indicate a transmission rate for the last year and a half in the ballpark of one incident case per 30 infectious prisoners per year. However, because mandatory screening was only conducted at intake, some instances of transmission were likely missed.\footnote{48} Other research has confirmed cases of intra-prison transmission in a variety of settings and with various levels of transmission.\footnote{49} Most studies suggest that transmission within the prison setting tends to occur at a low rate, such as a pair of studies of prisoners continuously incarcerated since the late 1970s (before HIV’s emergence) which found less than one percent infection over the more than two decades of follow-up.\footnote{50} Documented risk factors include sexual behavior, injection drug use, and tattooing.\footnote{51} It is thus fair to say both that HIV transmission occurs in prisons and that prisons are not the breeding grounds for HIV often depicted in the popular\footnote{52} or legal press.\footnote{53}

\footnote{43} Theodore M. Hammert, HIV/AIDS and Other Infectious Diseases among Correctional Inmates: Transmission, Burden, and an Appropriate Response, 96 AM. J. PUB. HEALTH 974, 974-76 (2006); Braithwaite & Arriola, supra note 22, at 760-61; Transmission among Inmates, supra note 11, at 423.

\footnote{44} Gerard Niveau, Prevention of Infectious Disease Transmission in Correctional Settings, 120 PUB. HEALTH 33, 34 (2006).

\footnote{45} Spaulding et al., supra note 13, at 310.

\footnote{46} Transmission among Inmates, supra note 11, at 421.

\footnote{47} Id. at 422.

\footnote{48} Transmission among Inmates, supra note 11, at 421.

\footnote{49} Hammert, supra note 43, at 974-75.

\footnote{50} Id. at 975.

\footnote{51} Transmission among Inmates, supra note 11, at 424. In the CDC study, injection drug use was only marginally significantly associated with an increased risk of HIV acquisition.

\footnote{52} A good example of such sensationalism can be found at William S. Weed, Incubating Disease, MOTHER JONES, July 10, 2001, http://www.motherjones.com/news/special_reports/prisons/disease.html.

\footnote{53} Many papers attribute HIV in prisons to “homosexual rape.” See, e.g. Sarah E. Frink, AIDS Behind Bars: Judicial Barriers to Prisoners’ Constitutional Claims, 45 DRAKE L. REV. 527, 529-30 (1997). Certainly, rape occurs in prisons, but basing concerns about intraprison HIV transmission on homosexual activity or rape is based more in sensationalist fears than epidemiologic data, and it risks further stigmatization of already highly stigmatized people. In the CDC study referenced above, prisoners who had been victims of rape had approximately the same in-
Screening can help to reduce intraprison transmission of HIV. One method by which it can do this is to facilitate treatment, which evidence strongly suggests reduces transmission. HAART suppresses the amount of virus in patients’ bloodstream and other bodily fluids, which is believed to reduce the risk of transmission. Treatment is known to reduce the risk of passing the infection from mother to child at birth, and research has demonstrated that HIV viral load is correlated with transmission risk in the perinatal context. Studies of sexual transmission are more difficult to conduct, but research in San Francisco found decreased risk of transmission following HAART’s introduction, and concluded that the reduction was at least in part due to treatment. Studies have not been conducted among incarcerated populations, but a similar effect would be expected.

Additionally, identification of HIV positive prisoners allows for targeted prevention programs. Some of these include drug rehabilitation, which reduces the risk of intravenous drug-associated transmission from infectious prisoners, as do needle exchange programs, which have been shown to be effective in prisons in Europe. A variety of other programs, including the distribution of condoms and educational programs, have been shown to be feasible in correctional settings and not lead to prison security problems. Counter to intuition, prevention programs may be particularly feasible in prisons because the population at risk is literally a captive audience. Although harms reduction, behavioral modification, and general educational programs could be implemented without screening, evidence suggests that contact with professionals at the time of an HIV test and the receipt of results provides a crucial opportunity to affect risk behaviors, both by people testing positive.

Increased risk of within-prison infection as those who had engaged in consensual or exchange sex. Far fewer prisoners who had seroconverted while incarcerated listed rape than consensual sex as a potential means of exposure. Transmission among Inmates, supra note 11, at 424. The studies on sexual behavior in prisons are limited, but research indicates that consensual sex acts are substantially more common than non-consensual. See Niveau, supra note 44, at 34-35 (summarizing the literature on prison sexual transmission of disease).


57. Spaulding et al., supra note 13, at 310.


59. Id. at 976.

60. Braithwaite & Arriola, supra note 22, at 760-61.

61. Id. at 761.
and negative, if such programs are well executed. Additionally, for many inmates, substantial barriers to testing prevent their acquisition of testing, treatment, or prevention services outside of the prison environment.

Some papers advocate segregation of HIV positive prisoners into separate facilities to limit spread of the disease, and some jurisdictions have adopted such a policy. While this might have an effect on within-prison transmission by reducing transmission-capable contact between infectious and susceptible prisoners, such an approach may have the unintended effect of substantially increasing the risk of tuberculosis infection among segregated and immunocompromised prisoners. At least three outbreaks of tuberculosis among segregated HIV positive prisoners have been reported. Because tuberculosis progresses more quickly in immunocompromised people, sequestration of HIV-positive inmates together can lead to more substantial within-prison transmission.

At the same time, HIV screening may reduce tuberculosis transmission within prisons, because people with immune suppression tend to show a reduced reaction on the tuberculin skin test, which is the standard screening method for tuberculosis. Knowledge of a patient’s HIV status allows for a more correct interpretation of tuberculosis screening results and will likely increase the rate at which cases are identified prior to developing active tuberculosis, reducing the risk of transmission in the prison system.

HIV screening in prisons is also likely to substantially improve HIV prevention, treatment, and other public health programs to the general public. Approximately one-quarter of all HIV-infected Americans are held in a jail or prison each year. The Department of Justice estimates that at the end of 2006, nearly 2.4 million Americans were in a prison, jail, or juvenile detention facility.
facilities. The majority of inmates serve relatively short terms (a few years or less) and are released back into the general community. Prisons can serve as an integral point for identification of cases prior to reintegration with society. For example, in Rhode Island, which has a long-established and well-run routine opt-out screening program for both short and long-term inmates, roughly one-third of all identified cases were found via screening at correctional facilities. Similarly, in the District of Columbia, one in ten HIV or one in eleven AIDS cases identified between 2001 and 2006 were identified through screening at the District’s jail, a short-term holding facility only.

For the same reasons that it can reduce transmission within the correctional setting, screening is instrumental in preventing transmission within the general population by facilitating treatment and behavioral interventions, which lowers the risk of transmission upon release. Upon return to the general public, prisoners continue to engage in risk behaviors that pose the chance of HIV transmission; providing education, drug habilitation, and other programs during prison terms can reduce this risk. Similarly, the provision of treatment prior to release may reduce the risk of transmission if prisoners stabilize on treatment before they re-enter society. Although there are legitimate concerns about the rate of treatment default following release, several states have proven that by linking HIV patients to community-based care and wrap-around services upon release, high rates of adherence to treatment can be obtained in the community. Particularly important are programs to reduce drug dependency, to assist in finding secure housing, and to provide consistent medical care. Additionally, multiple prison-based educational and behavioral modification programs have shown to alter risk beha-

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70. Bureau of Justice Statistics, supra note 18, at 3.
71. Spaulding et al., supra note 13, at 305.
73. Gov’t of D.C. Dep’t of Health, District of Columbia HIV/AIDS Epidemiology Annual Report 82-83 (2007), available at http://www.dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/epidemiology_annual_2007.pdf. Note that this measures cases newly identified at the D.C. Jail, not the proportion of people with HIV who passed through the jail, which is likely to be much higher. Inmates with a prior diagnosis were reported in the District of Columbia surveillance report by the facility of first diagnosis. (Citation needed)
75. See Kristen Clements-Nolle et al., Highly Active Antiretroviral Therapy Use and HIV Transmission Risk Behaviors Among Individuals Who Are HIV Infected and Were Recently Released From Jail, 98 AM. J. PUB. HEALTH 661, 662-63 (2008).
77. Springer et al., supra note 37, at 210; See also Edward N. Kassira et al., HIV and AIDS Surveillance Among Inmates in Maryland Prisons, 78 J. URBAN HEALTH 256, 262-63 (2001).
79. Clements-Nolle et al., supra note 75, at 663; see also Sandra A. Springer et al., Effectiveness of Antiretroviral Therapy Among HIV-Infected Prisoners: Reincarceration and the Lack of Sustained Benefit After Release to the Community, 38 CLINICAL INFECTIOUS DISEASES 1754, 1759 (2004).
viors following release, and evidence suggests that the point at which test results are delivered, whether positive or negative, provides a good opportunity for initiation of such programs.

Lastly, there is strong evidence that HIV screening programs are cost-effective. One paper modeled the effect of prison HIV testing and counseling, finding that such programs result in long-term societal savings by averting future cases, even if low-end estimates of testing uptake and prevalence are assumed; increases in either prevalence or uptake produced immense cost savings. For cost savings to accrue, testing must be linked to high-quality counseling and education for both HIV positive and negative inmates, with the higher the coverage of the screening program, the greater the cost savings to society. This is consistent with a study that found universal screening of pregnant women in prison to be cost-effective because of the ability to prevent mother to child transmission. Other research has found universal screening of pregnant women in the general public also to be highly cost effective.

At this point, it is evident that identification of HIV positive individuals via screening in the prison system entails substantial public health benefits if it subsequently enables or facilitates appropriate medical and public health intervention. However, a question remains as to what form or forms of case identification are preferable from a public health standpoint. The following section considers a range of potential screening options and evaluates their relative merits.

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80. Ronald Braithwaite et al., Short-Term Impact of an HIV Risk Reduction Intervention for Soon-to-be Released Inmates in Georgia, 16 J. HEALTH CARE POOR & UNDERSERVED 130, 137-38; see also Angela Bryan et al., Effectiveness of an HIV Prevention Intervention in Prison Among African Americans, Hispanics, and Caucasians, 33 HEALTH EDUC. & BEHAV. 154, 170-71 (2006).
81. Grinstead et al., supra note 62, at 556-57; see also Bourwell & Rich, supra note 62, at 1761.
82. Beena Varghese & Thomas A. Peterman, Cost-Effectiveness of HIV Counseling and Testing in US Prisons, 78 J. URBAN HEALTH 304, 308-09 (2001). In the base model, the authors assume a prevalence rate of 1%. However, holding other model assumptions constant, cost savings were realized at prevalence estimates as low as 0.1%. At 15% prevalence, estimated savings from even screening with low uptake (50%) exceeded two million dollars (for a population of 10,000 prisoners). Likewise, even at 1% prevalence, uptake of 90% saved society approximately $750,000 per 10,000 prisoners screened. Id. at 308.
83. Id. at 308.
86. Note that the method of screening that is best from a purely public health standpoint may not be optimal in a legal or ethical sense. These considerations will be considered later in this paper.
C. What Methods of Prison-Based Case Finding are Preferable?

Prison-based screening can take a wide variety of forms. At one end of the spectrum is to offer testing only to those prisoners who affirmatively request it or to couple this option with individualized testing when a prisoner’s clinical picture suggests he or she may be infected with HIV.87 This “on-demand” or “as-indicated” testing gives the prisoner the most control over the decision to be tested. At the opposite end of the spectrum is mandatory screening with no ability to opt out. This could be conducted at intake and potentially repeated periodically during incarceration and prior to release. To be credible, such a screening regimen would have to be enforced with penalties, so the degree of coercion from a mandatory screening program would depend in part on what sort of stick was used to back it up. Slightly less coercive is a mandatory testing regime that allows opting out only for designated reasons, such as religious exceptions. Finally, a middle road form is to utilize routine, but non-mandatory, screening. This can take different forms, primarily distinguished by whether affirmative consent is required for inclusion (opt-in or routine offering screening) or whether an HIV test is conducted so long as a prisoner does not affirmatively request that it not be done (opt-out). While opt-out screening does not require affirmative consent, it does require that the prisoner be notified that the test will be conducted and be given the opportunity to refuse.88 The Department of Justice reports that twenty states screen all inmates for HIV.89 Virtually all states and the federal government offer testing upon request or when there are clinical indications of HIV.90


88. The term “opt-out testing” is used differently by different authors. Some define it as routine testing without notification to the patient. See GOSTIN, supra note 87, at 138. However, as it is used in the medical literature and CDC guidelines, notification is an essential element. See Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, 55 MORBIDITY & MORTALITY WKLY. REP. RECOMMENDATIONS & REP. RR-14, at 2 (2006) [hereinafter Revised Recommendations] (“Performing HIV screening after notifying the patient that 1) the test will be performed and 2) the patient may elect to decline or defer testing [defines opt-out screening]. Assent is inferred unless the patient declines testing.”). This is the same meaning employed by the studies which evaluated levels of testing uptake under various screening regimes that are cited in this paper. Thus, in this paper, the primary difference between routine opt-in and opt-out testing is whether, after notification, no test is given unless the patient affirmatively consents (opt-in) or whether consent is inferred unless the patient affirmatively refuses (opt-out).

89. HIV in Prisons, 2004, BUREAU OF JUSTICE STATISTICS BULLETIN (U.S. Dept’ of Justice, Wash. D.C.), Nov. 2006, at 5-6, available athttp://www.ojp.usdoj.gov/bjs/pub/pdf/hivp04.pdf. Note, however, that this does not differentiate between states which routinely offer testing to all inmates and those for which testing is compulsory. Estimates of the number of states which compel tests vary due to difference in what writers consider to be mandatory screening.

90. Id. Every state that responded to the Department of Justice survey performs some sort of HIV testing, and most utilize multiple methods. One state, Alaska, did not provide information about HIV testing to the Department of Justice. Id at 6.
Substantial evidence suggests that when testing is conducted only when a prisoner asks for it or when clinical symptoms indicate an HIV infection, testing uptake is quite low. Data from such a program in Maryland found that only about forty percent of prisoners asked for an HIV test. An additional twelve percent were tested based on clinical suspicion of HIV. In the year studied, the majority of HIV diagnoses were not made until there was clinical suspicion, indicating that cases were not identified until relatively advanced disease progression.

The rates of testing uptake in other correctional facilities vary substantially. Several studies have looked at the rate of acceptance when prisoners are individually offered a test (opt-in testing). The type of testing conducted in these studies is likely representative of the level of uptake in routinely offered opt-in screening. At the Cook County Jail in Chicago, two studies reported that thirty-one percent and forty-six percent of patients offered tests had accepted them. The latter study compared voluntary prison testing uptake to other venues and found that uptakes were substantially higher than in Chicago’s hospital emergency departments, but lower than in STD clinics. The highest rate achieved through such a program appears to be about seventy percent, which was achieved by programs in Wisconsin and Massachusetts. Of concern, though, is evidence that HIV positive prisoners are likely not to volunteer for testing, which means that the proportion of HIV positive prisoners identified is lower than the proportion of prisoners tested.

Mandatory screening would obviously achieve higher uptake rates, as it by definition would require 100 percent of prisoners to undergo an HIV test. Routinely offered, opt-out testing can also achieve high rates of uptake; levels in excess of 90 percent generally have been reported. In recognition of the greater efficacy of routine, opt-out testing than other forms of non-mandatory testing, CDC recently altered its HIV recommendations to call for such screening in all health-care settings. Additionally, evidence exists that mak-

91. Kassira et al., supra note 77, at 259.
92. Id.
93. Id.
94. Lyons et al., supra note 63, at 94.
96. Id.
97. Lyons et al., supra note 63, at 94.
98. Rebecca V. Liddicoat et al., Implementing a Routine, Voluntary HIV Testing Program in a Massachusetts County Prison, 83 J. URBAN HEALTH 1127, 1128 (2006).
99. Lyons et al., supra note 63, at 95.
100. Grinstead et al., supra note 62, at 550; Amy Boutwell et al., Reply to Walker et al., 40 CLINICAL INFECTIOUS DISEASES 319, 320 (2005).
Screening of Prisoners for HIV

ing testing routine reduces stigma associated with the request and receipt of an HIV test.\footnote{Id. at 5.}

The greatest public health benefits accrue when a screening program can maximize the number of people who are tested for HIV. As noted above, this best facilitates linkage to care and prevention services for people testing positive. It also provides the greatest opportunity for successful operation of educational and prevention programs among those who test negative. Though greater screening coverage entails greater costs, benefits of routine, opt-out and universal have been found to outweigh costs, even at substantially lower expected prevalence levels than that of the incarcerated community.\footnote{Id. at 6.} Thus, for public health purposes, opt-in and on-demand screening are quite inferior to routine, opt-out and mandatory screening in the prison population. Of course, public health gains are not the only value to be considered; an acceptable prison screening program must also be legal and ethical. These issues are addressed in sections III and IV, infra.

D. How is Screening Conducted?

Because many of the legal and ethical issues surrounding prison HIV screening turn on the degree of intrusiveness which HIV tests entail, it is important to have a clear understanding of how such tests are conducted. Generally, initial screening is conducted using an enzyme immunoassay (EIA) test.\footnote{CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome, 48 MORBIDITY & MORTALITY WKLY. REP. RECOMMENDATIONS. & REP. RR-13, at 29 (1999) [hereinafter CDC Guidelines]. EIA tests do not detect the HIV virus directly, but instead they detect antibody against HIV. HIV-specific antibody is produced as part of the immune response to the virus, so the presence of antibody indicates infection.} These tests traditionally required a small amount of blood to be drawn by inserting a needle into a blood vein, but newly available rapid tests can be performed on the blood from a finger prick or on oral fluids from a cheek swab, and the results are available in less than one hour.\footnote{Greenwald et al., supra note 28, at 126.} If this test is positive, it must be confirmed by a second test; usually, either a Western blot or immunofluorescent assay (IFA) test, which require blood to be drawn.\footnote{CDC Guidelines, supra note 104, at 29. These tests also detect antibody against HIV but virtually eliminate false positive results. Additionally, confirmation can be via tests which detect viral nucleic acid or viral proteins, and which also require blood to be drawn. Id.} There is a short window of time after a person is infected during which antibody cannot be detected by the confirmatory test. However, most HIV-positive people will test positive on preliminary tests and a Western blot with-
in a month of exposure, and virtually all will be detected within three months.\textsuperscript{107}

**II. LEGAL ANALYSIS OF PRISON SCREENING PROGRAMS**

Mandatory programs to screen prisoners for HIV and other diseases have been challenged under a range of legal theories, but only those based on the Fourth Amendment’s prohibition on unreasonable searches and seizures, the First Amendment’s protection of free religious exercise, the Eighth Amendment’s prohibition on cruel and unusual punishment, and the Fourteenth Amendment’s guarantee of equal protection of the laws\textsuperscript{108} have any reasonable likelihood of success. This section examines each of these legal theories. Where a court denies the claim against mandatory screening, it is assumed that routine opt-out screening, which is less coercive, would also be acceptable. In those rare instances where a court strikes down a mandatory

\textsuperscript{107} Stefan Lindback et al., *Diagnosis of Primary HIV-1 Infection and Duration of Follow-up After HIV Exposure*, 14 AIDS 2333, 2336-37 (2000). Newer generation tests have been demonstrated to have quite short window periods. See generally S. Michele Owen et al., *Alternative Algorithms for HIV Diagnosis Using Tests that Are Licensed in the United States*, 46 J. CLINICAL MICROBIOLOGY 1588 (2008).

\textsuperscript{108} Two additional theories on which screening programs have been challenged were considered, but do not receive extensive coverage in this paper. The first comprises of claims based in the substantive due process right of informational privacy over medical information. In a few instances, prisons have been found to violate this right by improperly disclosing inmates’ HIV status, either directly or implicitly through restriction of privileges. See Doe v. Coughlin, 697 F. Supp. 1234, 1240-41 (N.D.N.Y. 1988) (finding improper disclosure of HIV status due to mandatory segregation of prisoners who tested positive for HIV); see also Nolley v. County of Erie, 776 F. Supp. 715, 733 (finding that the placement of red stickers on the personal items of HIV positive prisoners improperly disclosed their HIV status). However, these issues turn not on whether screening is conducted or what method of screening is employed, but rather on what officials do with information gathered via screening programs; thus, these issues are beyond the scope of this paper. Nonetheless, prisons should be sensitive to issues of informational privacy in designing HIV treatment and prevention programs. See generally Karen E. Zuck, *HIV and Medical Privacy: Government Infringement on Prisoners’ Constitutional Rights*, 9 U. PA. J. CONST. L. 1277 (2007).

Additionally, some prisoners have asserted that screening programs violate their right to be free from disability-related discrimination under the Americans with Disabilities Act (ADA) or the Rehabilitation Act. HIV is a disability under these laws. Bragdon v. Abbott, 524 U.S. 624, 641-42 (1998). However, challengers must show that they were treated adversely because of their disability. E.g., Scott v. Androscoggin County Jail, 866 A.2d 88, 96 (Me. 2004). By their very nature, mass screening programs are applied without regard to a prisoner’s HIV status. While some portions of the ADA forbid medical testing a prerequisite for services, there is no such testing prohibition in Title II, which is the portion applicable to prisons. E.g., Murdock v. Washington, 193 F.3d 510, 512 (7th Cir. 1999) (rejecting claim that prison violated the ADA by requiring an HIV test as a prerequisite for participation in a prison culinary class).

In some jurisdictions, state law may afford prisoners greater protections than the Constitutional floor. This paper does not attempt a comprehensive survey of state law.
testing regime, its reasoning is applied to determine whether other forms of screening would have endured the same fate.

A. Limitations on the Constitutional Rights of Prisoners in General

“Prison walls do not form a barrier separating prison inmates from the protections of the Constitution.”\textsuperscript{109} Prisoners retain the right to be free from arbitrary interference with their constitutional rights while incarcerated; however, the Supreme Court has ruled that the level of protection afforded to prisoners is substantially less than outside of jails and prisons.\textsuperscript{110} In 1987, the Court heard a challenge to Missouri prison regulations which limited prisoners’ rights to correspondence and marriage.\textsuperscript{111} If such restrictions were placed on the general public, they would be subject to strict scrutiny and invalidated unless the state could show a compelling government interest, which would be very unlikely. However, when applied to prisoners, the Court found a lesser degree of protection: “when a prison regulation impinges on inmates’ constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests.”\textsuperscript{112} Thus, prisoners’ constitutional rights are subject only to rational basis review. The Court states that this is to prevent the judiciary from becoming “the primary arbiters of what constitutes the best solution to every administrative problem” and to allow innovation in prison management.\textsuperscript{113}

Once a rule has been determined to implicate a prisoner’s constitutional right, four factors go into determining whether a constitutional violation has occurred under \textit{Turner}. First, the government’s interest must be legitimate, and it must be sufficiently “rationally connect[ed]” to the prison regulation as to not be “arbitrary or irrational.”\textsuperscript{114} Second, if there are alternative means by which the prisoner can execute the right—that is, if the regulation does not completely foreclose the right—then the regulation is more likely to be reasonable.\textsuperscript{115} Third, if accommodating a prisoner’s right would have significant impact on prison personnel, other inmates, or prison resources, a regulation which does not accommodate the right is viewed as more reasonable.\textsuperscript{116} Fourth, if “an inmate claimant can point to an alternative that fully accommodates the prisoner’s rights at a de minimis cost to valid penological interests, a court may consider that as evidence that the regulation does not satisfy the

\textsuperscript{110} This paper uses the term prisoner to refer both to convicted offenders and pretrial detainees. Pretrial detainees are subject to the \textit{Turner} test in the same fashion as post-conviction inmates. Bell v. Wolfish, 441 U.S. 520, 539-46 (1979).
\textsuperscript{111} \textit{Turner}, 482 U.S. at 81-82.
\textsuperscript{112} \textit{Id.} at 89.
\textsuperscript{113} \textit{Id.}
\textsuperscript{114} \textit{Id.} at 89-90.
\textsuperscript{115} \textit{Id.} at 90.
\textsuperscript{116} \textit{Id.}
reasonable relationship standard.” However, the Court explicitly states that prisons are not required to implement the least restrictive option.

Thus, to prevail on a claim that HIV screening violates constitutional rights, a prisoner has to climb a steep hill. First, he or she would have to demonstrate that the screening program implicates a constitutional right. Then, the prisoner would have to argue that the screening program either is not rationally related to a valid penological purpose—and courts have universally held that controlling the spread of infectious diseases is a valid purpose—or that there exists an alternative means of accomplishing the state’s goal that accommodates the right in question without unduly impacting others in the prison setting. As will be demonstrated in the following portions of this paper, this is a very difficult challenge.

One could make a strong argument that mandatory HIV screening of prisoners does not fall within the Court’s reasoning in Turner. After all, many state’s prisoner screening programs are mandated by legislative action, whereas the Turner Court justified its deference to the regulation of inmates in the level of expert judgment made by prison administrators. It is highly dubious that state legislatures created prisoner screening provisions out of their deep expertise in managing incarcerated populations; instead, there is evidence that such narrowly applicable laws are a cynical attempt to single out a disenfranchised population for political gain. In many other settings, when groups with limited legislative redress are targeted with coercive laws, the degree of constitutional scrutiny is increased, not decreased. However, as will

117. Id. at 91.
118. Id. at 90-91.
120. Many courts abridge their discussion of the Turner test. However, practitioners desiring an example of an excellent discussion of the Turner factors as applied to infectious disease screening should see Selah v. Goord, 255 F. Supp. 2d 42, 52-56 (N.D.N.Y. 2003) (enjoining the enforcement of tuberculosis screening over religious objections by the use of medical isolation for up to one year). Note, however, that Turner no longer applies to free exercise of religion claims because of Congressional legislation. See infra section III.C.
121. E.g., Ala. Code § 22-11A-17(a) (2008) (“All persons sentenced to confinement or imprisonment in any city or county jail or any state correctional facility for 30 or more consecutive days shall be tested for … sexually transmitted diseases … upon entering the facility, and any inmate so confined for more than 90 days shall be examined for those sexually transmitted diseases 30 days before release”).
122. Turner, 482 U.S. at 89.
124. See generally Charles R. Lawrence, The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism, 39 Stan. L. Rev. 317 (1987) (discussing the application of the representation reinforcement theory to equal protection claims made by marginalized groups). The standard of review which should be applied to prisoner’s claims of constitutional violations is a difficult question from an ethical perspective. On one hand, it makes perfect sense for prisoners’ rights
be seen below, the courts have universally applied the *Turner* doctrine to screening schemes of both legislative and administrative origin.

**B. Fourth Amendment Search and Seizure Claims**

The Fourth Amendment to the United States Constitution prohibits unreasonable searches and seizures.\(^{125}\) State compelled production of blood, bodily fluids, and other biological samples is a search for Fourth Amendment purposes.\(^{126}\) As a general rule, a search may be executed only pursuant to a warrant issued by a neutral magistrate upon the demonstration of probable cause.\(^{127}\) However, the Supreme Court has recognized a so-called “special needs” circumstance, a category of cases where the purpose of the search goes “beyond the normal need for law enforcement, mak[ing] the warrant and probable cause requirement impractica[ble].”\(^{128}\) In such circumstances, noting that the Fourth Amendment’s touchstone is reasonableness of the search, the Court balances the governmental interest in the search against the implicated privacy interest to determine whether it is practical to require a warrant, probable cause,\(^{129}\) or even individualized suspicion.\(^{130}\) Courts have overwhelmingly ruled that HIV testing programs are searches under the Fourth Amendment which are subject to the special needs balancing test.\(^{131}\)

Such searches have been conducted in a variety of circumstances relevant to mass screening of prisoners for HIV. A few courts have addressed the precise topic of this paper, and in no circuit is mandatory prisoner HIV to be curtailed when the interest of society is served. After all, prisoners, by definition, knowingly committed acts which offended society’s sense of decency, and limitations on their rights when reasonably related to deterrence of future harm against the public or rehabilitation of the prisoner seems appropriate. However, when the right being curtailed has no realistic bearing on deterrence or rehabilitation, and it is not necessary for maintaining safety in the prison system, such regulation should be highly suspect. For example, cell searches for drugs are related to the goal of rehabilitation; likewise, screening for tuberculosis is necessary for prison safety. However, a prison regulation that mandated blood pressure screening, which is not reasonably related to a societal goal of punishment and is not needed to keep prisoners and personnel safe, would be troubling. If an intrusion on prisoner freedom serves no purpose but the amorphous public good, and would not be acceptable in the general population, such an intrusion should be granted no deference.

125. U.S. CONST. amend. IV.


127. *Id.*

128. *Id.*

129. *Id.* at 624.

130. *Id.* at 624.

131. See, *e.g.*, Arizona v. Superior Court, 930 P.2d 488, 492 (Ariz. Ct. App. 1996) (finding that court mandated HIV testing of juvenile sex offenders falls under the special needs doctrine, and listing a multitude of other courts which have done likewise).
screening banned as a general proposition. The Tenth Circuit examined Oklahoma’s mandatory prisoner screening program in the late 1980s, which required testing of all prisoners but did not base any medical or public health intervention on the results. The court noted that prisoners have a greatly decreased expectation of privacy, and thus are unable to challenge physical searches of their living environment or personal effects, but that they retain a privacy interest in bodily searches. However, the court also found that, when a search is conducted for non-law enforcement purposes, application of the special needs doctrine is appropriate because warrants and probable cause are “unworkable, if not meaningless” in the context of HIV screening. Going on to note the significant intrusion of privacy that an HIV test entails, the court then referenced the Turner doctrine to conclude that, in the prison context, the government interest in a special needs test need not be as great as it would have to be for an identical test among the general public. Finally, the Tenth Circuit found a relatively diminished privacy interest in searches of prisoners’ bodies and bodily fluids and rational connection between prisoner testing and preventing the intra-prison spread of HIV. It thus found that the balance of interests favored the reasonableness of mandatory screening.

The Dunn decision came down at the height of AIDS phobia, and it would be easy to allege that it constitutes an early and unrepresentative case had the Tenth Circuit not reaffirmed it in 2003. In Hunt v. Ortiz, the court evaluated a §1983 claim stemming out of alleged punishment of a Colorado prisoner for refusal to submit to a mandatory HIV test. The claim asserted that the mandatory test violated the prisoner’s Fourth Amendment rights, but was dismissed for failure to state a claim. The court ruled that the state’s interest in identifying prisoners with HIV so that it could pursue treatment and prevention options outweighed the prisoner’s interest in being free from compulsory HIV testing.

The 11th Circuit has gone farther. In the late 1980s, prisoners challenged Alabama’s policy of mandatory HIV screening, which was followed by segregation of all HIV positive prisoners into separate living facilities. The trial

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132. Dunn v. White, 880 F.2d 1188, 1190 (10th Cir. 1989).
133. Id. at 1191.
134. Id. at 1193.
135. Id. at 1194. The court noted that the Turner doctrine is poorly suited to Fourth Amendment claims and did not attempt to apply the four-prong test. However, it asserted that Turner stands for the proposition that constitutional intrusions on prisoners are held to a lower standard of review than similar intrusions on non-prisoners.
136. Dunn, 880 F.2d at 1195-95 (10th Cir. 1989).
137. Id. at 1196.
138. Id. at 1197.
140. Id. at *3.
141. Id.
court noted that prisoners have a right to safety in their surroundings, and that this can require curtailment of the rights of other prisoners.\textsuperscript{143} It then analogized an HIV test to a prison body cavity search for contraband as a “reasonable measure[] to guarantee the safety of the inmates and [correctional officers].”\textsuperscript{144} This was upheld by the Supreme Court under the special needs doctrine in \textit{Bell v. Wolfish}\textsuperscript{145} Finding that there existed an even greater safety interest in protection from a deadly disease than from drugs or weapons, the trial court found that the mandatory screening program was permissible under the Fourth Amendment.\textsuperscript{146}

The case has since gone through several rounds of appeals. In the initial round, the denial of the Fourth Amendment claim against mandatory screening was not challenged, but the segregation of HIV positive prisoners was appealed.\textsuperscript{147} While not directly addressing the special needs balancing conducted by the trial court, the 11\textsuperscript{th} Circuit utilized the same reasoning as the trial court in evaluating claims that the mandatory segregation violated prisoners’ rights to informational privacy by making evident their disease status.\textsuperscript{148} The court found that there was only a limited privacy interest held by prisoners due to the nature of incarceration,\textsuperscript{149} and that there was a rational connection between infringements on prisoner privacy and the stated public health purposes facilitated by mass screening and segregation.\textsuperscript{150} In particular the court validated Alabama’s assertion that these programs were necessary to prevent intra-prison spread of HIV, stating that it was well established that “high risk behavior such as homosexual relations, IV drug use, tattooing, and ear piercing occurs regularly within the Alabama system, as well as frequent fights and blood spills.”\textsuperscript{151} In a second round of cases over the same testing and segregation system under the Rehabilitation Act\textsuperscript{152} the 11\textsuperscript{th} Circuit, in 1999, again affirmed the reasoning of the \textit{Harris} trial court with respect to the validity of screening and segregation as a public health intervention against the danger of intra-prison HIV transmission.\textsuperscript{153}

\begin{flushright}
\begin{footnotesize}
\begin{enumerate}
\item Id. at 1570.
\item Id. at 1569.
\item \textit{Bell v. Wolfish}, 441 U.S. 520 (1979).
\item \textit{Harris}, 727 F. Supp. at 1569.
\item Harris v. Thigpen, 941 F.2d 1495, 1501 (11th Cir. 1991).
\item Id. at 1512.
\item Id. at 1519.
\item The Rehabilitation Act is a federal act which forbids disability discrimination, and it is briefly discussed, \textit{supra} note 108.
\item Onishea v. Hopper, 171 F.3d 1289, 1298-99 (11th Cir. 1999). Specifically, the court found that even low probabilities of HIV transmission were a sufficiently great risk to justify segregation of prisoners and thus fell within the Rehabilitation Act’s “direct threat” exception to disability-based discrimination.
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There are two court decisions which cast a measure of doubt on whether mandatory HIV screening can pass constitutional muster, but both are unlikely to pose a serious impediment to most mandatory screening programs. The first is *Walker v. Sumner*, a Ninth Circuit decision from 1990 which invalidated an AIDS testing program in Nevada. The factual situation surrounding the case is somewhat unclear, but the Ninth Circuit accepted for the purpose of the appeal a prisoner’s contention that he was subjected to a blood test, allegedly to determine HIV status. The prisoner stated that he and others were threatened with tasers and forbidden to exercise or shower to enforce the mandatory test. Prison officials stated that all prisoners were subjected to this mandatory testing, and that the purpose was to determine whether any prisoner was infected with HIV. The Ninth Circuit invalidated this testing regime after analysis similar to that of the 10th and 11th Circuits. Specifically, it applied the four-factor *Turner* test, and ruled that the testing program was not rationally related to a legitimate penological interests, saying,

In the instant case, defendants have introduced absolutely no evidence to suggest that a mandatory AIDS test, if such was the purpose of the blood sampling, was based on a legitimate penological objective. Nor have they attempted to demonstrate the relationship between any such objective and the blood-testing policy. The only attempted justification for the policy … is the bare and unsupported assertion in their motion for summary judgment and brief on appeal that a mandatory AIDS test “clearly has a logical connection to legitimate governmental interests…. AIDS testing is clearly a legitimate governmental interest and a valid penological objective.” Such conclusory assertions are wholly insufficient to sustain … the defendants’ burden.

The court then noted its doubts that the blood draws were even really about screening prisoners for HIV, giving consideration to the prisoner’s assertion that the real purpose of the tests were to train public health workers in drawing blood, so that they could participate in voluntary HIV screening for the general public. The court went on to state that, if this was the real purpose for the blood tests, it clearly would not be a legitimate penal interests such to satisfy the reasonableness requirement of the Fourth Amendment.

For several reasons, *Walker* is unlikely to provide useful precedent to other prisoners challenging mandatory HIV screening programs. First, the court itself noted the exceedingly low bar set for the state to justify such a search; the state need only prove a legitimate purpose and a rational relationship between screening and that purpose, but the state instead only gave a

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155. Id. at 385.
156. Id. at 384.
157. Id. at 386-87.
158. Id. at 387.
159. *Walker*, 917 F.2d at 387 (9th Cir. 1990).
conclusory statement that it had met the Turner test. Thus, if the state had even gone through the motions of trying to justify its program, the court would have likely upheld it. Second, and perhaps more damning to a plaintiff trying to rely on Walker, the Ninth Circuit notes that all prisoners had already been subject to mandatory screening at prison intake and suggests in dicta that this would be a legitimate purpose. Thus, the extent of Walker’s impact is probably limited to those programs whose administrators cannot provide any justification for their existence, and no state is likely to repeat Nevada’s litigation errors.

An Illinois federal district court decision, Thompson v. County of Cook, might provide slightly better cover for a Fourth Amendment challenge to mandatory prisoner HIV screening, although it deals with screening for other sexually transmitted diseases, and not HIV. In Thompson, the court heard a challenge to a county jail screening program which conducted urethral swabs of all male pretrial detainees. The program was supposed to be voluntary, though there is a factual dispute about whether voluntary consent was, in practice, always sought before the STD screening was conducted. In any event, the court found that the consent to testing form insufficiently described the nature of the urethral swab, so it did not constitute a free and voluntary waiver of Fourth Amendment rights. Thus, the court proceeded to analyze the screening program’s reasonableness as a search as though it was a mandatory program, applying the four-part Turner test and Skinner special needs balancing in the same fashion as the cases discussed above which have analyzed HIV screening. This court, however, conducted a much more searching factual inquiry than other courts, and, while accepting that “multiple studies and surveillance projects have demonstrated a high prevalence of STDs in persons entering jails and correctional facilities,” that Cook County had not shown comparable levels in its jails. Of greater concern to the court, though, was the fact that the county did not seem to use the test results as a basis for any public health intervention; no inmate had ever been treated for an STD after a positive test result, so the court had difficulty finding a legitimate government purpose which was advanced by the screening. Additionally, the court noted that the invasiveness of a penile swab is substantially greater than many other kinds of screening procedures, and the county had made no effort to reduce the invasion of privacy by providing a private space

160. Id. at 388.
161. Id. at 387.
163. Id. at 883-84.
164. Id. at 886.
165. Id. at 891.
166. Id. at 891.
167. Thompson, 412 F. Supp. 2d at 892.
168. Id. at 893.
for the testing. Ultimately, the court found sufficient evidence of a Fourth Amendment violation that it denied the county’s motion for summary judgment.

The Thompson decision, while the strongest for a prisoner challenging a mandatory screening program, is still distinguishable from most HIV screening programs. The specifics of the Cook County procedure—a penile swab in the cell—is much more invasive than the oral swab or blood draw required for an HIV test. Courts have decline to find a similar level of invasion from even blood tests as the Thompson court attributed to a urethral swab. The Supreme Court has espoused a societal judgment “that blood tests do not constitute an unduly extensive imposition on the individual’s privacy and bodily integrity.” Additionally, had the county espoused any public health purpose for the screening, it likely would have been able to pass the deferential Turner test.

Because so few courts have ruled on the question of whether mandatory prisoner HIV screening violates the Fourth Amendment, it is helpful to look to related programs to gain a better understanding of how most courts would apply the special needs doctrine to prison HIV screening programs. One recent focus of litigation deals with state laws which require or authorize HIV testing of people convicted or accused of sex offenses or other offenses which the state has classified as posing a risk of transmission. Such laws have been overwhelmingly upheld against constitutional challenge. For example, in 2007, the Supreme Court of South Carolina upheld involuntary HIV testing of a man accused of sexual assault under the special needs doctrine. The court accepted the state’s assertion that such testing advanced important public health purposes by facilitating treatment and counseling of both the victim and the offender. It also found that the HIV test is minimally intrusive, tipping the balance of interests in favor of allowing testing without a warrant or individualized suspicion.

169. Id.
170. Id.
171. See Skinner v. Ry. Labor Executives Ass’n, 489 U.S. 602, 625 (1989) (holding the intrusion from drawing blood “is not significant, since such tests are a commonplace in these days of periodic physical examinations and experience with them teaches that the quantity of blood extracted is minimal, and that for most people the procedure involves virtually no risk, trauma, or pain.”).
172. Winston v. Lee, 470 U.S. 753, 762 (1985) (finding that forced surgery to recover a bullet from a criminal defendant for use in his prosecution was an unreasonable search under the Fourth Amendment).
174. Id. at 317.
175. Id.
Other courts have ruled the same way in cases involving sexual assault,176 prostitution or solicitation of prostitution,177 possession of drug paraphernalia,178 and assault of law enforcement officers179 on the belief that these offenses pose a risk of HIV transmission. Courts have given great deference to states’ espoused public health purposes, including assertions that testing offenders provides psychological benefits to the victim,180 facilitates prophylaxis,181 helps target prevention activities to the offender,182 and reduces transmission by informing victims of their potential infectiousness before they would test positive.183 Claims challenging the laws’ public health purposes on the grounds that testing does not benefit victims because the time lag between infection and testing positive would miss some cases,184 because too much time had passed for prophylactic treatment to prevent infection should the offender have been HIV positive,185 or because and offenders’ positive status does not prove that the victim has been infected186 have not been successful. Additionally, arguments that the offense inherently posed a very low risk of transmission have often,187 but not always,188 been rejected; claims that the

181. E.g., Roberts, 756 F. Supp. at 903-04; State ex rel. J.G., 701 A.2d at 1269-70.
182. E.g., People v. C.S., 583 N.E.2d at 730; Houey, 651 S.E.2d at 317; In re A, B, C, D, E, 847 P.2d at 461.
183. E.g., United States v. Ward, 131 F.3d 335, 341 (3d Cir. 1997); Roberts, 756 F. Supp. at 903; Houey, 651 S.E.2d at 317.
184. E.g., Adams, 498 S.E.2d at 272.
185. E.g., Isom v. State, 722 So.2d 237, 238 (Fla. Dist. Ct. App. 1998) (accepting the public health purpose of facilitating victim treatment even when the test was not conducted until 18 months after the assault); State ex rel. J.G., 701 A.2d at 1269-70 (holding that knowing the offender’s status would influence at least some prophylaxis decisions).
186. E.g., State ex rel. J.G., 701 A.2d at 1269.
187. E.g., People v. Hall, 101 Cal. App. 4th at 1022-23 (upholds testing where only bodily fluid exposure was sweat); J. v. Mun. Court, 218 Cal. App. 3d at 1279 (upholding test where transfer was a “theoretical possibility”); People v. C.S., 583 N.E.2d at 729-30 (upholds testing upon conviction for unauthorized possession of hypodermic needle even though possession does not necessarily entail any risk behavior for transmission); In re A, B, C, D, E, 847 P.2d at 461 (upholding testing even where the offense consisted of fondling and not any exposure to fluids).
per-incident risk is quite low have also not been accepted.\(^1^8^9\) Furthermore, courts tend to credit the assertion that HIV tests are not highly intrusive.\(^1^9^0\) Some courts have found a diminished expectation of privacy because the offender is incarcerated.\(^1^9^1\) Finally, a few courts have found that testing is justified not because of the nature of the act which constituted the offense but because the class of offenders is at a heightened risk of infection and subsequent transmission.\(^1^9^2\)

While these cases are distinguishable from challenges to mandatory prisoner HIV screening programs due to the individual nature of post-offense testing, they still provide valuable insight into how courts analyze HIV testing under the special needs doctrine. In particular, as noted above there appears to be essentially universal agreement that HIV testing is a minor intrusion, allowing a less compelling state interest to outweigh the intrusion of the search. Second, none of the courts looked behind the asserted public health purpose to ensure that it was valid, suggesting that courts will credit any rational public health purpose for screening. However, the greatest evidence that prisoner screening programs would be upheld is provided by those courts which evaluated the constitutionality of testing prostitutes or drug users. The argument in these cases, unlike the sexual assault and assault on a police officer cases, was not that mandatory testing advanced the health of an individual victim—an argument that could not be made in the context of general prisoner screening. Rather, in the prostitution and drug cases, the courts accepted that testing was justified as a means of screening and facilitating interventions to prevent transmission within and beyond a high risk population. Because this is the same argument that is often advanced as the purpose of prisoner

188. \(\text{E.g.},\) State ex rel. J.G., 701 A.2d at 1273 (requiring “probable cause to believe that the victim may have been exposed to the bodily fluids of the assailant such that there is a possibility of transmission of the AIDS virus”).

189. \(\text{E.g.},\) State ex rel. J.G., 701 A.2d at 1269 (noting risk of transmission per sexual act as low as two per 1000).

190. \(\text{E.g.},\) Roberts, 756 F. Supp. at 902 (rejecting that there is a great intrusion due to stigma associated with HIV because of the limited disclosure of test results); Love, 226 Cal. App. 3d at 774 (relying solely on past legal precedent about intrusiveness); Adams, 498 S.E.2d at 271 (terming the HIV test a “minor annoyance”); People v. Doe, 642 N.Y.S.2d 996, 1003 (Nassau County Ct. 1996) (terming the intrusion for an HIV test “de minimis”); Illinois v. Adams, 597 N.E.2d 574, 582 (Ill. 1992) (relying on previous courts’ statements of minimal intrusion); In re A, B, C, D, E, 847 P.2d at 460 (rejecting that there is a great intrusion due to stigma associated with HIV because of the limited disclosure of test results). But see State ex rel. J.G., 701 A.2d at 1267 (noting that the intrusion is amplified due to the subsequent analysis to detect HIV and potential disclosure).

191. \(\text{E.g.},\) United States v. Ward, 131 F.3d 335, 342 (3d Cir. 1997); People v. Adams, 597 N.E.2d at 583 (Ill. 1992).

192. \(\text{E.g.},\) People v. Adams, 597 N.E.2d at 581 (accepting that testing prostitutes appropriately targets interventions to a high risk group); People v. C.S., 583 N.E.2d 726, 729-30 (holding that intravenous drug users as a class are at an increased risk of transmission, justifying the state’s desire to test them for HIV); In re A, B, C, D, E, 847 P.2d at 461 (crediting legislature’s belief that sex offenders are at a heightened risk of transmission).
screening, the fact that courts upheld prostitute and drug offender testing suggests a willingness to also accept screening of other populations at heightened risk of HIV.

Another area which has seen a reasonable number of cases is HIV screening of government employees, and the courts have split on whether this constitutes a Fourth Amendment violation. In *Glover v. Eastern Nebraska Community Office of Retardation*, a state health agency required employees to undergo blood tests for HIV and hepatitis B, on the grounds that employees interacted with potentially aggressive clients, who could become infected if they came into contact with an infected employee's blood or other bodily fluids. The Eighth Circuit applied special needs balancing and, after determining that the risk of transmission was negligible, the court found that there was no sufficient government interest to outweigh employee's expectation of privacy, rendering the screening program unreasonable under the Fourth Amendment. Unlike the prison screening cases, the *Glover* court did not find a decreased expectation of privacy by the people subject to screening, and was not persuaded that the espoused public health purpose was sufficient to outweigh an undiminished privacy interest.

However, an Ohio federal district court went the other direction in *Anonymous Fireman v. City of Willoughby*, which involves a challenge to a city's mandatory HIV screening for firefighters and paramedics. The city stated that their reason for requiring HIV screening was to ensure that emergency workers were healthy enough to carry out their job functions and because the likelihood of transmission from firefighters and EMTs was greater than for most types of workers. The court found that emergency personnel employment is so highly regulated as to greatly reduce the expectation of privacy that firefighters and medics have when it comes to searches designed to protect public health and safety. Ultimately, the court ruled that the public health and safety interests advanced by the screening program outweighed the diminished privacy interests, so the screening program was reasonable under the Fourth Amendment.

After examining the run of relevant cases, it is apparent that the courts are highly permissive of mandatory screening programs when challenged under the Fourth Amendment. Certain common themes can be found in the cases discussed above. First, courts are quite deferential to the public health purposes which states give as justifications for mandatory screening programs.

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194. *Id.* at 462-63.
195. *Id.* at 464.
196. *Id.*
198. *Id.* at 412.
199. *Id.* at 415-16.
200. *Id.* at 417-18.
Only rarely did the courts look behind the espoused rationale for a screening program to evaluate whether it advanced the public’s health; in those cases where the public health purpose was deemed insufficient it was either because the state could not give a rationale for screening or because screening led to no public health benefit. Most courts, however, took the state at its word that screening identified new cases and led to more effective treatment or prevention programs, or would at least inform future programs, should the state decide to implement them. While this paper takes the position that high-quality prisoner screening programs can play an integral role in public health programs to address HIV, courts should not give prison systems carte blanche to screen without following up with interventions to address HIV transmission or prisoner health. As described earlier in this paper, the value of HIV screening is that it informs and helps target other interventions; counting cases is not a public health gain in itself unless the information gathered is put to some beneficial use. More courts should follow the example of the Thompson court and insist that there be some nexus between the screening program and some measure that could be reasonably believed to promote public health. However, Thompson was too restrictive in requiring a showing that there is presently a high level of disease before screening could serve a public health purpose; because screening is designed in part to determine what the prevalence of HIV is in a prison system, a lack of data about prevalence should support the legitimacy of the state’s purpose, not defeat it.

The second commonality among the relevant case law is that the courts do not consider an HIV test to be very intrusive, which allows even a relatively weak state interest to outweigh the intrusion from a mandatory HIV test. Most courts deal with this issue simply by citing to the Supreme Court’s bald assertion that medical tests are minimally intrusive. There is some evidence that, for at least a portion of the public, HIV testing is highly stressful. The courts tend to deny that much of the apprehension about testing is based not in the physical act of having blood drawn or oral fluids swabbed, but in-

201. Walker v. Sumner, 917 F.2d 382, 386-87 (9th Cir. 1990).
203. E.g., Dunn v. White, 880 F.2d 1188, 1196 (10th Cir. 1989).
204. Thompson, 412 F. Supp. at 893.
205. E.g., Love, 226 Cal. App. 3d at 744 (relying solely on past legal precedent about intrusiveness).
206. Patrick S. Sullivan et al., Failure to Return for HIV Test Results among Persons at High Risk for HIV Infection, 35 J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES 511, 512 (2004) (finding that 20-30% of people who failed to return to a testing site for their results did so out of a fear of what the results could be).
207. Roberts, 756 F. Supp. at 902. In other settings, the nature of the degree of fear or apprehension engendered in the person subject to a search has been held to be relevant to the intrusiveness of the search. Mich. State Police v. Sitz, 496 U.S 444, 452-53 (1990) (discussing the lesser degree of subjective intrusion due to fear and surprise when motorists are stopped at DUI checkpoints than when they are subject to roving-patrol stops).
stead in fears about the possibility of a positive test or the stigma associated with HIV testing or a positive result. By failing to accurately assess the level of intrusion from mandatory HIV screening, the courts improperly weight the balancing test and potentially allow too small of a public health purpose to outweigh their perceived level of intrusiveness.

Lastly, the courts significantly err in failing to evaluate alternatives. Under Turner, mandatory screening would not have to be the least restrictive alternative to be valid, but the existence of alternative measures which would not infringe on prisoners’ rights and entail minimal costs to penological purposes is evidence that the prison policy is an overreaction and not reasonably related to the government’s interest. However, all of the courts which have addressed this issue seemed to assume that their only options were mandatory HIV screening or no effective HIV surveillance at all. As discussed earlier in this paper, this is not true. There is strong evidence that a very high proportion of prisoners will consent to a HIV test under a well-executed routine, opt-out screening regime. Courts should at least consider this option and require correctional officials to demonstrate that opt-out screening is impractical before upholding mandatory screening programs.

The minority of courts which would strike down mandatory screening programs would likely uphold alternative programs, including opt-out, opt-in, and on-demand testing. As a general rule, consent to search eliminates the Fourth Amendment issue so long as it is given freely and voluntarily, a standard which is based on the totality of the circumstances and which tends to be interpreted deferentially to authorities. In fact, there is no bright-line rule that a person be notified of their right to refuse the search for it to be deemed voluntary. Only a few cases have dealt with the issue of consent to a search in the context of screening for health conditions. In Thompson v. County of Cook, a federal district court invalidated a prison STD screening program which required a penile swab, but suggested that the program would have been valid had the institution been able to demonstrate that inmates were informed of the purpose and degree of intrusiveness of the test beforehand.

Similarly, a federal court in Nebraska upheld a state law which called for the screening of all newborns for metabolic disorders over Fourth Amendment objections. Because parents were notified of the test before it was conducted,

210. E.g., Dunn, 880 F.2d at 1195 (stating, “The prison cannot determine the amount of infection without testing.”).
211. Grinstead et al., supra note 62, at 550; Boutwell et al., supra note 100, at 319.
212. Ohio v. Robinette, 519 U.S. 33, 39 (1996) (upholding consent search of vehicle where driver was not told he could decline the search).
213. Id. at 39.
Based on these decisions, it seems that even those courts which would invalidate mandatory screening would uphold the other screening options, all of which provide advance notice of the procedure.

C. Free Exercise of Religion Claims

The First Amendment states that “Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof…” The Free Exercise Clause protects against both state and federal laws which specifically target religious exercise, but in 1990 the Supreme Court ruled that laws of general applicability which only burden religious exercise are not constitutionally prohibited, overturning the previous requirement that such laws must advance a compelling government interest to be upheld. In response, Congress passed the Religious Freedom Restoration Act (RFRA) to require strict scrutiny of facially neutral state and federal laws substantially burdening religious exercise. However, in 1997, the Court ruled that RFRA, as applied to states, was beyond the scope of Congress’s 14th Amendment power to create laws which protect deter states from violating citizens’ constitutional rights. Congress responded by passing the Religious Land Use and Institutionalized Persons Act (RLUIPA) in 2000, which among other things, requires strict scrutiny to be applied to state and municipal inmates’ religious freedom challenges to prison regulations. In particular, it requires that no burden on an inmate’s free exercise can be upheld unless it “is in furtherance of a compelling government interest; and is the least restrictive means of furthering that compelling government interest.” Because the law only applies to those institutions which receive federal funds, which, in practice, includes all correctional facilities, the Court has ruled that RLUIPA was a valid exer-

216. U.S. CONST. amend. I.
217. Cantwell v. Connecticut, 310 U.S. 296, 303 (1940) (holding that the Free Exercise Clause is incorporated by the 14th Amendment).
cise of congressional authority. Thus, when federal, state, or local inmates challenge prison policies, which are facially neutral on free exercise grounds, their claims receive strict scrutiny. As a result, while the Court noted that legitimate concerns of prison “discipline, order, safety, and security” would be compelling state interests, the Turner decision, limiting oversight of infringements on prisoners’ constitutional rights to rational basis review, is explicitly abrogated in the free exercise context.

Involuntary HIV screening can substantially burden prisoner’s free exercise rights, as a variety of religious traditions limit the types of permissible medical tests or the points in time during which such tests can be conducted. Only one court has addressed a free exercise challenge to a mandatory HIV screening program. In Dunn v. White the Tenth Circuit considered a prisoner’s assertion that compulsory HIV testing violated his religious beliefs. Because the prisoner has the threshold obligation of demonstrating that the objection is based in a sincerely held religious belief, the court ruled that the plaintiff’s conclusory statement that his objection was on “generic religious grounds” was insufficient to state a free exercise claim.

Free exercise challenges to tuberculosis screening in correctional facilities have been much more common. While most of the claims have failed, some have been successful, and a great deal more would have likely succeeded had they been analyzed under RLUIPA’s strict scrutiny requirement. All of the cases which have addressed this question found tuberculosis screening to be

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226. Id. at 724-26.
227. Id. at 726 (upholding strict scrutiny in state and local inmate challenges and noting that strict scrutiny had been applied for several years under RFRA for federal inmates’ free exercise claims). See also Gonzales v. O Centro Espirita Beneficiente Uniao do Vegetal, 546 U.S. 418, 439 (2006) (upholding RFRA’s strict scrutiny test as applied to drug laws of general applicability).
228. Wilkinson, 544 U.S. at 722-23, n.11.
229. See, e.g., Dunn, 880 F.2d at 1197-98 (noting the objection to an HIV test based on the tenants of an unspecified religion, but rejecting it for lack of specificity about the nature of the religious objection); Jones-Bey v. Wright, 944 F. Supp. 723, 728 (N.D. Ind. 1996) (noting the objection of an adherent to the Islamic faith to a tuberculosis skin test); Karolis v. New Jersey Dep’t of Corr., 935 F. Supp. 523, 527 (D.N.J. 1996) (noting the objection of an adherent to the Christian Science faith to the administration of a tuberculosis skin test); Hasenmeier v. Rose, 986 F. Supp. 464, 466 (S.D. Ohio 1998) (noting the religious objection of an adherent to the Christian faith to a tuberculosis skin test).
231. Dunn, 880 F.2d at 1188.
232. The threshold question in a free exercise claim is the sincerity of the religious belief—though its “truth” obviously could not be open to review without Establishment Cause implications. Cutter v. Wilkinson, 544 U.S. 709, 725 n.13 (2005). For the purposes of this analysis, it is assumed that at least some potential objections to HIV screening would be based in a sincerely held religious belief.
233. Dunn, 880 F.2d at 1197-98 (stating that the prisoner gave no details of his religious beliefs or how they were inconsistent with HIV testing).
facially neutral laws of general applicability; in no instance was there evidence that the screening program was intended to limit the exercise of religion. All courts that addressed the question found tuberculosis control to be a legitimate or compelling state interest, given the high rate of intraprison transmission, the possibility of treating patients before they developed illness, and the disease’s asymptomatic nature prior to its becoming transmissible. Those courts that invalidated a screening program did so on the grounds that there were less restrictive alternatives to the enforcement method or post-refusal response employed by the prison. For example, some jurisdictions placed prisoners who refused the tuberculosis skin test in medical isolation for up to a year, reduced privileges, or forcibly administered the test. In most cases, the doctrine was applied, requiring only a rational relationship between the government interest of disease control and the screening program, though a few courts applied strict scrutiny. Those courts which applied strict scrutiny did not necessarily invalidate the screening program, but they did require a showing that the particular method of en-

234. The courts also universally held, at least arguendo, that the policies substantially burdened the prisoner’s exercise of religion. E.g. Jihad v. Wright, 929 F. Supp. 325, 330 (N.D. Ind. 1996).
240. E.g., Reynolds, 103 F. Supp. 2d at 338-39; Jihad, 929 F. Supp. at 330-31. Contra Ballard v. Woodard, 641 F. Supp. 432, 437 (W.D.N.C. 1986) (finding that, where prisoner would have allowed the test to be administered after sundown, there was no violation in proceeding with forcible administration of tuberculosis skin test).
241. Jihad, 929 F. Supp. at 328; Jones-Bey, 944 F. Supp. at 728; Selah, 255 F. Supp. 2d at 48; Word v. Croce, 230 F. Supp. 2d 504, 5106 (S.D.N.Y. 2002). In those jurisdictions with a one-year medical isolation policy, the theory is that active tuberculosis is most likely to develop within one year of exposure, so if a person who refuses the test is held for one year and does not develop tuberculosis, they are unlikely to do so afterwards. Some courts have found this reasoning dubious. Reynolds, 103 F. Supp. 2d at 339.
244. Hasenmeier, 986 F. Supp. at 467; Reynolds, 103 F. Supp. 2d at 336; Rossi, 714 N.Y.S.2d at 817; Selah, 225 F. Supp. 2d at 52; Word, 230 F. Supp. 2d at 512; Cannon, 824 N.E.2d at 1230; Africa, 998 F. Supp. at 559; Bailey, 666 N.Y.S.2d at 384.
246. Karolis, 935 F. Supp. at 528 (finding that screening for latent TB was the least restrictive means of preventing transmission because identification of latent cases is an integral component of TB control).
forcing mandatory tuberculosis screening was the least restrictive of religious exercise. A few courts ruled that screening for latent tuberculosis by skin test was not the least restrictive means of preventing transmission because prisoners with clinical signs of active disease could be tested with a chest x-ray or sputum sample at the point where they posed a transmission risk.

Most courts upheld involuntary tuberculosis screening over religious objections, because the courts analyzed prisoners’ claims under rational basis review, which is no longer the applicable law. Of those courts which applied strict scrutiny—the current standard under RLUIPA—only one court upheld mandatory screening. This court did so on the grounds that identification of latent tuberculosis was integral to preventing cases of the active form of the disease and preventing transmission. HIV is not nearly as transmissible as tuberculosis—it cannot be transmitted through casual contact—so it is less likely that courts would find a compelling state interest in the identification of each and every case. It is likely that many courts would find education or risk behavior modification to be alternatives to mandatory screening for those who decline testing, or for opt-out testing to be an appropriate programmatic alternative. Thus, prisoner HIV screening programs which allow for opting out on religious grounds are substantially more likely to avoid constitutional violations (and the associated costs from litigation and damages) than those which enforce screening of all prisoners. At the very least, if states utilize mandatory screening for HIV, they must enforce such a policy with the least restrictive means of enforcement that serves the state’s interests.

D. Cruel and Unusual Punishment Claims

The Eighth Amendment prohibits the infliction of cruel and unusual punishments. In a handful of cases, inmates have challenged prison programs which involuntarily screen for HIV or other infectious diseases under the Eighth Amendment. These claims take two forms: that the medical procedure used to carry out a screening program is itself unduly painful or that methods used to enforce mandatory screening are cruel and unusual. The former claims universally fail, and the latter are only rarely successful.

248. Jihad, 929 F. Supp. at 331 (finding that the availability of alternatives failed to satisfy strict scrutiny); Reynolds, 103 F. Supp. 2d at 338-39 (finding that availability of alternatives failed to satisfy even a rational basis test). One court aptly noted the lack of this alternative where the prisoner refused both the skin test and subsequent tests for active tuberculosis—a chest x-ray or sputum smear. Word, 230 F. Supp. 2d at 512.
250. U.S. CONST. amend. VIII.
251. Additionally, some prisoners have asserted 8th Amendment claims for being placed in prisons that do not conduct mandatory screening for HIV. These claims have universally failed, and they will not be discussed at length in this section. For more information, see, e.g., Myers v. Md. Div. of Corr., 782 F. Supp. 1095, 1096-97 (D. Md. 1992) (finding no violation for
Because no state uses its screening programs as a punishment for crime, but rather as a public health measure once incarcerated, the relevant Eighth Amendment test is whether any aspect of the screening program creates conditions of confinement so depraved as to be cruel and unusual. When “official conduct that does not purport to be the penalty formally imposed for a crime” is challenged as cruel and unusual punishment, a prisoner must make two showings. First, the prisoner must show that the treatment is “objectively, sufficiently serious … [as to] result in the denial of the minimal civilized measure of life’s necessities … [or] under conditions posing a substantial risk of serious harm.” Second, the prisoner must also show prison officials’ bad intent: “deliberate indifference to inmate health or safety,” which the Court has stated is the equivalent of the criminal mens rea of recklessness, requiring that the official be actually aware of the substantial risk and disregard it.

In a few instances, prisoners have challenged screening programs, or similar public health endeavors, on the basis of pain or risk of disease that the program directly inflicts. In Langton v. Commissioner of Correction, prisoners

failure to implement mandatory HIV screening); Feigley v. Fulcomer, 720 F. Supp. 475, 480 (M.D. Pa. 1989) (finding no violation for failure to implement routine HIV screening). However, failure to provide prisoners treatment after identification of a disease can support a claim of cruel and unusual punishment if it rises to the level of deliberate indifference to the health or safety of the prisoner. Estelle v. Gamble, 429 U.S. 97, 106 (1976). Though interesting, this issue is beyond the scope of this paper, as the constitutional dimensions of inadequate treatment are unrelated to the fashion by which cases are identified. See the text of this section for a general discussion of the deliberate indifference standard.

252. Note that the Eighth Amendment only applies to prisoners who have been convicted of crimes. If the inmate is a pretrial detainee, such claims would be evaluated under the 5th or 14th Amendment’s due process clause instead of the Eighth Amendment. The deliberate indifference standard for claims of unconstitutional living conditions is the same when applied to pre-trial detainees as to post-conviction inmates. Tesch v. County of Green Lake, 157 F.3d 465, 474-75 (7th Cir. 1998) (applying the same test to pre-trial detainee’s allegation of unconstitutional conditions for not accommodating disability as have been applied under the Eighth Amendment). See also Thompson, 412 F. Supp. 2d at 887 (finding that a pretrial detainee could not sustain an 14th Amendment claim against mandatory STD screening because, so long as the program was rationally related to a legitimate state interest, it did not constitute punishment without conviction).

253. Specific acts or omissions that are not formal punishment fall within the conditions of confinement test, even if they are not related to environmental conditions within the institution. Wilson v. Seiter, 501 U.S. 294, 299 n.1 (1991). If, on the other hand, a prisoner challenges the nature of his or her sentence itself, the test is whether the punishment constitutes “unnecessary and wanton infliction of pain.” Gregg v. Georgia, 428 U.S. 153, 173 (1976) (reinstating the death penalty).

254. Wilson, 501 U.S. at 301.
256. Id.
257. Id. at 839-40.
258. Id. at 834.
challenged a mandatory Massachusetts program which tested inmates for tuberculosis and *Candida albicans*, a fungal infection. Among other challenges, the prisoners asserted that the tests were done under unsanitary conditions which posed a risk of disease acquisition, and that the tests “caused both of the plaintiffs’ arms to bleed, discolor, and further to become inflamed.” The court did not credit the plaintiffs’ claims of substantial harm; it also found that the prisoners had failed to demonstrate, even if the level of harm had been sufficient, that prison officials inflicted pain or risk with a deliberate indifference for the prisoners’ health or safety.

In *Zaire v. Dalsheim*, an inmate asserted that forcible diphtheria-tetanus vaccination violated the Eighth Amendment by subjecting him to unspecified severe physical and emotional pain. A New York federal district court dismissed the action for failure to state a claim, largely on the grounds that no argument of deliberate indifference could be made because the inoculation was performed to protect inmates from dangerous diseases. Thus, the officials’ state of mind was benevolent and not “callous indifference.” Additionally, the court ruled that the forcible nature of the vaccination did not cause sufficient distress as to violate the Eighth Amendment, as it was at most “rude and unpleasant.”

Similar claims against HIV screening would likely meet the same fate, so long as prison officials do not disregard basic medical procedures designed to protect patients. (Reuse of needles used to draw blood, for example, might be such a gross deviation from appropriate medical care as to constitute deliberate indifference to prisoner safety.) Just as the courts which have dealt with the direct pain inflicted by inoculations or the tuberculosis skin test found the harm to be insufficient for an Eighth Amendment violation, the courts that addressed the intrusion from drawing blood for HIV tests (when analyzing Fourth Amendment claims) universally found the tests to be safe, of minimal pain, and only a minor intrusion. The recent availability of preliminary HIV screening tests, which involve only an oral swab, makes a claim of undue pain or risk even harder to make.

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260. See id. at 1004. The state alleged that the *Candida* test was to determine immune system functioning; in order to read a tuberculosis skin test accurately, it is necessary to have knowledge about the patient’s immune function. However, the prisoner claimed that the *Candida* test was really an HIV test. *Id.* While the test could not detect HIV, the assertion was somewhat plausible since oral and esophageal candidiasis is often one of the early clinical signs of HIV or immunosuppression due to other causes.

261. *Id.* at 1007.

262. *Id.* at 1007-08.


264. *Id.* at 59-60.

265. *Id.* at 59-60.


267. See Wesolowski et al., *supra note* 25, at 1663 (describing the oral swab technique).
The second form of cruel and unusual punishment claims against mandatory screening programs stem not from the inherent nature of the test, but instead from the means that the prison uses to enforce the screening requirement. This issue has arisen repeatedly in the context of tuberculosis screening. Some prisons, if an inmate refuses the tuberculosis test, will place the prisoner in isolation, transfer the prisoner into a medical ward containing infectious or presumably infectious prisoners, or forcibly administer the test. These claims have usually failed to meet the Eighth Amendment’s high bar, but courts have found violations where isolation deprived the inmate of exercise or where the amount of force used to involuntarily administer the test was excessive. Additionally, while segregating HIV positive prisoners has not been held to violate the Eighth Amendment, if prisoners who refuse an HIV test were placed in medical isolation with inmates who had diseases which could be transmitted by casual contact—such as tuberculosis—an Eighth Amendment claim might succeed, though prison officials would have to know that the inmate’s contacts were infectious. Thus, while a mandatory HIV screening program, in itself, would almost certainly pass Eighth Amendment muster, it could be deemed cruel and unusual if officials’ methods of enforcing the testing mandate expressed deliberate indifference to inmate safety. Such a program, though, would have to be grievously deficient of safeguards for prisoners to violate the Eighth Amendment.

268. Williams v. Greifinger, 97 F.3d 699, 701-02 (2d Cir. 1996); Bailey, 666 N.Y.S.2d at 386; Africa, 998 F. Supp. at 560.
269. Jihad, 929 F. Supp. at 332; Jones-Bey, 944 F. Supp. at 733 (rejecting the claim of increased risk because the prisoner did not actually contract tuberculosis).
271. Jolly v. Coughlin, 76 F.3d 468, 481-82 (2d Cir. 1996); Williams, 97 F.3d at 707; Jihad, 929 F. Supp. at 332 (denying defendant summary judgment on Eighth Amendment claim where prisoner who refused tuberculosis test was placed in infectious disease wing and given very limited exercise rights).
272. Ballard, 641 F. Supp. at 438 (denying defendant summary judgment where correction official allegedly choked prisoner while compelling submission to tuberculosis skin test).
274. See Drug Susceptible TB, supra note 67, at 1041-44; TB Outbreaks, supra note 67, at 79-82.
275. See Powers v. Snyder, 484 F.3d 929, 931 (7th Cir. 2007) (suggesting a potential Eighth Amendment claim for knowingly exposing a prisoner to infectious disease); Billman v. Ind. Dep’t of Corr., 56 F.3d 785, 788-89 (7th Cir. 1995) (denying dismissal of Eighth Amendment claim where defendants assigned prisoner a cellmate with HIV and a history of raping his cellmates).
276. One of the tuberculosis cases explicitly drew this distinction. Jolly, 76 F.3d at 481 (“The plaintiff does not challenge the DOCS testing policy; rather, the plaintiff challenges his continued isolation in medical keeplock.”).
E. Equal Protection Claims

The Fourteenth Amendment prohibits denial of “equal protection of the laws.”277 The basic doctrine behind equal protection dictates that “all persons similarly circumstanced shall be treated alike.”278 In its modern formulation, the level of scrutiny given an equal protection claim turns on the classifications created by the law. If the law implicates a suspect class, such as race, strict scrutiny is applied, and the classification must be necessary to fulfilling a compelling state interest with no less restrictive alternative.279 If, however, no suspect class is implicated, rational basis scrutiny is applied. Under this test, the classification must bear only a rational relationship to a legitimate government interest, and substantial over and under-inclusiveness in the classification is permitted.280 Because mandatory prisoner screening programs create a facial classification on the basis of inmate status, equal protection challenges are possible. However, courts have consistently held that inmates are not a suspect class and equal protection challenges based on prisoner status are thus subject only to rational basis review.281 Thus, either inmates who challenge mandatory HIV screening programs, which apply to incarcerated people but not people in the general public, have the difficult task of showing that such programs are not designed to advance a legitimate government interest or that the classification is so irrational as not to advance the interest. With the exception of programs such as the Nevada screening program at issue in Walker v. Sumner282—in which the state could not give any purpose for mandatory HIV testing and which was struck down on Fourth Amendment grounds

277. U.S. const. amend XIV, §1. While the 14th Amendment’s equal protection clause applies only to the states, the right has been incorporated against the federal government through the Fifth Amendment’s due process clause. See Bolling v. Sharpe, 347 U.S. 497, 498-500 (1954) (ordering the desegregation of District of Columbia schools under the 5th Amendment’s due process clause).
279. See, e.g., Loving v. Virginia, 388 U.S. 1 (1967) (invalidating anti-miscegenation laws). Sex is subject to intermediate scrutiny, requiring an important government interest to be furthered by substantially related means. See, e.g., Craig v. Boren, 429 U.S. 190 (1976) (upholding different drinking ages for men and women in Oklahoma).
280. E.g., New York City Transit Auth. v. Beazer, 440 U.S. 568 (1979) (upholding city transit authority’s refusal to hire methadone patients even though there was no evidence that they posed a safety risk since the policy was rationally related to the legitimate interest of public safety and the fit between the classification and the purpose need not be tight in the absence of a suspect class).
281. See, e.g., Roller v. Gunn, 107 F.3d 227, 233 (4th Cir. 1997) (holding that prisoners are not a suspect class under the 14th Amendment); Pryor v. Brennan, 914 F.2d 921, 923 (7th Cir. 1990) (holding that prisoners are not a suspect class under the 14th Amendment); Nicholas v. Tucker, 114 F.3d 17, 19-20 (2d Cir. 1997) (holding that prisoners are not a suspect class under the 5th Amendment).
282. Walker v. Sumner, 917 F.2d 382 (9th Cir. 1990). See supra, section III.A, for a full discussion.
without having to reach the equal protection question—these challenges will invariably fail.

In 1992, the Supreme Court of Illinois heard *Illinois v. Adams*, which involved an equal protection challenge to a state law that mandated HIV testing for all people convicted of prostitution or solicitation of prostitution. The plaintiff argued that there was extensive over- and under-inclusiveness to the statute, and, as a result that it was insufficiently tailored to evince a rational relationship to the government’s interest in AIDS control. For instance, one could be subject to the law for solicitation of activities that did not entail a risk of sexual transmission. Conversely, one could engage in a variety of risky behaviors—including other forms of illegal sexual misconduct—without facing a mandatory HIV test. However, the court ruled that no class applicable to the plaintiff—such as her status as a convict or prostitute—was subject to heightened scrutiny. The court then went on to explain that, when heightened scrutiny is not applied, the state is free to address social problems in an incremental or piecemeal manner, and the fact that the law’s classifications do not bear a tight relationship with the government’s interest is not constitutionally problematic. The government need only show that the law rationally could be expected to advance “the state interest in combating the spread of AIDS.”

The Supreme Court of Georgia heard a similar case in *Adams v. Georgia*, in which a man struggled with a police officer during arrest and may have bled on the police officer. Under a state statute, which authorized testing of any defendant whose blood or bodily fluids came into contact with the victim in a fashion that the Centers for Disease Control and Prevention had demonstrated to entail a risk of infection, the arrestee was compelled to undergo an HIV test. As with the Illinois case, the Georgia court ruled that people arrested for crimes that the legislature has deemed to pose a transmission risk are not a suspect class, so rational basis review is appropriate. It then went on to rule that, because the classification was based on a risk category for infection, there was a rational relationship between the classification and the government interest in HIV control.

Given the low level of scrutiny afforded laws which differentiate between inmates and non-inmates, and the low level of fit that courts require between the population targeted for testing and the government interest of
HIV control when applying rational basis review, challenges to mandatory prisoner screening laws on the grounds that they deny prisoners, as a class, equal protection of the law are likely to fail. Any state that makes a bare effort to justify mandatory prisoner screening on the basis of epidemiologic data that suggests a greater prevalence of infection in correctional institutions is likely to be able to demonstrate a rational relationship to the legitimate government interest of reducing transmission or facilitating treatment. There might well be reasons to require heightened scrutiny of classifications which target inmates, such as their lack of electoral power—including, sometimes, legal disenfranchisement—and inability to acquire political allies. One theory of equal protection law is that it should operate to correct defects in the workings of representational democracy, and, under this view, inmates would be a group highly subject to political scapegoating and least able to organize and achieve their goals, so heightened scrutiny would be appropriate. Nonetheless, no court has ever granted anything beyond rational basis scrutiny to inmates in equal protection cases.

One might also assert that mandatory prisoner screening violates equal protection because its burdens would fall disproportionately on groups that receive heightened protection. Both males and people of minority heritage are substantially over-represented in prisons. Classifications on the basis of race are subject to strict scrutiny under equal protection analysis, and classifications based on sex are subject to intermediate scrutiny. Assertions that facially neutral public health laws are applied in such a disproportionate manner as to evince “an evil eye and unequal hand” occasionally succeed. However, such assertions are exceedingly difficult to successfully maintain. In addition to showing that the burdens of a policy fall more heavily on a protected class, challengers must prove that the policy was motivated by discri-

294. One additional case merits mention, in part because it is one of the more amusing equal protection challenges raised. In California v. Hall, the California Supreme Court upheld HIV testing of a man who, in the process of struggling with a police officer, sweated on him against a statutory interpretation challenge. The court ruled that the statute authorized testing of anyone who transferred bodily fluids onto a police officer. People v. Hall, 101 Cal. App.4th 1009, 1019 (Cal. Ct. App. 2002). Obviously, the application of the law to this circumstance is absurd, as there is absolutely no risk of sweat-borne transmission of HIV. However, after losing the statutory challenge, the defendant raised an equal protection claim, arguing that the law inappropriately treated differently people who sweat and people who do not. Unsurprisingly, the court rejected this challenge. Id. at 817.
297. Intermediate scrutiny requires an important government interest to be furthered by substantially related means. See e.g. Craig v. Boren, 429 U.S. 190 (1976) (upholding different drinking ages for men and women in Oklahoma).
minatory intent.299 In fact, a law can be motivated in part by invidious discrimination but still escape heightened scrutiny if the government can show independent causes of its creation.300 A plaintiff challenging mandatory prisoner screening would have difficulty demonstrating that racial (or gender) discrimination motivated the screening programs; after all, screening for various infectious diseases has been a long-standing practice in American prisons. Even if challengers could prove that discrimination played a role in the creation of prisoner screening programs, the state could still point to the multitude of public health purposes which can be advanced by screening and, given the courts’ deference to states public health purposes, would likely carry its burden of showing independent motivators for the law.

It appears that only one court has squarely addressed this issue in regard to compulsory HIV testing laws. In *Illinois v. Adams*,301 a woman challenged a law which mandated HIV testing of all people convicted of prostitution. One ground for the challenge was that, while facially neutral, the burdens of the law fell more heavily on women, who comprise the vast majority of prostitution convictions.302 Conviction for other crimes which involve sexual conduct—and which, arguably, would not disproportionately impact women—did not entail testing.303 The court, however, found that there was no evidence that the legislature created the law out of intent to discriminate against women, but rather out of a judgment that prostitutes are at a particularly elevated risk of transmission, so heightened scrutiny was not justified.304

This approach to heightened scrutiny has been heartily criticized. Professor Charles Lawrence, for example, has argued that disproportionate impact claims must be evaluated through the lens of cultural understandings about what legal classifications symbolize. For example, if decisions about what services to include in welfare benefits facially neutral but motivated largely out of stereotypes regarding the racial heritage and behavior of welfare recipients, then such laws should be subject to heightened scrutiny.305 There is a non-frivolous argument that mandatory prisoner screening laws are

300. Village of Arlington v. Metro. Hous. Dev. Corp., 429 U.S. 252, 271 n.21 (1977) (finding that denial of rezoning to allow multiple unit housing for low-income residents did not violate equal protection, even though there was some evidence that racial discrimination was one factor in the denial).
302. *Id.* at 585.
303. *Id.*
304. *Id.* at 585-86.
created by legislators’ risk perceptions about HIV transmission in prisons—populated largely by minorities—and the need to protect “innocent” society from the reservoir of HIV posed by such inmates. If this is true, then such laws reflect exactly the sort of democratic process defect that justifies heightened scrutiny.\textsuperscript{306} While practically sensible, such a view of equal protection would be difficult to apply, and the courts have squarely rejected it.\textsuperscript{307}

III. \textbf{ETHICAL ANALYSIS}

At this point, it should be clear that both mandatory and routine, opt-out screening of prisoners can serve important public health goals, and that, while there are serious constitutional concerns about compulsory HIV screening of prisoners, courts will usually uphold such programs. However, effective and lawful policy which violates fundamental notions of justice has no place among the policy of a civilized people, so this paper next turns to ethical considerations in prisoner screening. The crux of the ethical debate is the balance between the legitimate goals facilitating treatment and prevention of HIV infections—goals of life and death importance—and the dictate that, in a free society, individuals be compelled to serve the common good only after careful consideration and with the utmost caution. Unfortunately, much of the legal literature on this subject falls at one pole or the other, denying the utility of public health interventions\textsuperscript{308} or glossing over substantial infringements on personal freedom.\textsuperscript{309} This paper seeks to provide a balanced ethical analysis. Ultimately, it concludes that mandatory prisoner screening is ethically unacceptable, but that routine, opt-out screening best serves public and individual health interests while maintaining adequate respect for individual liberties.

\begin{itemize}
  \item \textsuperscript{306} Id. at 377-78.
  \item \textsuperscript{307} A minority of the Supreme Court has subscribed to this view, at least in dissent. See McCleskey v. Kemp, 481 U.S. 279, 332-33 (1987) (Brennan, J., dissenting) (arguing that cultural understanding of the role race plays in the death penalty demands greater scrutiny of disproportionate sentencing decisions).
  \item \textsuperscript{308} An exemplary of this can be found in the denial that there is any state interest in compulsory testing of newborns for HIV because “the administration of HIV treatment is costly, invasive, and ultimately ineffective.” Kellie E. Lagitch, \textit{Mandatory HIV Testing: An Orwellian Proposal}, 72 St. John’s L. Rev. 103, 131 (1998). This paper does not take the position that mandatory screening of newborns is appropriate, only that the debate over such issues should not resort to unjustified hyperbole.
  \item \textsuperscript{309} \textit{See}, e.g., Roberts, 756 F. Supp. at 902 (denying HIV testing is a significant intrusion because medical tests are a routine part of life and test results are not broadly distributed).
\end{itemize}
A. An Ethical Framework

This paper adopts, for ethical analysis, a framework largely based on the human rights impact assessment proposed by Mann and Gostin, though it argues for extensions to the framework to help guide policymakers’ evaluation of tradeoffs between individual rights and public health goals. This Mann and Gostin framework is adopted for two reasons. First, it is intuitive and gives practical guidance to the evaluation of difficult public health dilemmas. Second, it has gained broad acceptance in public health and public health law, and it is familiar to practitioners in both fields. This framework consists of six steps, which are outlined below.

The first step is to conduct rigorous fact-finding, collecting unbiased information about the health and ethical dimensions of a public health problem. Such information is vital to accurate weighing of the values at stake in any ethical analysis, and it is frequently conducted quite poorly by the courts when analyzing public health issues. For example, courts have held that intra-prison HIV transmission is rampant and largely due to homosexual rape or that drawing blood for medical testing is merely a minor annoyance. Of particular concern in the law, statements of fact should be based in empirical evidence and not by reference to determinations by appellate courts. For example, it is troubling that many lower courts have decided that there is little intrusion from blood tests simply because other courts believed this to be true, essentially creating an irrebuttable presumption as to the factual extent of medical tests’ intrusions. Issues such as the degree of intrusion from a particular test, the extent of the public health gains from a screening program, and so forth are questions of fact that should be determined in the context of individual instances, not questions of law for which the finding of one court should bind others.

The second step in the assessment is to clarify the public health purpose. Courts often assume that screening programs advance HIV control in general, which is clearly an important public interest, without regard to the method in which this is done. Consider the Tenth Circuit decision in Dunn v. White which upheld mandatory prisoner screening as a means to control intra-prison HIV spread, even though the prison was taking no steps to limit transmission or treat patients if a prisoner tested positive. It is illegitimate to claim as a public health purpose objectives which a policy has no possibility of attaining. In Dunn, the public health purpose would have been more app-
appropriately labeled case identification within prison than control of transmission.

The third step is to evaluate the likely effectiveness of a policy. This step should be self-evident. Great intentions to achieve public health purposes do not justify intrusions on personal freedoms; only reasonably likely results should be balanced against other ethically-relevant values. For example, a variety of statutes mandate testing of people who assault police officers in a fashion that exposes them to bodily fluids; this is not inherently unreasonable, but when bodily fluids are defined to include sweat, which cannot transmit HIV, no weight should be afforded the supposed public health purpose of HIV control. Estimates of the effectiveness of a policy should be based on the best available scientific evidence; neither unrealistic arguments for a program’s success by supporters nor speculative assertions about why a policy might fail by opponents are appropriate.

The fourth step is to evaluate how well-targeted the program is. The goal of any policy which grants benefits should be to target them to those who will gain the most or who need the greatest help; conversely, when an intrusion is necessary, it should be visited on the least number of people possible. This is similar to the law of equal protection, but requires a more searching analysis than is usually applied to non-suspect classes. For example, the law in Illinois v. Adams which mandated HIV testing for prostitutes but not offenders charged with other sexual crimes would be problematically over and under-inclusive. Additionally, this analysis should consider both the intent and foreseeable disproportionate impacts.

The fifth, and perhaps most crucial, step is to identify potential burdens from proposed policies. Here, as with earlier stages guiding the evaluation of programs’ effectiveness, it is important to seriously analyze the issue and not be wildly speculative. Focusing on four key factors can help narrow this investigation: identification of the specific principle involved; the extent to which the invasion occurs; the number of people affected; the frequency; and the duration of the burdens.

The last step is to evaluate the effectiveness and ethical burdens of each prospective policy. The goal is to adopt the most effective and least restrictive alternative, including considerations of cost-effectiveness. In some cases,
this assessment is easy; if a cheaper, voluntary screening program can obtain high rates of uptake, then it would be clearly improper to adopt a more expensive, compulsory program with lower rates of uptake. However, in many instances, the evaluation will not be so clear-cut. In some instances, efficacy will, at least to some extent, parallel intrusiveness, and then difficult decisions must be made about the point at which the marginal cost of a more intrusive policy outweigh the benefits. Furthermore, there is no natural exchange rate between public health benefits (deaths avoided, years of health preserved, etc.) and the largely intangible ethical burdens that policies can cause (loss of dignity, stigma, etc.). Reasonable people can, and will, disagree on what level of tradeoff is appropriate. Some policies are largely non-intrusive, and this paper does not address them. However, for those policies which are intrusive or coercive this paper extends the Gostin and Mann framework.

The first step in evaluating the tradeoffs from a coercive policy is to determine whether individual consent at the implementation level is required. This investigation begins by identifying to whom the benefits flow and on whom the burdens are placed. If the purpose (and likely result) of a policy primarily is to advance the interests of the individuals affected by the policy, such as pre-treatment screening for non-communicable diseases, then consent is an absolute requirement. It is beyond the purview of society to decide for a competent person what level of potential benefit justifies the burdens a program will entail, so the tradeoffs must be left to the individual. A harder question arises when a policy’s primary benefits are to the public, but, as will often be the case, the burdens fall on discrete individuals instead of being shared diffusely. Coercive policy should be used only with great care, but may be necessary in this instance.

This paper proposes a two prong test to determine whether individual consent at the implementation level is required in the context of programs to serve the public good. In all instances, consent should be presumptively required unless the test can be met. First, is there some measurable benefit gained from non-consensual policy that could not be obtained if it was consensual? Without this, coercion is applied wantonly. The second prong

327. Such as entitlement programs (so long as intrusive information is not demanded to demonstrate qualification).
328. Gostin, supra note 87, at 72.
329. An example of where burdens fall diffusely is airline safety, where all passengers are (at least if screening is done properly) subject to the same level of intrusiveness in searches. On the other hand, quarantine during an infectious disease emergency benefits the general public, but the burdens fall heavily on discrete individuals.
330. Consider, for example, the public health goal of stopping drunk driving. This is a goal that benefits society as a whole, and those who benefit are not identifiable. At the same time, DUI stops and alcohol tests burden discrete individuals. To require the consent of those individuals would necessarily frustrate the purpose.
331. This is related to, but distinct from, the general requirement that the policy must reflect an appropriate trade-off between intrusions and benefits. This prong is more of a threshold
deals with whether one of two distributive justice preconditions are met: consent must either not be required because of concepts of desert, or society must have imposed burdens on itself in a uniform or universal manner.

The first concept, desert, applies narrowly. However, in some instances, a person will have intentionally, and knowing it to be wrong, inflicted harm on another in a way that justifies them to be used against their own will for the benefit of the public. In the context of HIV transmission, this should be extremely narrowly construed: a person must have committed a violent offense which involved the exchange of bodily fluids in such a way that transmission is biologically plausible. This situation should be distinguished from situations which posed a risk of transmission consensually, including private high-risk sexual behavior or prostitution; criminal behavior which is primarily self-regarding, such as drug use; or behaviors which posed a risk without volition, such as exposure of health care workers during medical procedures. The basic idea is that when one has intentionally caused substantial harm to another, the victim does not deserve a further dignitary intrusion. Even if requiring the intrusion to be placed on the offender is less effective than requiring the victim to endure it, as between the two, the offender is more deserving of the intrusion. Because relative desert of the victim and offender is the fundamental touchstone, at least some benefit from the compulsory public health policy must flow from the offender to the victim.

The alternative route past required consent, that society must have imposed burdens on itself in a uniform or universal manner, reflects basic democratic theory. If the burdens are placed with intent to make a discrete group of society bear the burden for others’ gain, or if there exist significant disproportionate impacts, then one may infer that the democratic process is inquiry—without going to the ultimate loss/gain analysis, is there at least some measurable public benefit for which the mandatory nature of an intervention is a “but for” cause?

333. Note that I am not saying that laws which mandate testing of sex offenders or batterers are justified from a public health standpoint or after consideration of additional claims in justice; they may well not be, and an evaluation of that issue is beyond the scope of this paper. The only point to this argument is that such a person should no longer be entitled to challenge the test on the grounds that they do not deserve it.
334. See Rachels, supra note 332, at 181-82. These other actions might be risky, but do not rise to a level of blameworthiness sufficient that one deserves to be used against their will. Consensual behavior or self-regarding behavior does not wrong another person, so there is nobody who can make a claim of desert against the actor. Inadvertent infliction of risk is not morally blameworthy because the individual did not act with any intent to cause harm, and desert flows only intentional harm. Id. at 180.
335. That is, I am not arguing that for intrusions as punishment for the offense, but solely that relative desert means that the utility gained by the victim should be weighed more heavily and disutility endured by offender weighed less heavily.
336. Essentially, this is an argument in favor of the judicial philosophy of representation reinforcement, but applied prospectively by policymakers in deciding how to place burdens.
not reasonably evaluating the costs and benefits of a policy.\textsuperscript{337} If this is the case, the right to weigh the level of intrusiveness should revert to the individual facing a burden, and society’s obligation is to educate and persuade that individual, not to compel him or her. If, on the other hand, burdens fall uniformly or universally across society’s groups, then there is a strong indication that society has weighed the costs and benefits of an intrusive policy, as costs flow to the same people as the benefits.\textsuperscript{338} Under certain circumstances, this will permit non-consensual interventions.

This prong does not create as large an end-run around consent as one might initially think. First, it is quite difficult to demonstrate that the burdens fall uniformly or universally, and the presumption in favor of consent requires that the policy maker have good cause to believe the burdens will fall equitably before acting. Second, remember that even if the burdens were placed uniformly, meeting this prong, non-consensual nature of the program must be a “but for” cause of some measurable benefit. An example of this can be found in the policy of random DUI checkpoints, which stop all vehicles passing a particular spot. There are clear public health benefits from such policies, but there are equally clear intrusions. Because the non-consensual nature of the program is a necessary ingredient of its success, the “but for” requirement is met. Thus, so long as the checkpoints are used neutrally (that is, they are not placed only in majority-minority parts of town or the police do not let some drivers off without testing), the burdens fall uniformly on society, and the plan would be permissible under this framework.

Finally, if a consent exception is met—meaning that society, and not the individual affected, is entitled to weigh the costs and benefits—the intervention still must reflect an appropriate tradeoff between the magnitude of the intrusion and the public health gain. If two programs are equally effective, that with the least intrusion must be adopted.\textsuperscript{339} If, however, there is a gradient of effectiveness and intrusion, policymakers should rely on public preferences. If the public as a whole is to bear the burdens and receive the benefits of a policy, great deference should be given to their preferences as to what tradeoffs are acceptable. Thus, policymakers should diligently gather information on the tradeoff preferences through surveys and public hearings, much as they are required to gather information on the public health benefits and potential intrusions under the Mann and Gostin framework.\textsuperscript{340} This grants a public version of consent to those who will be affected, recognizes the pre-

\textsuperscript{337} Ely, supra note 293, at 135-36.
\textsuperscript{338} Id. at 135-37.
\textsuperscript{339} See Gostin, supra note 87, at 77-78. Note, however, that intrusion is not just the multiplicative product of the amount of intrusion times the number of people affected. There may be cases where important values, such as equality, make a policy which intrudes on more people ethically superior because it reduces the magnitude of the dignitary harm from being unequally targeted. In fact, under this framework, such broadening of inclusion might well be required to allow compulsory interventions at all.
\textsuperscript{340} Id. at 69-70.
sumptive good in self-governance, and allows for regional heterogeneity of preferences—how people in New York view the tradeoff between the relative effectiveness of various policies and their costs may vary significantly from that of people in Kansas.

B. Application of the Ethical Framework to HIV Screening in Prisons

The final process in this analysis is to apply the ethical framework described above to the issue of screening prisoners for HIV. Many of the steps have been discussed in depth earlier in the paper and will only be summarized at this stage. First, one needs to clarify the public health purpose of prisoner screening policies. As described in detail earlier in the paper, there are three such purposes. The first, and most important, is to facilitate the treatment of infected patients. Additionally, screening facilitates prevention of transmission within the institutional setting and also can assist interventions to prevent transmission in the general community after release. Because of the very high proportion of HIV positive individuals who cycle through the corrections system in any given year, these goals are compelling; a great many people have the potential to be treated and a great many new infections could be prevented if screening leads to adequate medical and public health interventions.

The crucial question is whether these interventions are actually conducted. Screening by itself has little utility, and informing patients of HIV status but providing no care is cruel. For prison screening to be effective, three conditions must be met. First, patients must be provided appropriate care. This will consist of antiretroviral therapy for those who meet treatment criteria, *Pneumocystis pneumonia prophylaxis*, isoniazid therapy for those with latent tuberculosis, and any other indicated care. Additionally, proper post-test counseling, other risk education, and harm reduction programs—including the distribution of condoms—must take place, both for patients who are positive and those who are negative. Lastly, appropriate linkages between prison and community-based services must be created, so that patients who are managed in correctional facilities do not default upon release.

Substantial obstacles to each of these policies exist and valid concern exists that screening is often not linked to care and prevention services; however, programs in several states have demonstrated that each of these interventions

341. Zaller et al., supra note 23, at 440
342. Mary C. White et al., supra note 40, at 380.
343. Drug Susceptible TB, supra note 67, at 1041-44.
344. Hammett, supra note 43, at 976-77; Braithwaite & Arriola, supra note 22, at 760-61.
345. Bourwell & Rich, supra note 62, at 1762; Zaller et al., supra note 23, at 440; Clements-Nolle et al., HAART use and HIV transmission risk behaviors among individuals who are HIV infected and were recently released from jail, 98 Am. J. Pub. Health 661, 662-63, (2007).
can be successfully implemented for inmates in both short-term jails and longer-term prisons.347

The second necessary component to achieving screening’s public health goals is to identify a high proportion of positive individuals. Only mandatory and routine, opt-out testing strategies have achieved high levels of coverage consistently, frequently as high as 90 percent.348 Opt-in testing and testing only on demand or when medically indicated tend to result in coverage below 50 percent, though a few programs have reported coverage as high as 70 percent.349 Thus, it appears that the most successful prisoner screening programs are going to be those which either mandate screening or routinely offer it in an opt-out fashion, and these programs must be coupled with comprehensive prevention and care programs. In the absence of either component, program success will be seriously compromised.

Next in the ethical evaluation is an evaluation of the extent to which prisoner screening programs are well-targeted. Clearly, there are problems with mandatory screening in this regard. Mandatory screening of prisoners is both under and over-inclusive. It is under-inclusive because there are several groups with higher HIV prevalence than inmates who are not subject to mandatory screening.350 Additionally, it is over-inclusive because many inmates are not at particularly high risk for HIV infection. Thus, relative to the policy for HIV screening in the general public and among other high-risk populations, there is a significant lack of fit between mandatory screening and the incarcerated population.

However, the same is not true for routine, opt-out testing. In the fall of 2006, CDC changed its recommendations for HIV screening in health-care settings to make routine, opt-out testing the standard of care in all clinics unless the undiagnosed prevalence of infection had been shown to be less than 0.1 percent in the population the clinic serves.351 The recommendations explicitly include correctional health settings under the umbrella of health-care settings.352 Because physicals are a routine part of intake, and virtually all correctional institutions could be expected to have an undiagnosed prevalence above 0.1%, for a state to carve its prisons out of routine, opt-out screening would be to make screening programs badly under-inclusive by failing to pro-

347. Zaller et al., supra note 23, at 440-41; ART in correctional facilities, pg 28-29
348. Grinstead et al., supra note 62, at 550; Boutwell et al., supra note 100, at 320.
349. Kassira et al., supra note 77, at 259; Lyons et al., supra note 63, at 94; Kendrick et al., supra note 95, at 2209; Liddicoat et al., supra note 98, at 1128.
350. For example, one study of black men, who identified as men who have sex with men (MSM), conducted at MSM-oriented establishments in five cities found HIV prevalence to be 46 percent. Ctrs. for Disease Control and Prevention, HIV Prevalence, Unrecognized Infection, and HIV Testing among Men Who Have Sex with Men—Five Cities, June 2004 – April 2005, 54 MORBIDITY AND MORTALITY WKLY REP. 597-601 (2005). This example is illustrative only; obviously, mandatory screening of black MSMS is unjustified and would be deeply disturbing.
352. Id.
vide the standard of care to incarcerated populations. Because receiving a positive test result is the crucial first step to care and prevention, such a policy would be essentially denying to one of the highest risk populations an equal possibility of treatment.

Nonetheless, all screening programs entail potential ethical burdens. At the very least, there is the dignitary interest in being secure from intrusions into one’s body, the right to control the flow of information about one’s health, the entitlement to decline procedures that violate one’s religious convictions, and potential infliction of mental and emotional pain and suffering from testing and the results it returns. Additionally, there is the risk that screening programs may be used in a discriminatory fashion, or that test results might be used to create repressive policy. Strong evidence that mandatory screening does not adequately respect these interests can be found in the fact that the citizens of no state have seen fit to subject the general public to mandatory screening; if most people found the intrusions from mandatory screening to be balanced by potential benefits, one would expect that at least some populations would subject themselves to it. On-demand and opt-in screening—if it is universally available—probably gives the greatest deference to individuals’ liberties by not providing a test unless the patient goes out of his or her way to request one. However, opt-out testing—which requires that patients be notified of a test before it is performed—provides an adequate opportunity for refusal by those patients with strong objections. Additionally, by routinizing testing, there is a better chance that people who would benefit from testing are offered it, and CDC suggests that making testing routine may help to decrease stigma associated with HIV disease and testing.

Finally, one must evaluate the benefits from various potential screening programs against their burdens. As noted above, only mandatory screening and routine, opt-out screening is sufficiently effective to serve the public health goals of care and prevention. To decide between the two, one should turn to the extension to the Mann and Gostin framework proposed in this paper; this requires an examination, first, of whether there is an ethical justification for compulsory policy. Although mandatory screening may be the “but for” cause of slightly higher screening coverage, meeting the first prong of this inquiry, compulsory screening is not ethically justified.

There is no claim of individual desert to justify overriding consent in the context of HIV screening of the general prison population. The vast majority of prisoners will not have been incarcerated for a violent offense which posed an epidemiologic risk of transmission. Even for those who are, the justification for screening is not the relative desert of the offender and victim; general

353. Gostin, supra note 87, at 135.
354. Id.
356. Id. at 440.
357. Revised Recommendations, supra note 88, at 5.
screening programs are unlikely to provide any benefit to victims and are being operated not for the benefit of victims, but instead to promote population health.

The second justification is also not met, as mandatory screening is not applied in a universal fashion; prisoners are one a very few groups of people singled out for mandatory screening. Furthermore, they are highly marginalized in the political system, often being legally disenfranchised, and, even when they are not, they have a relatively difficult time attracting politically powerful allies. This being the case, consent should be an integral part of any prisoner screening program.

Of course, determining whether consent is given freely by prisoners is more difficult than it is when dealing with patients in the general population. As one panel of experts has noted, “In a correctional setting, a prisoner’s capacity to exercise independent judgment may have atrophied.” Some have, in fact, argued that consent is sufficiently problematic within incarcerated populations that routine screening is “virtually synonymous with mandatory testing.” These concerns should be taken seriously, especially in light of research which indicates that some prisoners consent to routine screening under the impression that it is mandatory. To minimize this risk, inmates should be informed that they have the right to refuse testing. Prison medical staff, at the time of taking a sample, should say something in the nature of, “Unless you object, this we will run an HIV test as part of the standard tests conducted during this examination.” This would preserve the essential nature of opt-out testing while still providing the prisoner notice of their right to refuse the test.

After applying the ethical framework, it is evident that routine, opt-out screening is the least restrictive program that can achieve sufficiently high testing coverage to meet public health goals. It is also the program that treats prisoners most similarly to the general public, balancing legitimate privacy concerns against patients’ important interests in being offered a test and finding out their status and society’s interest in facilitating prevention and care. Thus, on balance, routine opt-out screening—if it is linked to comprehensive care and prevention services—is the ethically superior screening option.

IV. CONCLUSION

Prisons should implement routine, opt-out screening for HIV, and link screening programs to care and prevention services. Education and prevention services should be made available both to prisoners who test positive and those who are negative. This approach best facilitates treatment of a large

358. INSTITUTE OF MEDICINE, ETHICAL CONSIDERATIONS FOR RESEARCH INVOLVING PRISONERS 15 (Lawrence O. Gostin et al. ed. 2006).
359. Walker et al., supra note 346, at 319.
number of HIV positive individuals who do not currently know their status, and it would provide a crucial point to intervene and prevent transmission, both within prisons and in the general public. Such an approach is more effective than on-demand or opt-in testing, but avoids the serious legal and ethical implications posed by mandatory screening. Only routine opt-out testing meets the three criteria of being effective, legal, and ethical.