



the State Pen

The Newsletter
of the
California/Nevada
Chapter
of the
American
Correctional
Health Services
Association

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Summer 2006

NCSA Issue Spotlight: Human Papillomavirus and Cervical Cancer

*“You can get so confused
that you’ll start in to race
down long wiggled roads at a break-necking pace
and grind on for miles across weirdish wild space...”*

Oh the Places You’ll Go, Dr. Seuss

Research shows that both patients and providers find HPV, with its many types, absence of acute symptoms, and variable clinical presentations difficult to fully understand. Once fairly obscure, genital Human Papillomavirus (HPV) has become much more widely known—if not completely understood. It has been at the heart of political and scientific research and debate, and a source of media attention. The increased awareness of HPV in recent years has been driven largely by new diagnostic methods (such as HPV DNA testing) and its role in sexual health politics. The recent U.S. Food and Drug Administration (FDA) approval of Gardasil, Merck’s HPV vaccine, and the months leading up to approval, put HPV and cervical cancer solidly in the public eye.

Human Papillomavirus is a nearly universal STI that most sexually active Americans are thought to contract at some point, though most are never diagnosed clinically. At any one time, about 20 million people are infected with HPV although most will have no visible symptoms and are unaware of their infection. This issue brief provides an overview of HPV and an update on the HPV/cervical cancer vaccine.

HPV—THE BASICS

Genital HPV is one of the most common sexually transmitted infections (STIs) in the United States. About 6.2 million people get genital HPV each year. It is estimated that about 80% of sexually active people have been infected with HPV at some point in their lives.

HPV is a group of DNA viruses that infect the skin. There are well over 100 different types, many of which are associated with benign lesions such as common warts of the hands and feet. About 30 HPV types are associated with anogenital skin and sexual transmission—of these, some are “low-risk” HPV types that can cause lesions such as genital warts, which are usually harmless.

Of greater concern are the “high-risk” types that can lead to abnormal cell changes (most often cervical). Most HPV infections resolve spontaneously and generally do not lead to health complications

The Cervical Cancer Link

The immune system of most healthy people is able to suppress HPV within a few months. In some cases, though, these cell changes persist over many years and if left undetected can eventually progress to cervical cancer. Although most HPV infections do not lead to cancer, about 99 percent of cervical cancer tissue contains high-risk HPV.

It is not clear why some cases fail to clear naturally and progress along the continuum to cancer. However, co-factors linked with cervical cancer include smoking or exposure to second-hand smoke, having intercourse at an early age, and long-term use of oral contraceptives.

Cervical cancer develops slowly, often taking 10 years or more, and is seldom detected in women who have regular Pap screening (either alone or in combination with HPV DNA tests). Mortality related to this disease is especially tragic considering that it is virtually always preventable through screening at consistent intervals. According to the American Cancer Society, the number of cervical cancer deaths in the U.S. has dropped 74% since the advent of Pap screening in 1955—there are now approximately 10,000 cases of cervical cancer in the U.S. each year, and nearly 4,000 deaths as a result. Yet cervical cancer is preventable, treatable, and curable.

The burden of cervical cancer is now experienced most keenly in countries lacking screening programs. The World Health Organization (WHO) estimates approximately 80% of global cervical cancer deaths occur among women in developing nations. WHO estimates that there are over 500,000 cases of cervical cancer worldwide annually and nearly 300,000 deaths, making it the second-leading cause of death from cancer among women globally.

Psychosocial Impact

The psychosocial impact of HPV can be devastating. HPV can cause emotional anguish that many newly diagnosed women find overwhelming. Research by Ellen Daly, Ph.D. and Kay Perrin, Ph.D., found that 94% of infected women felt the need to hide the fact that they had HPV. Over 75% of women diagnosed with HPV reported feelings of anxiety and blamed themselves for the diagnosis, as if they were “paying” for past sexual behaviors. Similarly, a survey of health care providers conducted by the Centers for Disease Control and Prevention (CDC) found patients commonly react with fear and anger upon diagnosis.

CDC is conducting additional studies in this area. Initial data from surveys of women recently diagnosed with HPV reveal that many are concerned about the source of HPV transmission, lack of support and communication with partners, and potential damage the diagnosis may have on relationships.

HPV and Men

As confusing and unfamiliar as the subject of HPV is for women, it’s even more difficult to find information for men. Not a great deal is known about the “natural history” of the virus in males. Diagnostic options are essentially limited to a visual inspection to detect lesions (warts or cell changes) – there is no direct test for the virus itself currently approved for clinical use with men. Health issues with HPV occur even less often with males than females, but “high-risk” HPV types are associated with some penile and anal cancers, the latter of which raises discussions on the need for anal screening for men who have sex with men (and women with a history of anal sex). This is often elusive, though, as many health care providers and laboratory staff are unfamiliar with means of anal cytology sampling and specimen interpretation.

Prevention, Diagnosis, and Treatment

Outside of sexual abstinence, the surest way to prevent HPV (and other STDs) is to refrain from sexual contact with an infected

person, or to be in a mutually monogamous relationship with an uninfected person. Although condoms may not provide complete protection, multiple studies have shown that using condoms consistently and correctly can reduce the risk of HPV-related diseases, such as genital warts and precancerous and cancerous changes to the cervix. Peer reviewed published data presented by researchers from the University of Washington in Seattle offers evidence that consistent, correct condom use does reduce risk (perhaps as much as 70%) of HPV acquisition.

The most common diagnostic methods for HPV involve visual exams, Pap tests, and HPV DNA tests. Pap tests can detect abnormal cell changes in the cervix, but cannot directly diagnose HPV. Specialized DNA tests can diagnose HPV in the cervix. These tests are routinely used to clarify abnormal Pap test results. They are also approved for primary screening in women over 30, in combination with conventional Pap testing. Regular screening through Pap and HPV DNA tests can catch cervical cancer in its early stages, when there are no symptoms. Since cervical cancer typically takes years to develop, with regular screening, nearly all cases can be prevented or cured.

Genital warts (which do not cause cancer) can now be treated with patient applied topical therapies, as well as through conventional clinic-based approaches.

HPV and Politics

Given the ubiquitous nature of the infection and the need for awareness of both the potentially harmful outcomes of the virus and the importance of screening to prevent them, one might assume HPV discussions would be a straightforward addition to the public health agenda. But at times it has been difficult to separate the intertwined, often ideological, messages surrounding HPV, condoms, and abstinence.

HPV found its way to the political forefront in 2001. A provision inserted into the

FY 2001 Labor, Health and Human Services, and Education (Labor-HHS) appropriations bill by former Representative Tom Coburn (R-OK), now a U.S. senator, fueled a political debate around HPV and condoms. The provision required the CDC to conduct research projects and a series of public education efforts to better inform providers and the general public about HPV. It also required the FDA to reexamine condom labels to determine whether they are medically accurate with respect to condoms' "effectiveness or lack of effectiveness" in preventing HPV. Earlier this year the FDA issued (and NCSD commented on) a revised condom label for public comment. Final guidelines have not yet been issued.

The HPV vaccine was initially a source of controversy. Beyond the normal concerns found with any new childhood vaccine (such as worries that kids are becoming little "pincushions"), HPV vaccines have the added element of offering protection against a virus acquired through sexual activity. However, the development and approval of the vaccine have been widely supported. Access to vaccines is likely to be the next battleground.

Looking Forward: Vaccines

On June 8, the U.S. Food and Drug Administration (FDA) approved Gardasil as safe and effective for use among girls and women ages 9–26. The vaccine, developed by Merck & Company, prevents infection with the types of human papillomavirus (HPV) responsible for 70% of cervical cancer (16, 18) and 90% of genital warts (6,11). GlaxoSmithKline has a cervical cancer vaccine in development that may be available early next year.

On June 29, the Advisory Committee on Immunization Practices (ACIP) at the Centers for Disease Control and Prevention recommended routine immunization of girls ages 11–12. The ACIP also approved the vaccine for those aged 13–26 who have not been vaccinated—called catch-up vaccines. Health care providers can administer the

vaccine to children as young as nine at their discretion. ACIP's recommendation will guide immunization practices and policies at the federal, state and local levels in the United States.

Decisions regarding compulsory vaccination for school admission are made at the state level, so it is impossible to know if vaccines will be mandatory. Because vaccine requirements were established to protect students against infectious diseases that are transmitted in schools through casual contact (sneezing, touching), some experts believe it is unlikely that they will be mandatory in all states. Genital HPV is not transmitted through casual contact in schools.

Many public health advocates argue that there are benefits to mandatory vaccine requirements. And, according to a 2005 report on adolescent vaccination by the National Foundation for Infectious Diseases, school-based immunization requirements are by far the most effective means to ensure rapid and widespread use of childhood or adolescent vaccines. There is a positive correlation between school immunization requirements and reduction in diseases. Vaccines are an important tool in eliminating racial disparities. Making a vaccine mandatory influences both private and public funding.

NCSA provided statements to both the FDA and the ACIP on safety issues and the concerns of clinics. NCSA made the following critical point to the ACIP:

NCSA urges the ACIP to address these access and safety issues:

- *Include Gardasil in the Vaccines for Children Program. In addition, we ask the Committee to encourage vaccine manufacturers to make*

special pricing available to public health clinics.

- *Urge providers to advise women and girls of the importance of continued routine cervical cancer screening and appropriate follow-up. Continued screening will be essential for detection of the HPV types that cause cancers but are not included in the vaccine. In addition, since it is unclear how long vaccines will remain protective, it will be important for people to continue to be screened.*
- *Urge providers to ensure that consumers are aware that the HPV vaccine will not provide protection against other STDs. Those receiving vaccines must protect themselves against HIV and other sexually transmitted infections.*

HPV presents multi-faceted challenges, impacting individuals on many levels. As vaccines come to market and new diagnostic technologies inevitably gain wider use, these issues are likely to receive even greater scrutiny. Many issues remain unresolved – including access for low income and uninsured populations. And, the vaccine is very costly, at \$360.00 for the full series of three shots.

The vaccine poses opportunities and challenges for STD clinics. It is unsure what the role of STD clinics will be in education or immunization. NCSA will advocate for access for low-income patients and in the coming months will work with members to determine the most effective role for STD programs in cervical cancer prevention.

From the July-August NCSA (National Coalition of STD Directors) Newsletter.

The CA-NV Chapter Board of Directors

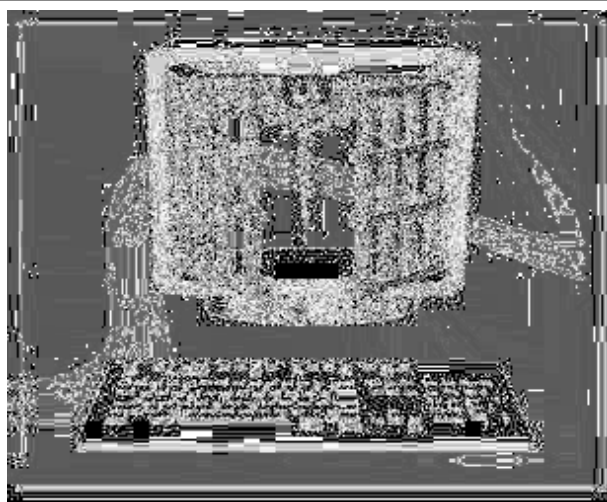
Here are the current members of the CA-NV Chapter Board of Directors. Board members serve in an unpaid capacity, with the length of their terms established by the chapter by-laws (interested parties may view these on the chapter web page). Members may be contacted via their e-mail addresses, or by writing them c/o the chapter's mailing address, 2140 Shattuck Avenue, PO Box 2491, Berkeley, CA 94704. Alternately, any member may be reached via the chapter's e-mail, ca_nvachsa@lycos.com

Position	Name	Organization	E-mail
Past President	Kathy Wild, RN	San Bernardino Sheriff's Department	kathy@statepen.org
President	Douglas Peterson, MD	California Department of Corrections	doug@statepen.org
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Treasurer	Jeff Shannon	Contra Costa Sheriff's Department	****
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Communications Coordinator	Kevin Connor, RN	San Bernardino Sheriff's Department	kevin@statepen.org
Member at Large	vacant	****	****
Member at Large	Ernie Williams, MD	Orange County Sheriff's Department	****
Member at Large	Sandra Hand, MD	Sacramento Sheriff's Department	hands@saccounty.net
Member at Large	vacant	****	****

If you have any questions or concerns, please do not hesitate to notify one of the board members above.

\$10 Gift Certificates

A gift certificate, good for \$10 off dues, conferences, regional meetings, or any other CA-NV ACHSA chapter activities will be issued to members who submit articles, news items, or other contributions to *the State Pen* (that's \$10.00 for each contribution!). Get out your pens, fire up the word processors, and send us the latest on your work sites, your accomplishments, case studies, humorous or sad stories (or whatever else you may have). We want your input to make *the State Pen* a networking and outreaching format. Contributions need not be grand or wordy, but please type or print!



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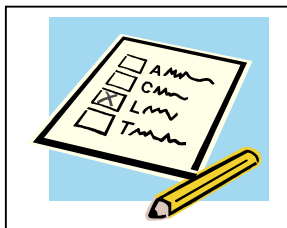
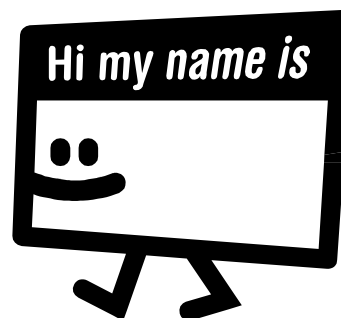
For the most up-to-date information, visit our site on the World Wide Web. You can find us here:

<http://www.statepen.org>

Thanks to Mr. Alan Wild for the use of this logo

It's Conference Time!

The CA-NV chapter is hosting its first annual conference since 2004 (last year the National Chapter had its conference in Oakland), and this year we're going to meet October 4-6 in San Diego. See the flyer on page 9 for more details. Hope to see you there!



OUR ELECTION DILEMMA...

BASIC COMMON SENSE TELLS US THAT IN ORDER TO HAVE AN ELECTION, THE VOTERS MUST HAVE A CANDIDATE (OR CANDIDATES) TO SELECT. WITH ME SO FAR? GOOD! THEREIN LIES OUR DILEMMA: DESPITE NUMEROUS SOLICITATIONS FOR CANDIDATES FOR OFFICE IN THE CA-NV CHAPTER, THE LACK OF RESPONSE HAS BEEN RATHER DISTRESSING, TO SAY THE LEAST.

CURRENT POSITIONS THAT ARE EITHER VACANT OR UP FOR RE-ELECTION INCLUDE:

PRESIDENT-ELECT (MUST BE FROM SOUTHERN CALIFORNIA REGION)

TREASURER

SECRETARY

MEMBER AT LARGE (4 POSITIONS)

COMMUNICATIONS COORDINATOR

IF YOU OR ANYONE YOU KNOW MIGHT BE INTERESTED IN SERVING IN ONE OF THESE POSITIONS, PLEASE SUBMIT THE FORM TO THE RIGHT AND MAIL TO:

CA-NV ACHSA
2140 Shattuck Ave., Box 2491,
Berkeley, CA 94704

Nomination Form

CA-NV Chapter
 American Correctional Health
 Services Association

Name of nominee: _____

Name of institution: _____

Title: _____

Contact information: _____

Does nominee know about his/her nomination?
 Yes No

Is nominee a member of ACHSA?
 Yes No Unknown

Position:
 President-elect
 Member at Large

Nominees for President-elect should come from the Southern California region, though all applications will be considered.

Terms of office:
 The President-elect serves a two-year term in this office, then two years as President, followed by a one year term as Past President.

Members at Large serve a two-year term.

Position Statement on Forced and Involuntary Psychotropic Medication

Adopted August 12, 2006

A patient's right to refuse treatment is well-established and protected by case law. For the inmate patient, however, this right is not absolute, and its limitations have also been established by case law. The legitimate interest of the state in the safety and security of the correctional institution, in preventing unnecessary inmate death, and in preventing harm to self or others will prevail over the inmate's right to refuse treatment. However, involuntary treatment only to render an inmate competent to stand trial is not clearly permitted as being within constitutional bounds. Likewise, treatment to restore competence to be executed is clearly unethical.

In an emergency situation, where there is an imminent danger of harm to self or others, a physician may order a one time involuntary administration of a psychotropic drug. As in all cases of forced medication, an effort must first be made to obtain informed consent. When consent is refused, the patient should be asked to sign a formal refusal of medication. If the patient refuses to sign the refusal form, a second health care staff member should witness that fact. Since both signed consent and signed refusal are unlikely in an emergency situation, it is imperative that a careful clinical note is written documenting the condition requiring involuntary treatment, the inmate's reason for refusing treatment (if given), the treatment given and its necessity.

If the condition requiring emergency intervention is not resolved with a one time dose of forced medication, then additional steps are constitutionally required, to provide adequate evaluation and justification of the need for further involuntary treatment. Some states follow the procedure established by the U.S. Supreme Court in the case of *Washington v. Harper*, which states:

- Only a psychiatrist may order the drug.
- The patient is entitled to an administrative hearing before professional staff not currently involved in the treatment.
- The patient may attend the hearing, present and cross-examine witnesses, and have the assistance of a lay advisor with psychiatric knowledge.
- Minutes must be kept, with judicial review available.
- Continuation of the medication is subject to periodic review.

Other states seek a judicial process, in which the psychiatrist petitions the court to permit involuntary medication approved by a court-appointed mental health treatment guardian. This process involves a court hearing attended by the inmate patient as well as the treating psychiatrist, attorneys for both parties, and the potential treatment guardian, who may be a member of the inmate's family.

Correctional health care programs need to have policies, procedures, and multidisciplinary education/training covering forced and involuntary medication. State mental health codes and relevant case law should be consulted and legal guidance

sought. Since individual cases vary greatly, any policies need to recognize this fact and allow for a variety of approaches

The treatment chosen must follow the principle of the least intrusive, least drastic, and least hazardous intervention that is judged to be effective. Adverse reactions should be watched for and vital signs monitored. Medication chosen should also minimize the effect on the patient's mental clarity and ability to make informed decisions and participate cooperatively in treatment.

In summary, it is essential to establish policies and procedures that meet legal requirements or guidelines, and that protect the patient's rights to make decisions about his/her own health care. The administration of involuntary treatment must be based on careful consideration of the conflict between the patient's expressed wishes and a medical judgment of the need to protect the patient from morbidity or mortality, or to protect the patient from harm to self or others. In emergency situations the decision of the physician shall prevail, but when the emergency situation has passed, others must be involved as described above. Once involuntary or forced treatment has been instituted, ongoing assessment is important so that the treatment or its forced nature can be terminated as soon as it is no longer necessary.

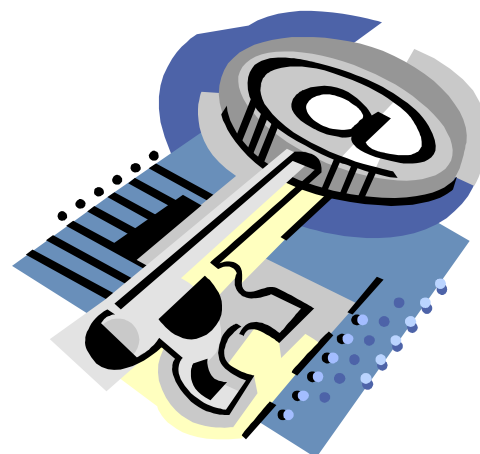
Relevant Case References:

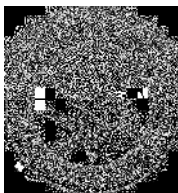
- Washington v. Harper, 494 U.S. 210 [1990]
- Riggins v. Nevada, 504 U.S. 792 [1992]
- Ford v. Wainwright, 477 U.S. 399 [1986]
- Louisiana v. Perry, 610 So2d 746 [La 1992]
- American Medical Association Code of Medical Ethics, Council on Ethical and Judicial Affairs, Current Opinions with Annotations, 2004-2005 Edition, Rule 2.06, Capital Punishment.
- Singleton v. Norris, 319 F.3d 1018 (8th Cir) (en banc)
- Sell v. United States 02-5664 [2003]
- Vitek v. Jones, 445 U.S. 480 [1980]
- John Doe v. United States, 150 F.3d 170 [2d Cir. 1988]

Did you know...

The CA-NV chapter is not the only branch of ACHSA that has its own website. National has an excellent site full of many, many resources to help you in your day to day operations in correctional health (including position papers such as this). Visit them at

www.achsa.org





CA/NV Chapter - ACHSA

American Correctional Health Services Association
2355 Foothill Blvd, Suite 127
La Verne, CA 91750



2006 Multidisciplinary Correctional Conference *San Diego, CA* *October 4, 5, & 6, 2006*

Name: _____ Job Title: _____
(As you would like it to appear on your conference name badge)

Agency: _____

Address: _____

Phone: _____ E-mail: _____

Other: _____

Early Bird Special must be postmarked 9/15/06

- Special Member Price **\$125**
 Non-Member with Membership **\$190**
 Non-Member **\$210**

All registrations received after 9/15/06

- Members **\$150**
 Non-Members **\$225**
 One Day Attendees (anytime) **\$115**

Continuing Education – Available CEUs for Nursing, California MFT & LCSW, and CME for Physician attendees

This year's program will include sessions that address sexually transmitted diseases, suicide prevention, tuberculosis, communication skills, methadone maintenance, transgender issues, and much more.

Sheraton San Diego Hotel & Marina
1380 Harbor Island Drive
San Diego, California 92101
Phone (619) 291-2900

Mention ACHSA for the special conference rate of \$120/night. Rate applies if booked by September 4th.

Please make checks payable to: CA-NV ACHSA Conference 2006

Mail completed registration form and check to:

ACHSA 2006 c/o Kathy Wild
2355 Foothill Blvd, Suite 127, La Verne, CA 91750
Non-Profit Tax ID# 23-202909-3

Questions? Contact Patti Gonzalez (619) 692-8529 or pgonzal5@dhs.ca.gov

Name _____
Mailing Address _____
Name of Organization/Institution _____
Address _____
Work Telephone No. _____
Specialty/Discipline _____
Position _____

Are you a member of ...

ACA? Yes No

National ACHSA? Yes No

The American Correctional Health Services Association (ACHSA) is an affiliate of the American Correctional Association (ACA). Although not mandatory for ACHSA membership, please indicate if you are a member of the ACA on application.

In order to be a member of the California/Nevada Chapter of the ACHSA, you must be a member of the national ACHSA; please indicate if you are a member of the national ACHSA on application.

Annual dues for ACHSA are: \$50.00 (National) and \$15.00 (State). Total due = \$65.00

Please make check payable to: ACHSA, California/Nevada Chapter, and send to: Treasurer, 2140 Shattuck Ave., Box 2491, Berkeley, CA 94704.

Membership is open to all individuals interested in correctional health services

California/Nevada Chapter
American Correctional Health Services Association
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