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AIDS: THE IMPACT ON THE CRIMINAL JUSTICE SYSTEM
MANAGEMENT OF AIDS IN CORRECTIONS

Erich Manning Spranger
B.A., California State University, Fullerton, 1980

THESIS

Submitted in partial satisfaction of
the requirements for the degree of

MASTER OF SCIENCE

in

CRIMINAL JUSTICE

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

FALL
1991

AIDS: THE IMPACT ON THE CRIMINAL JUSTICE SYSTEM
MANAGEMENT OF AIDS IN CORRECTIONS

A Thesis

by

Erich Manning Spranger

Approved by:

Thomas R. Phelps, Committee Chair
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Thomas R. Phelps, Graduate Coordinator — 1 November 1991 Date

Department of Criminal Justice

Abstract

of

AIDS: THE IMPACT ON THE CRIMINAL JUSTICE SYSTEM
MANAGEMENT OF AIDS IN CORRECTIONS

by

Erich Manning Spranger

Statement of the Problem

Acquired Immune Deficiency Syndrome (AIDS) is the most complex health problem to evolve in history. Society has seldom faced such challenges that impact so heavily on the medical, legal, and ethical rights of not only those inflicted with AIDS, but of all people. Jails and prisons have been viewed by some as likely contributors to the spread of the virus, because they house a substantial number of persons at risk for AIDS. As a consequence, correctional administrators have been forced to deal with the issues of mandatory testing, whether infected inmates should be segregated, prevention information, and adequacy of medical care. With few precedents to rely on, difficult decisions faced by policymakers, science and ourselves will sharply redefine the future of AIDS treatment in correctional institutions.

Sources of Data

The data utilized in this research were obtained from an extensive literature review in which numerous sources were considered. Medical, legal, and ethical writings were examined in an effort to help define and evaluate current treatment rationale used in the correctional setting in comparison to that of "normal" society.

Conclusions Reached

Medical science indicates no cure of AIDS for 5 to 10 more years. Therefore, government, health professionals, and the community must unite in educating the populace of America and deal with AIDS from a public health perspective and not a moral or prejudicial point of view. Correctional staff must address medical, legal, and ethical decisions which protect the confidentially of people with AIDS within their institutions.

Thomas R. Phelps, Committee Chair
Thomas R. Phelps

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DEDICATION

To the glory of God and in memory of Marc Anthon Reilly, my brother.

ACKNOWLEDGEMENTS

I would like to thank my wife, Kathy, and my two children, Ian and Sean. Without their support and understanding this work would never have been possible. Thank you Mom and Dad for always believing in me and encouraging me to be successful in any endeavor I choose. A special thanks to Dr. Thomas R. Phelps for his guidance and wise counsel during the time this study was being completed. Finally, thanks to God, for without him, I would not even be here to share my life and knowledge that he has given me.

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CHAPTER ONE

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) will be the most challenging and complex health problem of the century. Because of the catastrophic nature of AIDS and the fear the disease engenders, the AIDS epidemic in the United States is posing medical, legal, and ethical questions to policy makers at all levels.

The issues raised by AIDS are controversial and the center of public attention. These issues parallel many of the legal, ethical, professional, and social issues that exist in the provision of health care for the entire population. It is paramount that the medical, legal, and ethical questions related to the provision of health care for those with AIDS be addressed, particularly at a time when many health related decisions being made are based on economic concerns. We must not lose sight of individuals' rights.

Though pockets of public hysteria over AIDS have calmed down as confidence grows that the disease is not casually transmitted, it should be remembered that there were sporadic early and continuing calls from some political-fundamentalist groups for quarantine, including the recommendation that Boston Harbor's Peddocks Island, the former home of a now-abandoned leprosy sanatorium, be used as the site.[1] The 1986

political campaign waged by Lyndon LaRouche in California embodied similar ugly proposals.

Artificial importance has been given the topic of mandatory blood tests for AIDS, as if by identifying all AIDS virus carriers, some easy solution for dealing with the epidemic would emerge. Copious energy has been devoted to the issue of AIDS testing, hardening the lines between advocates and opponents. As Adlai Stevenson said of nuclear weaponry, "There is no evil in the atom," only in what society does with it.[1] So it is with AIDS testing: the problem lies in the use made of it. No problem would exist at all were it not for the stigma that some have assigned to AIDS. In despicable judgements, AIDS is dismissed as a disease of the sexually perverted, depraved junkies, and pariah prostitutes who deserve what they get. Though more subtly expressed, stigma still misshapes much of society's - and the government's - response to AIDS.

The second social force feeding reaction to AIDS is fear. AIDS patients have been evicted from apartments and fired from their jobs; few have even been ousted from hospitals. Even when the AIDS victims have been children, surely unwitting victims of the disease, fear has turned otherwise reasonable adults into brute-faced protestors, refusing to allow AIDS children to attend school, shunning them and their parents, and even acting out violently against them. Despite the protection afforded by standard precautionary measures, some

doctors, dentists, and nurses have refused to care for AIDS patients, and some undertakers have refused to bury them.

Fear and the prejudice born of fear are one thing. Toleration of discrimination against AIDS patients and carriers is another. Education can minimize fear and defuse prejudice, but law and the enforcement of law are needed to prevent future AIDS discrimination. Such legal protection falls within the realm of public policy. While some states have specifically outlawed AIDS discrimination, here, too, there is need for a national stance. U.S. Sen. Edward Kennedy (D-Mass.) and Rep. Henry Waxman cosponsored federal legislation to ban discrimination against people with AIDS, to guarantee confidentially of AIDS-related records, and to assure privacy. Their bill was filed on June 23, 1987, in the aftermath of the Third International Conference on AIDS, during which police in Washington, D.C., donned heavy, yellow rubber gloves in a fear-mongering reaction to a march by AIDS victims. Until destigmatizing legal protection is in place, progress on the whole roster of civil rights issues concerning AIDS will be stalled. These reach into the rights of homosexuals to fair and impartial treatment, of drug addicts and prostitutes to life-saving preventive and curative services; of prisoners whose AIDS infectivity can diminish their prospects for release; of military personnel whose careers may be thwarted because of their AIDS status; of public and private employees to job equity; of children to

attend school; and of all people with AIDS to obtain housing, social services, and adequate and compassionate medical care.

Alongside these rights stand the conflicting issues of whether those in sexual contact with AIDS carriers are entitled to know they have been placed at risk; whether insurance companies should be allowed to test applicants; the limits under which public health officials can detain AIDS carriers who deliberately continue behavior that can transmit the infection to others; and how workers in direct care or contact with AIDS patients and AIDS carriers are to protect themselves from infection.

These are formidable public policy issues, ones that are "unlikely soon to be met," says Dr. Harvey Feinberg, dean of the Harvard School of Public Health. As a guideline, he urges that the least restrictive means be sought to protect the community and that a graded series of responses be devised before public policy steps are taken "that run the risk of infringing upon the rights of individuals."[1]

AIDS continues to be a major policy and management issue throughout the criminal justice system. Correctional institutions are a focus of public concern because of the perception (1) that prisons and jails hold high concentrations of individuals at risk of developing AIDS as a result of prior intravenous (IV) drug abuse and (2) that correctional inmates frequently engage in behaviors associated with transmission of human immunodeficiency virus (HIV)-particularly homosexual

activity and needle sharing.[4]

More than 5,000 cases of AIDS have been reported among U.S. correctional inmates since 1981. No job-related cases of HIV infection or AIDS, however, have been documented among correctional staff.[5]

While the crisis atmosphere seems to have dissipated somewhat, AIDS remains a serious correctional issue. Most correctional systems have adopted policies regarding AIDS, with certain indisputable principles such as the importance of educating both inmates and staff about the disease.

STATEMENT OF THE PROBLEM

The concern among correctional systems has shifted significantly from short-term "crisis" matters such as fear of casual transmission to "long haul" issues such as housing, programming, and medical care for prisoners with HIV disease. Resolving these issues is often complicated by political, legal, and cost considerations.

In the U.S., public health authorities have attempted to control the spread of HIV through education, voluntary testing and by counseling persons at high risk. With the exception of immigrants and military personnel, most testing has been conducted on a voluntary basis. From the beginning of the epidemic, correctional administrators have debated whether this approach is appropriate in prisons and jails. Before discussing the controversy regarding mandatory testing, it is

necessary to touch upon the available medical technology for diagnosing HIV.

The current blood test is not able to predict which seropositive individuals are likely to develop medically documented AIDS, nor at what point symptoms may appear. The test cannot detect the AIDS virus, merely the presence of antibodies to HIV. Because the human immune system will generally not develop antibodies until 6 to 12 weeks (some persons do not develop antibodies until several months after exposure to the virus) after exposure, persons tested during this period will be seronegative (the term "seronegative" refers to those individuals whose HIV blood test indicates that they have not been exposed to the virus) despite the fact that they are able to infect others. These results are commonly referred to as "false negatives." They pose a real concern for any program of mass screening.

Mandatory mass screening involves testing all inmates or all incoming inmates for HIV infection. A more limited version involves testing only members of high-risk groups (homosexuals, IV drug users, or prostitutes). Proponents argue that mass screening is the best way to identify seropositive inmates. Such a policy provides correctional administrators with an opportunity to target education and prevention programs. In addition, infected individuals can be placed under specialized supervision to ensure that they do not transmit the virus to others. Supporters of this policy

argue that institutions must take action to identify infected inmates and to prevent the spread of this virus, or face civil liability. Finally, it has been suggested that mass screening could provide a more accurate projection of how many cases of full-blown AIDS will eventually develop. This will enable correctional officials to plan more effectively and to seek an appropriate level of funding to meet future needs.

Critics of mass screening do not accept these rationale. They assert that education and prevention programs must be directed toward all inmates, and that all prisoners should be encouraged to refrain from high-risk behavior, not just those identified as seropositive. Furthermore, opponents of mass screening decry the practice of segregating infected individuals from the inmate population. Because any system of mass screening would produce some false negatives, it is not possible even to identify all infectious inmates.

Opponents of mass screening are also skeptical about the civil liability concern. They note that institutions already have rules that prohibit those types of conduct which can transmit HIV (i.e., sexual contact and IV drug use). As a consequence, inmates who engage in these practices do so at their own risk. Most correctional lawyers argue that the institution would not be held liable unless an inmate became infected through a sexual assault.[7]

The claim that correctional institutions must be able to project accurately the number of future AIDS cases is not

disputed. However, critics of mass screening note that anonymous testing procedures can satisfactorily achieve this goal. In fact, the Centers for Disease Control (CDC) are now utilizing this procedure to determine the prevalence of HIV in ten geographically diverse institutions across the nation.[1] Blood samples will be coded in such a manner as to ensure that prison officials do not learn the names of infected inmates.

Opponents of mass screening also fear that it will create a class of outcasts within the institution, with seropositive inmates subjected to harassment, discrimination and perhaps even violence within the prison, and to difficulties in obtaining employment and housing upon release. Finally, they argue that such a policy is not a wise expenditure of resources.

There is also the question of how prisoners will respond to the knowledge that they are seropositive. Because institutions contain a substantial number of individuals with sociopathic personalities, it can be argued that inmates who learn they are carrying a deadly virus might be more likely to engage in predatory behavior.

Need For Study

In recent years, the pressure to conduct widespread testing of inmates has come from politicians, not state correctional officials.[1] In some cases, state legislators have proposed statutes that require mandatory testing over the objections of correctional and public health officials.

Officials are faced with protecting the rights of infected prisoners against the rights of noninfected prisoners and prison personnel. As administrators develop policies for the management and prevention of AIDS, these laws will undoubtedly be challenged for legality in the courts. This paper will examine the challenges that have reached the federal courts concerning AIDS in correctional facilities. Litigation has primarily centered upon derivations of policies concerning the testing of prisoners for exposure to the AIDS virus and segregation of HIV positive prisoners.

Current policies and rulings by the courts paint a dismal picture for the future of prisoners who are HLTV-III seropositive, have ARC, or with AIDS. The courts have not mandated equal treatment for infected prisoners. It seems that they face the possibility of isolation in a medical segregation unit, absent many of the privileges enjoyed and granted to the general population. Hence, they may bear the brunt of punishment within punishment as the result of a medical condition. As such, the lowly status provided by imprisonment may be further exacerbated by contracting what may be a fatal disease. This could be felt to be specifically unjust by prisoners who have been exposed, but suffer no ill effects.

Purpose of the Study

The purpose of this research is to: 1) describe what AIDS

is and how science has responded to this epidemic; 2) discuss the problems of testing for the HIV which leads to AIDS; 3) review the controversy of mandatory/voluntary testing and the confidentiality problems of the test results; 4) describe the correctional administrators' responsibilities to the AIDS patients, staff, and the community; 5) report on the financial implications for corrections in the caring, treatment, education, and prevention of AIDS; 6) identify the legal/ethical issues associated with AIDS in the criminal justice system; 7) discuss the different sides of the issues associated with AIDS and how potential liabilities exist with each; and 8) recommend approaches for responding to the problems.

Methodology and Organization of the Study

This research is a descriptive study of the emergence and growth of the AIDS epidemic and its impact on the criminal justice system. At the heart of public policy considerations concerning AIDS is the conflict between individual rights and the need to protect the public health. The AIDS outbreak here began and persists in three groups - homosexual men, drug addicts, and prostitutes - who, regrettably, are classic targets of discrimination and neglect. Chapter Two, through a review of the literature, will expose major issues and controversies surrounding AIDS issues. Chapter Three will be a critical, analytical chapter focusing on innovative

approaches dealing with medical, legal, and ethical problems associated with AIDS and corrections. In chapter Four, the author will make recommendations based on policy options designed to help correctional administrators continue the refinement and improvement of their AIDS policies.

List of Terms

Acquired immunodeficiency syndrome (AIDS): A disease caused by a virus known as HIV, in which the body's immune system is seriously damaged, leaving it vulnerable to infections and some rare cancers that ultimately result in death.

AIDS-related complex (ARC): ARC patients have some symptoms of AIDS, but not the clinically evident disease. Symptoms may include unexplained swollen glands or fever, weight loss, or persistent diarrhea.

Antibody: A unique protein produced by blood plasma cells to counteract or kill some specific infectious agents - viruses and bacteria.

Antibody-positive: A blood test showing that a person has been infected with HIV at some time and has developed antibodies to HIV. it does not mean that a person has AIDS.

Antigen: A substance that is foreign to the body and that stimulates the formation of antibodies to combat its presence.

Asymptomatic "carrier": A person who has had an infectious organism within the body but who feels or shows no outward symptoms.

Asymptomatic infection: The ability of certain organisms, such as viruses, to get inside a person's cells without resulting in clinical signs or symptoms that tell the person that he or she is infected.

AZT: Azidothymidine, an antiviral drug that has been shown to prolong life in AIDS patients.

Cofactors: Agents or other factors that are necessary to increase the probability for development of a disease when the basic causative agent of that disease is present.

ELISA: Enzyme-linked immunosorbent assay test for antibody.

Epidemiology: The study of relationships among various factors thought to determine the frequency and distribution of diseases in humans.

Exposure: The act or condition of coming in contact with but not necessarily being infected by a pathogenic agent.

Hemophilia: A hereditary blood condition found in males, in which even minor bodily injuries can be followed by prolonged bleeding.

HIV: The virus that causes AIDS. Formerly referred to as LAV or HTLV-III.

HIV-antibody screening test: A test whose purpose is to reveal the presence of antibodies to HIV. It is used on all donated blood and organs and in all medical and clinical testing programs. It is also used at alternative or anonymous test sites. If antibodies are detected, it is assumed that the individual or organ is infected.

Idiopathic thrombocytopenic purpura (ITP): A persistent decrease in blood platelets, of unknown cause, resulting in bruising of skin and tissues.

Immune system: A system within the body which helps the body resist disease-causing organisms such as germs, viruses, or other infectious agents.

Immunosuppressed: A state of the body in which the immune system defenses do not work normally - usually as a result of illness or the administration of certain drugs to fight cancer or prepare the body to accept transplanted donor organs.

Incubation period: The interval between infection and the appearance of the first symptom. (See "Latency.")

Infected: The state of the body in which a part of it has been invaded by a pathogenic agent that ordinarily multiplies and causes harmful effects.

Intravenous drugs: Drugs injected by needle directly into a vein.

Kaposi's sarcoma: A tumor of the blood vessels most frequently seen in the skin or mucous membranes and associated with AIDS.

Latency: A period when the virus is in the body but rests in as inactive, dormant state. (See "Asymptomatic infection.")

Lymphocytes: Specialized white blood cells involved in the immune response.

Morbidity: The degree of symptomatic illness associated with an infectious organism.

Opportunistic infections: Those diseases which are caused by agents that are frequently present in our bodies or environment but which cause disease only when there is an alteration from normal healthy conditions - for instance, when the immune system becomes weak or damaged.

Pathogen: Any disease-producing microorganism or substance.

Perinatal: Occurring in the period during or just before or after birth.

PGL: Persistent generalized lymphadenopathy. A persistent swelling of the lymph nodes. In AIDS, a condition of long-term generalized lymph-node swelling characteristic of the so-called AIDS-related complex.

Pneumocystis carinii pneumonia (PCP): An opportunistic infection of the lung which results in a diagnosis of AIDS.

Prevalence: The total number of persons in a given population with disease at a given point in time - usually expressed as a percentage.

Prognosis: Prediction of course and end of a disease, and outlook based on these factors.

Retrovirus: A genus of viruses which contains the enzyme reverse transcriptase and which requires the synthesis of proviral DNA for its replication.

Seroconversion: The point at which antibodies to specific antigens are produced by B lymphocytes and become detectable in the blood. "Conversion" refers to change from a negative to positive status, or vice versa.

Seronegative: Resulting in a negative reaction to a blood test - the HIV antibody test(s). If high-risk, a person cannot be assumed to be uninfected on the basis of a negative test.

Seropositive: Producing a positive reaction to a blood test - the HIV antibody test(s). A person who has a positive and confirmatory test is presumed to be both infected and infectious.

Syndrome: A set of signs and symptoms that occur together.

Vaccine: A preparation of killed, living attenuated, or living virulent organisms or part of microorganisms which can be administered to produce or increase immunity to a particular disease.

Viruses: Submicroscopic pathogens that grow and reproduce only inside living cells, thus causing disease.

Western blot: Confirmatory test for antibody.

CHAPTER ONE

NOTES

[1] Loretta McLaughlin, "AIDS: An Overview," in **The Aids Epidemic: Private Rights And The Public Interest**, ed. Padraig O'Malley (Boston: Beacon Press, 1989), 28.

[2] Ibid.

[3] Harvey Feinberg, "Public Health and Private Rights: Health, Social and Ethical Perspectives," **Proceedings of AIDS International Symposium** (New York: Hummler Plenum Press, 1986).

[4] Theodore M. Hammett and Saira Moini, "Update on AIDS in Prisons and Jails," **National Institute of Justice: AIDS Bulletin** (Washington: GPO, Sept. 1990), 1.

[5] Ibid.

[6] John C. Petricciani, and Jay S. Epstein, "The Effects of the AIDS Epidemic on the Safety of the Nations Blood Supply," **Public Health Reports** 103, no. 3 (May/June 1988): 236.

[7] Theodore M. Hammett and Saira Moini, "AIDS in Correctional Facilities: Issues and Options," **National Institute of Justice: AIDS Bulletin** (Washington: GPO, May 1987), 35.

[8] "CDC Funding Study To Measure The Spread Of AIDS In U.S. Prison Population," **Corrections Digest** 19, no. 11 (June 1988): 1.

[9] Judy Greenspan, "NPP Gathers Statistics On AIDS In

Prison," National Prison Project Journal 16 (Summer 1988): 8.

CHAPTER TWO

REVIEW OF THE LITERATURE: ISSUES AND CONTROVERSIES SURROUNDING AIDS ISSUES IN CORRECTIONS

In order to understand the legal/ethical issues surrounding AIDS, it is important to understand exactly what AIDS is, how science has responded to the AIDS epidemic, and how the testing for the virus which causes AIDS is significantly difficult to interpret and be conclusive.

What is AIDS?

AIDS is a condition that impairs the body's normal ability to resist harmful diseases and infections. The syndrome is caused by a virus known as Human Immunodeficiency Virus (HIV).

Transmission of any human virus requires a portal of exit, survival through the environment into which it is released, and entrance into a susceptible host with establishment of infection in a cell capable of supporting replication. The HIV has been isolated from fluids obtained from a variety of body sites, including blood, semen, vaginal fluid, tears, and saliva. Epidemiologic studies have established that those fluids that provide sufficient virus for transmission seem to be limited to blood, semen, saliva, and vaginal secretions. Presumably, the presence of lymphocytes in these fluids increases the concentration of infectious virus and may be important, or even essential, for

transmission.

According to the Center for Disease Control, casual contact with persons who have AIDS, or who might be susceptible to contracting AIDS, does not place an individual at risk. No case of AIDS has been attributed to airborne infection or casual contact or touching. The virus must enter the bloodstream to infect someone. Thus, there is no risk of contracting AIDS from engaging in normal daily activities such as working in a group setting, eating in public, or shaking hands.

AIDS is thought to be transmitted most often through sexual contact or needle sharing, and less frequently through blood or its components. AIDS may also be transmitted from an infected mother to a child during or shortly after birth. There is now medical evidence that the AIDS virus can enter the body through cells in the mucous membranes; mucosal cells are found in the lining of the genitals, anus and mouth, as well as in semen and vaginal fluids.[1]

HIV infection is similar to hepatitis B virus (HBV) infection with respect to modes of transmission, i.e., sexual contact, blood or blood products and perinatal transmission from infected mothers to their offspring. In fact, the CDC states that the risk for HBV transmission "far exceeds" that for HIV transmission.

Therefore, the risk of AIDS or HIV infection to the general population is low. Only those known to engage in

"high risk activities"--unprotected sexual contact with an HIV carrier, sharing of needles contaminated with the virus, or childbirth involving an infected mother--are at risk. Individuals in the health care professions, law enforcement and corrections, however, carry an inherent risk of exposure to many diseases. HIV is no exception. Personnel who are exposed to the blood and body fluids of HIV infected individuals are at risk of acquiring the virus.

Scientific Response to HIV

At no other point in the history of medicine has the reaction to a disease been so strong as what we have seen lately to HIV infection. The response by the medical community, both governmental and through the private sector, has been unprecedented.

In less than one decade scientists have identified the problem of AIDS, found its causative agent, developed tests to recognize the existence of the virus in the human body, and developed a myriad of drugs to attempt to treat the problem. Only a year or two ago it was believed that any form of vaccine would be many years in the coming. Now, researchers are testing variations of a vaccine aimed at curtailing the spread of the virus in the body of an already infected individual.

The response to this disease, this syndrome, has been amazing. And all the while AIDS has received priority ratings by the press. In fact, probably in part because of the wide

publicity AIDS has received, the scientific community has settled into an accelerated pace in its response to the crisis.

Mass communication has played its part in allowing researchers to learn from each other. There are, from year to year, more national and international symposiums on AIDS and HIV infection than any other single infectious agent or syndrome. Private industry and the government have formed an unwritten alliance to stop AIDS. Drug companies have donated massive amounts of money and offered free use of drugs to assist researchers in finding an effective form of treatment. The Federal Food and Drug Administration has streamlined the usually cumbersome process for testing and approval of drugs to accommodate a rapid response to the flood of new drugs which must be analyzed for their efficacy in treating AIDS.

HIV Test Results

The tests which are commonly used to detect the presence of HIV in the human body are by most standards new and without their flaws. The enzyme-linked immunosorbent assay or ELISA test which was developed for mass testing of donated blood at blood banks is inexpensive and easy to perform. Unfortunately, the ELISA has a significant degree of error associated with false positive results. In other words, a person might test positive on the ELISA test for the presence of HIV in their blood when indeed they are not positive. Therefore, the test cannot be used diagnostically and on its

own cannot be used for anything other than mass pre-screening of blood bank donations. Additionally, more specific and more costly tests like the Western Blot test must be used to confirm positive ELISA results.

Another, and probably more significant, problem associated with the commercially available HIV tests, is that they are designed to detect antibodies, or the body's reaction to the virus, not to detect the virus itself. The problem stems from the amount of time it takes for an individual to develop antibodies to HIV, usually eight to twelve weeks, but it can be as long as six months in some people. Therefore, the problem is specifically that even with the use of the more sophisticated antibody test the results are dependent upon the development of HIV antibodies. It is quite possible that an individual could harbor the virus and therefore be infectious, fully capable of spreading the disease, but test negative for antibodies to HIV.

The problem of false positive and false negative results to HIV antibody testing are great. The fact that the potential for false results exists impacts significantly on any argument for or against mass testing. These facts also suggest that one cannot base how they will prevent exposure to the disease on the test results. For instance, in the hospital setting employees must protect themselves from exposure to the blood and body fluids of all patients, not just those who test positive for the presence of the virus.

Similarly, those individuals who are sexually active and not involved in a long-term mutually monogamous relationship must use protection in all of their sexual relationships.

Another important point about HIV testing is that the confidentiality of people being tested is strongly guarded in many states. California has one of the toughest laws associated with HIV antibody testing. These laws are designed to reduce discrimination against those who test positive and to protect their confidentiality. In California, significant penalties, financial and criminal, can be levied against any individual who knowingly discloses the results of another person's HIV antibody test, whether positive or negative. These considerations also impact the debate over testing. The questions surrounding testing on a mass scale of correctional facility inmates, and of confidentiality will be addressed in greater depth later. For now, however, it is important for the reader to recognize that present testing techniques do not offer conclusive evidence of infection at all times, and that even if they did, test results can only be shared with others with the clear understanding and approval of the person being tested.

Literature Review

The amount of literature generated during the past decade encompassing the AIDS epidemic is enormous. AIDS the disease, and AIDS literature transcends the medical field and impacts society daily. Legal issues are almost as paramount as the

medical ones. Social scientists contribute as many articles on AIDS as do their medical counterparts. Education, economics, and religious writers have also provided numerous treatises on the AIDS issue.

The issues raised by AIDS are controversial and the center of public attention. These issues parallel many of the legal, ethical, professional, and social issues that exist in the provision of health care for the entire population. Trying to limit the literature review to that specifically dealing with criminal justice and corrections was like opening Pandora's box.

The managers and staff of correctional institutions were among the first criminal justice professionals to confront the problem of AIDS. Time has not diminished that challenge. By October 1989, a cumulative total of 5,411 confirmed AIDS cases (the vast majority the results of intravenous drug use) had been reported among inmates in the United States' prisons and largest jail systems--an increase od 606 percent over the first survey of inmate AIDS cases in 1985.[1]

Ten years ago, on 5 June 1981, Dr. James Curran and his colleagues at the Centers for Disease Control in Atlanta released a puzzling report: five men in Los Angeles, all homosexuals, had come down with a rare, inexplicable type of pneumonia.

Then 26 gay men - most of them on the other side of the country, in New York - were found to have a form of cancer

until then virtually non-existent in the United States.

As Curran and his fellow epidemiologists were to later discover, they had encountered the first known cases of AIDS.[3]

A decade later, the AIDS epidemic is surging toward 200,000 cases in the United States, with another 500,000 cases expected to develop by the end of the century and millions more around the world.[4]

Beyond the sheer numbers, AIDS has served as a "lens" through which to view contemporary American society , says Energy Secretary James D. Watkins, who chaired President Reagan's AIDS commission. It is a society that has been "quick to reject, deny, condemn and discriminate," he says, but also one that can demonstrate "the spark of human spirit that rises high when faced with the gravest of human tragedy."

While most medical writers are in agreement about the cause and treatment of AIDS, there appears to be a definite split among the remainder of the "educated" authors on what course of action society needs to take regarding the AIDS issue.

Since 1985, the National Institute of Justice has worked with the Centers for Disease Control and other public health officials to provide important information about AIDS to criminal justice professionals. The most prolific writer in this arena is Theodore M. Hammett, Ph.D. Dr. Hammett is a senior analyst in the Law and Public Policy Area at Abt Associates Inc., where he directs a long-range historical

study of CDC's response to the AIDS epidemic; a study for the National Institute on Drug Abuse on AIDS Outreach to Female Prostitutes and Sexual Partners of Intravenous Drug Abusers; and, for the National Institute of Justice, a study on the Syntheses of Innovative Criminal Justice Practices and Research Findings for Dissemination to the Criminal Justice Community. Dr. Hammett was the Principle Investigator for the fourth edition of AIDS in Correctional Facilities: Issues and Options, based on surveys of correctional systems in the United States and Canada.

Dr Hammett is a leading expert in this field of research and has written extensively on the subject of AIDS in correctional facilities.

His findings indicate that while the crisis atmosphere seems to have dissipated somewhat, AIDS remains a serious correctional issue. Most correctional systems have adopted policies regarding AIDS, with certain indisputable principles such as the importance of educating both inmates and staff about the disease. However, concern among correctional systems has shifted significantly from short-term "crisis" matters such as fear of casual transmission to "long-haul" issues such as housing, programming, and medical care for prisoners with HIV disease. Resolving these issues is often complicated by political, legal, and cost considerations.[5]

The Impact of HIV on Criminal Justice Agencies

Many defendants who pass through the criminal justice

system have a history of intravenous drug use (IVDU) or have engaged in behavior that puts them at increased risk of AIDS. As a consequence, police officers, prison guards and others who work in the system often express anxiety that they will become infected with HIV as a result of their employment.

Most epidemiological studies have concluded that the rate of seroprevalance within the general inmate population is low, less than three percent.[1] Nonetheless, many correctional administrators remain concerned that seropositive inmates will transmit HIV to others within the institution either through homosexual activity, or by sharing contaminated needles or tattoo equipment. Although no cases have been documented in which an inmate seroconverted during incarceration, "logic and common sense both suggest that even in the best managed correctional institutions, there may be at least some transmission of the AIDS virus occurring among inmates."[7] On the other hand, there is little doubt that incarcerated IV drug users face far less risk of becoming infected with HIV than do those addicts who remain on the street.

Several states have attempted to determine through HIV testing whether the virus is being transmitted within the institution. These studies indicate that very few prisoners who have been continuously incarcerated since the beginning of the epidemic are infected. Maryland authorities observed that only two of 137 inmates were seropositive.[1] Similar findings have been reported in New York and Florida.[1] However, because

the upper limit of the incubation period for AIDS has not been established, it is uncertain whether these inmates actually seroconverted during incarceration.

Mass HIV screening of all inmates both upon entry and at release has been instituted in four states (Alabama, Idaho, New Hampshire, and West Virginia). These data should eventually provide some indication of how frequently the AIDS virus is being transmitted within the prison. However, because Alabama is the only state among these systems with a substantial number of AIDS cases, it is questionable whether these findings will be generalizable to those systems that contain the largest number of inmates with AIDS (New York, New Jersey, and Florida).

Mass Screening

In the U.S., public health authorities have attempted to control the spread of HIV through education, voluntary testing and by counseling persons at high risk. With the exception of immigrants and military personnel, most testing has been conducted on a voluntary basis. From the beginning of the epidemic, correctional administrators have debated whether this approach is appropriate in prisons and jails. Before discussing the controversy regarding mandatory testing, it is necessary to touch upon the available medical technology for diagnosing HIV.

The current blood test is not able to predict which seropositive individuals are likely to develop "documented"

AIDS, nor at what point symptoms may appear. The test cannot detect the AIDS virus, merely the presence of antibodies to HIV. Because the human immune system will generally not develop antibodies until 6 to 12 weeks after exposure, persons tested during this period will be seronegative despite the fact that they are able to infect others.[11] These results are commonly referred to as "false negatives." They pose a real concern for any program of mass screening.

Mandatory mass screening involves testing all inmates or all incoming inmates for HIV infection. A more limited version involves testing only members of high risk groups (homosexuals, IV drug users, or prostitutes). Proponents argue that mass screening is the best way to identify seropositive inmates. Such a policy provides correctional administrators with an opportunity to target education and prevention programs. In addition, infected individuals can be placed under special supervision to ensure that they do not transmit the virus to others. Supporters of this policy argue that institutions must take action to identify infected inmates and to prevent the spread of this virus, or face civil liability. Finally, it has been suggested that mass screening could provide a more accurate projection of how many cases of fully developed AIDS will eventually occur. This will enable correctional officers to plan more effectively and to seek an appropriate level of funding to meet future needs.

Critics of mass screening do not accept these rationale.

They assert that education and prevention programs must be directed toward all inmates, and that all prisoners should be encouraged to refrain from high-risk behavior, not just those identified as seropositive. Furthermore, opponents of mass screening decry the practice of segregating infected individuals from the inmate population. Because any system of mass screening would produce some false negatives, it is not possible to identify all infectious inmates.

Opponents of mass screening are also skeptical about civil liability concerns. They note that institutions already have rules that prohibit those types of conduct which can transmit HIV (i.e., sexual contact and IV drug use). As a consequence, inmates who engage in these practices do so at their own risk. Most correctional lawyers argue that the institution would not be held liable unless an inmate became infected through a sexual assault.[11]

Opponents of mass screening also fear that it will create a class of outcasts within the institution, with seropositive inmates subjected to harassment, discrimination and perhaps even violence within the prison, and to difficulties in obtaining employment and housing upon release.

The debate surrounding testing of parole or probation service populations in many ways mirrors that regarding the general population. But community corrections supervisors are particularly vulnerable to potential liability for release of an infected person into the community. In addition, they may

be liable for the potential leaking of confidential test information. For example, probationers or parolees may face stigmatization and discrimination if their HIV antibody-positive status is disclosed. Officers on the other hand, may be liable to third parties as a result of non-disclosure of information.[12]

As these results suggest, the issue of testing parole and probation populations engenders considerable debate. Some practitioners feel that it is important to know the HIV status of persons under supervision for several purposes: to protect staff from possible transmission; to protect public safety, including the sexual partners of HIV-infected individuals or others in community facilities; and to prepare for managing the individual's incipient illness.[13]

Some prison systems are reluctant to parole HIV seropositive inmates in response to an unrealistic fear of possible future liability if the inmate infects someone after release. New York State has refused known HIV seropositive inmates or those with AIDS permission not only for conjugal visits with a knowledgeable spouse but also for visits with parents, siblings, and children. Inmates dying of AIDS are deprived of the time and space for private moments of grieving.[14]

Confinement and separation are invariable principles of correctional philosophy; levels of punishment and deprivation, as expressions of these principles, change over time. HIV

infection converts segregation and separation to punishment, deprivation, or even brutality, if the health and social needs of HIV infection in the prison population are not adequately and humanely met.[15]

Mandatory screening programs may not be possible in many states under existing statutes. Laws in California, Washington, D.C., New York, Wisconsin, and Massachusetts, for example, prohibit testing without the informed consent of the subject. Case law is continually developing in this area and will be discussed in the following chapter. In addition, the right to refuse testing may be legally viable, if it is argued that disclosure of results could have serious negative consequences for such things as insurance benefits, employment opportunities, or family relations.[16]

It will be interesting to see whether lawmakers continue to press for mandatory HIV testing in correctional institutions now that Zidovudine (AZT) has been demonstrated to be beneficial for many asymptomatic carriers of HIV. This drug is extremely expensive ; the average cost of treating one patient can be $800 to $1,000 a month. For just one state prison, the California Department of Corrections has budgeted $300,000 for the drug this year.[17]

With the universe of individuals who can benefit from this medication now greatly expanded, politicians may become less interested in identifying infected inmates. In fact, the pressure to conduct testing may come increasingly from inmates

whose past behavior has put them at risk of developing AIDS. Whether institutions will be required to provide testing on demand and AZT to those seropositive inmates who could benefit from this drug is something that the courts are likely to be asked to decide.[11]

Segregation

Correctional systems commonly segregate prisoners who are diagnosed as having AIDS or ARC. The Federal Bureau of Prisons transfers male inmates with AIDS or ARC to the Medical Center for Federal Prisoners in Springfield, Missouri. Female prisoners suffering the same condition are sent to the medical center at the Federal Correctional Institute in Lexington, Kentucky. Half of all state systems segregate inmates with AIDS or ARC.[11]

In addition to the controversy over testing, correctional administrators must also decide whether to separate infected prisoners from the inmate population. Segregation can be undertaken for medical reasons, to protect an infected individual from violence, or as a general policy to prevent the transmission of HIV within the institution. It is the latter rationale which raises controversy and is thus the focus of attention.

Proponents of segregation assert that this is necessary to prevent the transmission of HIV within the institution. Advocates make the following arguments:

1. Previous research indicates that homosexual activity is a fact of life in prison. Nacci and Kane report that 30 percent of male inmates have hade a homosexual experience as an adult in prison.[11] Data from another institution indicated that 65 percent of the male prisoners have had sex with another male during their current period of incarceration.[11]
2. Other sexually transmitted diseases (e.g., rectal gonorrhea) are sometimes transmitted in the correctional setting.
3. Tattooing, although prohibited in most institutions, is a common practice, illicit drug use probably takes place as well.
4. Studies conducted within various institutions conclude that a small proportion of inmates are sexually assaulted during incarceration.[12]

Civil libertarians are opposed to the practice of segregation except for valid medical reasons or in cases involving protective custody. They argue that because HIV is *NOT* spread through casual contact, separate facilities are not necessary. In fact, the CDC opposes special housing for AIDS patients except when medically necessary. Critics contend that institutional segregation undermines the basic public health message that AIDS is not transmitted except through intimate contact.[11]

Opponents of this practice also express concern because infected inmates are often placed in substandard living quarters and denied an opportunity to participate in certain work assignments, rehabilitation, and recreation programs or to be eligible for work release. Furthermore, because these prisoners are excluded from many institutional programs, they frequently also lose the opportunity to earn "good time" credit toward eventual release.

The problem of "false negative" HIV test results has already been noted. Vaid has suggested that a policy of mandatory testing and segregation could actually be counterproductive for this reason. Because individuals who remained in the general prison population would be perceived as HIV-free, inmates might be encouraged to continue engaging in high risk behavior due to the mistaken notion that all infectious persons had been placed in isolation. Furthermore, such a policy could conceivably place seropositive inmates in greater jeopardy as well. Believing that they have little to lose, these individuals might continue to engage in risky activities. However, it is possible that a seropositive individual will eventually suffer the occurrence of fully developed AIDS.

Segregation raises other problems as well. Critics note that it can become very expensive. In those jurisdictions that have a large number of infected inmates, this policy may require the development of what is in fact a second

corrections system. Officials may be required to duplicate many existing institutional programs. As the number of cases continues to grow over the next few years, this could become an administrative nightmare.

Clearly, correctional administrators have a legal as well as an ethical responsibility to pursue policies that minimize the transmission of HIV within the institution. However, it is questionable whether a blanket policy of segregation is the best way to accomplish this objective. As an alternative, prison and jail administrators could reduce the incidence of "high-risk" behavior through such steps as increased supervision, hiring more correctional officers, intensive educational programs, and harsh penalties for sexual assault. In addition, the classification process can be used to identify both inmates who are likely to engage in predatory behavior as well as those who are more likely to be victimized. Bowker notes that the latter are "more likely to be middle class, young, inexperienced, convicted of minor property offenses, and slight of build." This is an important piece of information for correctional officials who wish to place potentially vulnerable prisoners under special supervision.

Confidentiality

Another issue that must be confronted by policymakers is the question of who should have access to information with

regard to HIV antibody status. Clearly, the attending physician must have these results if the inmate is to be provided with proper medical attention. The case for disclosure to other personnel within the institution is far less compelling. Although correctional officers have sometimes asserted that they have a right to know who is seropositive, relatively few systems routinely disclose this fact to line officers according to Hammett.[14] In fact, state law in some jurisdictions prohibits the disclosure of HIV test results without the written authorization of the infected party.

Correctional officers base their case for disclosure on the rationale that this knowledge is necessary if they are to be able to take appropriate precautionary measures when interacting with seropositive inmates. The latter, on the other hand, are genuinely concerned that they will be subjected to threats, ridicule, or even attack, if their condition becomes known. Policymakers are thus confronted with the task of balancing these competing concerns. In those jurisdictions that do not prohibit disclosure, does the officer's right to know outweigh the inmate's right to privacy? Are line officers put at increased risk when they are forced to operate without this medical information?

Examination of the circumstances under which HIV is and is not transmitted suggests that the inmate's right to privacy should take precedence over the employee's right to know. For

one thing, this virus is not transmitted through casual contact. The basic modes of transmission are now clearly understood. If correctional officers become infected as a result of their employment, it is quite probable that they have engaged in activities with inmates that would be cause for dismissal even if AIDS was not a concern. Second, educational programs are designed to teach staff that it is advisable to take proper infection control measures (e.g., wearing latex gloves when contact with blood or other body fluid is anticipated) with all inmates. By providing institutional personnel with a "master-list" of seropositive prisoners, a false sense of security could be created for persons working in the facility. This may lead to a situation in which correctional officers fail to take adequate precautions when dealing with other inmates. Because available technology for detecting HIV antibodies in newly infected persons is unreliable, this would not be a wise course of action.[15]

Whatever policy is followed with respect to notification of line officers, institutions must ensure that the antibody status of infected inmates does not become known within the general prison population. Administrators should develop clearly enunciated policies that prohibit medical personnel and others from making disclosures to unauthorized individuals. Care must be also exercised in the handling of "master-lists" that contain the names of seropositive inmates.

However, despite the best efforts of correctional administrators, the identity of some infected individuals is still likely to become known. On occasion, inmates will disclose their HIV status to others. In other instances, the fact that an inmate has been denied the opportunity to participate in a particular activity or release program will serve as a "tip-off" for the institutions "rumor-mill." Finally, in cases where the individual has progressed to ARC or "full-blown" AIDS, the physical manifestations of the disease may become obvious to other inmates. Therefore, educational programs, as part of their mission, must articulate the message that infected prisoners pose no danger to other individuals within the facility (as long as "high-risk" behaviors are avoided)."

California's law dealing with the results of the HIV-antibody tests for the AIDS virus and any release of that information in a patient identifiable form is one of the strictest in the nation. Health and Safety Code (HSC) Section 199.21 requires a written authorization by the patient for each disclosure and also expressly forbids the use of test results for purposes of "insurability or suitability for employment." HSC Section 199.27 provides that when a person is not competent to consent to the HIV blood test, written consent may be obtained from the patient's parents, guardian, conservator, or other persons lawfully authorized to make health care decisions for the subject. The law further

specifies that a minor is deemed incompetent to consent if he or she is under 12 years of age.

Recent revisions in HIV-antibody test confidentiality laws provide that a physician who discloses a positive test result to a person believed to be the spouse of a patient shall not be held criminally or civilly liable for doing so. It is important to note that this immunity from liability only applies to the physician. If the physician knows that the patient is not married and discloses the test results to the patient's partner, the physician will be liable for any damage that this may cause the patient. No civil or criminal liability will be imposed for disclosure of HIV blood tests to a public health officer when the disclosure is necessary to locate and notify a blood donor of a reactive result if reasonable efforts by the blood bank to locate the donor have failed.

Protecting confidentiality creates legal, ethical, and social burdens on physicians with no clear guidelines available from which to be guided. In the absence of a clear legal mandate, the difficult ethical dilemma is one of balancing long-term societal benefits against short-term benefit to an individual. Although it is a difficult decision, and there may be exceptions to the rule, maintaining the patient's confidentiality ought to be the first principle.

As administrators respond to AIDS in the correctional setting, they have a unique opportunity to demonstrate concern

for, and a fair and humane attitude toward, inmates with AIDS or ARC. At the same time, they can protect the legitimate safety interests of all employees. To do this, administrators must understand applicable laws and enlightened strategies to deal with these sensitive issues.

CHAPTER TWO

NOTES

[1] "Finding On AIDS Transmission: Disease Can Enter Through Mucous Membranes, Researchers Say," **The Sacramento Bee Final**, 20 June 1991, A6.

[2] Saira Moini and Theodore M. Hammett, "1989 Update: AIDS in Correctional Facilities," **National Institute of Justice: Issues and Practices** (Washington: GPO, May 1990), iii.

[3] Marlene Cimons, "Grim Anniversary: AIDS First Reported 10 Years Ago," **The Sacramento Bee**, 5 June 1991, A1.

[4] Ibid., A14.

[5] Theodore M. Hammett and Saira Moini, "Update on AIDS in Prisons and Jails," **National Institute of Justice: AIDS Bulletin** (Washington: GPO, Sept. 1990), 1.

[6] Theodore M. Hammett, "AIDS in Correctional Facilities," **National Institute od Justice: Issues and Options** (Washington: GPO, May 1988), 29.

[7] Theodore M. Hammett, "AIDS in Correctional Facilities," **National Institute of Justice: Issues and Options** (Washington: GPO, May 1987), 15.

[8] Urvashi Vaid, "Prisons" in **AIDS and the Law: A Guide for the Public**, ed. Burris Dalton (New Haven: Yale University Press, 1987), 238.

[9] Theodore M. Hammett, "AIDS in Correctional Facilities," **National Institute of Justice: Issues and Options** (Washington: GPO, May 1988), 31.

[10] John C. Petricciani and Jay S. Epstein, "The Effects of the AIDS Epidemic on the Safety of the Nation's Blood Supply," **Public Health Reports** 103, no. 3 (May-June 1988): 236.

[11] Theodore M. Hammett, "AIDS in Correctional Facilities," **National Institute of Justice: Issues and Options** (Washington: GPO, May 1987), 35.

[12] Dana Eser Hunt, "AIDS in Probation and Parole," **National Institute of Justice: Issues and Practices** (Washington: GPO, June 1989), 27.

[13] Ibid.

[14] Nancy Neveloff Dubler and Victor W. Sidel, "On Research on HIV Infection and AIDS in Correctional Institutions," **The Milbank Quarterly** 67, no. 2 (1989): 182.

[15] Ibid., 183.

[16] Hunt, op. cit., 27.

[17] Steve Taravella, "AIDS: A Complex Issue for Corrections Officers," **Modern Healthcare** 18, no. 24 (June 1988): 28.

[18] Mark Blumberg, **AIDS: The Impact on the Criminal Justice System** (Columbus: Merrill Publishing Company, 1990), 201.

[19] Vaid, op. cit., 7.

[20] Peter L. Nacci and Thomas R. Kane, "The Incidence of Sex and Sexual Aggression in Federal Prisons," **Federal Probation** 47, no. 4 (Dec. 1983): 35.

[21] Wayne S. Wooden and Jay Parker, **Men Behind Bars: Sexual Exploitation in Prison** (New York: Plenum Press, 1982), 50-51.

[11] Lee H. Bowker, Prison Victimization (New York: Elsevier, 1980), 2-3.

[12] Mark Blumberg, "Issues and Controversies with respect to the Management of AIDS in Corrections," Prison Journal 69, no. 1 (Spring-Summer 1989): 6.

[13] Ibid., 7.

[14] Ibid.

[15] Ibid.

CHAPTER THREE

MEDICAL/LEGAL/ETHICAL PERSPECTIVE

It is often said that a society's ills are mirrored in its prisons. This notion, though somewhat banal, is nonetheless true concerning acquired immune deficiency syndrome (AIDS), with the exception that the mirror should be a magnifying glass. Prisons are indeed, a confluence of high risk populations and practices that form a particularly volatile, closed environment for the spread of the disease.[1]

AIDS has emerged as a major public health problem in the current decade. End-stage AIDS and its precursors, asymptomatic HIV (Human Immunodeficiency Virus) infection and ARC (AIDS-Related Complex), pose a particularly thorny management and health care challenge for the nation's prisons and jails. Correctional administrators must deal not only with the general public health concerns of education, confidentiality of testing, infection control, and medical treatment, but also with unique issues of offender housing, victimization, and access to support services.[2]

The response in prisons and jails has mirrored -but lagged far behind- the community and medical developments surrounding this issue. Panic and fear have, in some jurisdictions, led to such measures as mandatory testing, segregation and isolation, and punitive treatment of

offenders. Several court challenges are now in process. As new information on HIV infection and AIDS has become available, many states are revising policies so as not to create "leper colonies" within their prison walls.[1] HIV infected inmates need not be treated as a distinct, homogeneous set of offenders, all requiring the same management approach. Instead, commonly understood principles and procedures of offender classification can form a rational basis for the multiple decisions being made about their risk level, their housing/supervision requirements, and their health, mental health, and program needs within the prison setting.

Current Practice

The prevalence of U.S. prisoners infected with the AIDS virus poses a special and mounting problem behind prison walls. There has been a 156% increase in AIDS-infected prisoners in correctional facilities since 1985.[4] This is probably due to elevated numbers of high-risk group members within prisons, primarily intravenous (IV) drug users. Correctional administrators are confronted with the management and prevention of AIDS, and at the same time must address the needs of the infected versus the noninfected. The solution has been a travesty for infected prisoners who find themselves punished within punishment as a result of their medical condition.

Prison-based AIDS policies are undoubtedly influenced by the general stigma associated with its primary victims - homosexual or bisexual men, IV drug users, and Black and Hispanic persons. This stigma combined with the early concerns -and misinformation- about transmission and the potential epidemic nature of AIDS led to policies which appear to have ignored or minimized earlier rulings and standards affecting prisoner management.

The treatment of AIDS-exposed prisoners is influenced by many factors. State legislators have been reluctant to provide adequate funding to manage AIDS in prison. It seems that politicians do not wish their names to be associated with or to endorse the lifestyle of groups with a high-risk of contracting AIDS. Moreover, most correctional facilities have been plagued with overcrowding for years as well as with a lack of funding, which is attributable to government neglect.[5]

In addition, most of those infected in prison come from minority groups - Black and Hispanic people especially - who have traditionally held less social power with which to influence the government. For several years in the 1980s, Black people represented approximately 12% of the total general population of the United States and yet account for 48% of all prisoners in state correctional facilities.[6] In addition, in the general population of the country Black people represent 25% of all reported AIDS cases, while among prisoners with AIDS, 46% are Black, 27% are Hispanic, and 27%

are white.[7]

Treatment within prison may also be related to social power in the prison community. The operant organization of correctional facilities is a result of political conflict between various groups (prison administrators, correctional officers, counseling staff, prisoners, ect.) seeking to secure their vested interests. Prisoners who have been exposed to AIDS appear to be an "outgroup" (and are stigmatized as such) within the prison community. Prison administrators may be forced to treat AIDS-exposed prisoners according to this outgroup status.[8]

Stemming from their fear of "catching" AIDS, prisoners and prison personnel alike hold great disdain for these unfortunate individuals. The reaction of noninfected prisoners may be more serious than that of correctional officers. Infected prisoners have been forced into protective custody or segregation out of administrative concern for their safety. In *Cordero v. Coughlin* (1984), a federal court supported the argument of prison administrators that the segregation of infected prisoners was mandated to "protect both the AIDS victims and other prisoners from tensions and harm that could result from fears of other inmates."[9]

Prison personnel have refused to work with AIDS-exposed prisoners. A 1986 survey of correctional officers throughout the United States revealed that 93% had concerns about casual contact with infected prisoners.[10] Theodore M. Hammett

reported that correctional officers refused to work with AIDS-infected prisoners in 20% of the state and federal correctional facilities in the United States.[11] In a similar fashion, there have been reports that they ignore requests for assistance by AIDS-exposed prisoners and wear masks and gloves while escorting prisoners with AIDS. Further, correctional officer unions have pushed for the disclosure to prison staff of the results of prisoner AIDS-antibody tests, for mandatory testing, and for the segregation of AIDS-exposed prisoners.

Legal Issues

In the history of prisons in the United States, it has been the courts which have stepped in to assure adequate treatment of prisoners. Until the early 1940s, the courts followed what is called the "hands off" doctrine. That is to say, the courts allowed prison administrators to have a free reign in operating prisons since prisoners were granted a state's slave status. In 1944, in a turnabout, the Supreme Court abandoned the hands-off doctrine and ruled that "a prisoner retains all the rights of an ordinary citizen except those that expressly, or by necessary implication are taken from him by law."[12]

Litigation has been derived from policies concerning the testing of prisoners for exposure to the AIDS virus; segregation of infected prisoners; the conditions of segregation; adequacy of medical treatment; and the

commutation of prison sentence for the dying. For example, in May 1988 the American Civil Liberties Union's National Prison Project filed a suit on behalf of a group of Alabama prisoners. The suit asserts that the AIDS policy in today's prisons unconstitutionally compels prisoners to undergo testing, fails to advise prisoners of the "inconclusive and sometimes misleading significance of the results, fails to provide adequate counseling and medical care to seropositive inmates, compels them to live in a segregated unit in conditions resembling a 'leper colony,' and deprives them of programs available to other inmates."[11] Previous court decisions in this regard almost uniformly allow the victimization of AIDS-exposed prisoners.

In late 1985 most legal issues regarding AIDS in correctional facilities remained theoretical; few actual cases had been filed. Since then, however, numerous cases have been filed by inmates, and many have reached disposition. Most cases have been filed in United States District Courts, although some have been filed in State and county courts as well.

One example of current litigation was a Nevada prisoner's suit challenging forcible blood testing of inmates for AIDS. The suit was filed by Andrew J. Walker, who said prison guards at the Nevada State Prison in Carson City forced him to submit to the test by threatening him with an electric stun gun.[11] Walker said all prisoners had already been screened for AIDS

when they entered prison. A U.S. District Judge dismissed Walker's suit without a trial, saying the state's interest in identifying carriers of the AIDS virus justified mandatory testing.

But the suit was revived by tne 9th U.S. Circuit Court of Appeals, which said the state had not yet shown a legitimate justification for the tests. Nevada prison officials merely cited the need to protect the inmates' health and safety, and did not say whether they planned to isolate AIDS carriers, provide medical treatment, or make any use of the results of the tests.[15]

AIDS-related issues continue to produce substantial litigation involving correctional inmates and staff. Several major cases are moving toward decision or settlement. The year 1989 brought the first successful challenges to correctional systems' policies on segregation, medical care, and AIDS education. However, there remains a good deal of uncertainty on the legal status of other important correctional policies related to HIV infection and AIDS.

The main types of cases brought by inmates have involved challenges to mass screening and to segregation and conditions of confinement for persons with HIV infection or AIDS. Lawsuits also include allegations of inadequate medical care for persons with AIDS, breaches of confidentiality, and inadequate AIDS education.

Today, in contrast to the philosophy of the old "hands

off doctrine," convicted prisoners do not forfeit all constitutional protection by reason of their conviction and confinement in prison. When official policy or practice contravenes "a fundamental constitutional guarantee, federal courts will discharge their duty to protect" that guarantee.[16]

Medical Care

Rudimentary health care has been provided to confined inmates since the mid-nineteenth century. In England in 1784 social reformer Sir George Onesiphorus Paul instituted basic procedures for hygiene, not for the benefit of the prisoners but rather to increase the "salutary humiliation" of prison life and to prevent the spread of epidemic disease beyond the prison walls to the general citizenry. The object was clear: "The daily cleanups and hygienic inspections were intended not only to guard against disease, but also to express the State's power to order every feature of the institutional environment, no matter how minor.[17]

Health care in most correctional settings was woefully inadequate through the late 1960s when, following the revolt at Attica and the reports of civil rights advocates who had experienced incarceration, citizen groups, civil liberties organizations, and newly funded prisoners' rights attorneys began to investigate conditions of confinement.

In 1973 the U.S. Supreme Court decreed the end of the "hands off" doctrine that had maintained that prisons and

jails were so administratively complex and so ill-suited to judicial consideration and decree that decisions made by administrators would be shielded from judicial scrutiny and review. In 1976 the Supreme Court held that the Eighth Amendment, which prohibits "cruel and unusual" punishment, required that the deliberate indifference to the serious medical needs of inmates constitutes a violation of an inmate's protected rights. The court reasoned that to put people in prison where they cannot secure their own care and then to fail to provide that care results in precisely the sort of pain and suffering that the Eighth Amendment was designed to prohibit."

Correctional facilities vary widely in the age and architecture of the buildings, the training and numerical adequacy of staff, the level of overcrowding, and the history of hostility between inmates and officers. Correctional health services must diagnose, comfort, and treat in a setting designed to confine and punish. The resulting tension between the deprivation of liberty and the provision of care has led many jurisdictions to conclude they cannot provide care and to contract out correctional health services. The Supreme Court has recently held that these contracted services are equally subject to requirements of the Eighth Amendment. The moral imperatives of care and punishment must coexist. This uncomfortable alliance provides a paradigm for the care of IV-drug-using AIDS patients in the community: the visible

indication of criminal behavior in persons needing, wanting, and demanding care.

At present, there is no cure for AIDS and no vaccine to protect against the virus. In fact, most public health experts do not believe that a general vaccine to prevent AIDS will be available until the mid-1990s, at the earliest.[11] Physicians are able to treat some of the opportunistic infections that plague AIDS patients. However, the only drug approved to treat AIDS is azidothymidine (AZT). A number of antiviral agents have been developed in an effort to eradicate HIV, and many are now undergoing clinical trials. These include suramin, ribavirin, HPA-23, phosphonoformate, interleukin-2, and alpha and gamma-interferon. AZT has been shown to prolong the lives of persons with AIDS as well as to delay the onset of symptoms in some individuals infected with HIV. None of these agents rids the body of HIV, but they decrease the amount of virus in the bloodstream, make the patient less infectious to other persons, and/or stimulate the depressed immune system, which may help prolong life. Most of the currently studied drugs interrupt the AIDS virus at an important point in its cycle. Most are reverse transcriptase (RT) inhibitors. Once HIV penetrates the cell, RT, one of its enzymes, makes a circular double-standard prodromal DNA molecule coded by the viral RNA genome. Several antiviral agents interrupt HIV at this step. AZT inhibits replication of the AIDS virus and the cytopathic effects of HIV. It does

this by intercepting HIV as it is preparing to invade the nucleus of the cell. AZT interferes with the synthesis of new DNA during reverse transcription by terminating the growth of the DNA chain.

AZT inhibits RT, the enzyme HIV needs in order to replicate in the cell. This drug has already produced a clear-cut drop in mortality for a short term of treatment (24 weeks) and has produced a decrease in the numbers of opportunistic infections in patients with severe ARC.[11]

Legally, correctional medical care must meet community standards. That is, it must be equivalent to generally acceptable medical practice in the outside community. Prisoners may not be entitled to "state-of-the-art" treatment, but they should have access to all approved therapeutic drugs and generally employed treatment strategies. There have been, and continue to be, many lawsuits alleging substandard or inadequate medical care for various groups of prisoners, including those with HIV infection and AIDS.

Medical care costs have escalated dramatically in recent years and represent a major budget item for correctional systems. The increasing numbers of prisoners with HIV infection and AIDS have rendered medical care costs an even more severe financial strain for many correctional systems than was already the case. Since prisoners are statutorily ineligible for Medicaid, the costs of their care must be borne entirely by the jurisdiction in charge of the correctional

system. States with large numbers of HIV-infected prisoners may be spending significant percentages of their total AIDS budgets for prisoner medical care. Three-quarters of New York State's non-Medicaid patient care funds are used for HIV-infected prisoners. Almost 80 percent of Georgia's state-provided AIDS funds are needed to pay for treatment of prisoners infected with HIV. Moreover, since the costs of care for prisoners and other institutionalized populations are "fixed" and required to be paid from certain limited budget accounts, there are bound to be increasingly difficult funding tradeoffs as the epidemic expands. HIV treatment and prevention programs for other populations may have to be cut in order to pay for prisoner care.

In these constrained circumstances, correctional systems are, and will continue to be, under pressure to contain medical costs. However, cost containment should not come at the expense of reducing standards of care for HIV-infected prisoners.

Many improvements in treatment depend upon early identification and ongoing careful monitoring of HIV-infected persons. For this reason, it is important that all correctional systems offer HIV antibody counseling and testing to all inmates on request.

It is increasingly well-established that there is a close link between psychological and physiological health in HIV-infected persons. Therefore, it is critical that they be

provided with a range of supportive services. Counseling and support groups for HIV-infected prisoners can help them increase their will to live with the disease as well as to address issues of death and dying. It is important that, where possible, family members be involved in such services as well.

Support during treatment is essential. Some modes of treatment, such as use of interferon and some antibiotics, cause weakness and depression, which only adds to the patient's feeling of dysphoria. In addition, some treatments require frequent visits to outpatient clinics, uncomfortable or painful tests, and procedures, and long-term hospitalization, sometimes in isolation and with infection precautions.

Isolation can be stressful to prisoners with AIDS because they are taken away from others and have sensory deprivation at a time when they need closeness and acceptance. Isolation is especially stressful for these patients because it is a constant reminder of discrimination and alienation. Thus, the extra precautions correctional staff might impose on the AIDS infected inmate may be interpreted as further punishment rather than a medical necessity. Isolation also tends to discourage visitors, who may be frightened by all the precautions and may fear contracting HIV infection or other infections themselves. The family and friends must be encouraged to maintain the closest contact possible -

sometimes this is impossible with extremely infectious cases or because of the criminal classification of the inmate.

Ethical Issues

The acquired immunodeficiency syndrome poses a compelling ethical challenge to medicine, science, public health, the legal system, and our political democracy. One aspect of that challenge: the use of blood tests to identify individuals who have been infected with the retrovirus human immunodeficiency virus will be examined along with distribution of condoms and needle exchange programs.

Screening may seem to be a minor intrusion in the face of a deadly disease; yet even such an ostensibly limited intervention can have dramatic and deleterious consequences for individuals. Such intrusions must, therefore be warranted by the potential public health benefits.

It is important to reaffirm our society's commitment to promoting the health of its citizens, but public health efforts undertaken with a beneficent intent have sometimes had the opposite effect. An example is mandatory screening for sickle cell trait among blacks in the 1970s, which resulted in misinformation, stigmatization, and discrimination.[11]

In the United States, public health authorities have attempted to control the spread of HIV through education, voluntary testing, and by counseling persons at "high-risk." With the exception of immigrants and military personnel, most

testing has been conducted on a voluntary basis. From the beginning of the epidemic, correctional administrators have debated whether this approach is appropriate in prisons and jails. Before discussing the controversy regarding mandatory testing, it is necessary to touch upon the available medical technology for diagnosing HIV.

The current blood test is not able to predict which seropositive individuals are likely to develop AIDS nor at what point the symptoms may appear. The test cannot detect the AIDS virus, merely the presence of antibodies to HIV. Because the human immune system will generally not develop antibodies until six to twelve weeks after exposure, persons tested during this period will be seronegative despite the fact that they are able to infect others. These results are commonly referred to as "false-negatives." They pose a real concern for any program of mass screening.

Mandatory mass screening involves testing all inmates or all incoming inmates for HIV infection. A more limited version involves testing only members of "high-risk" groups. Proponents argue that mass screening is the best way to identify seropositive inmates. Such a policy provides correctional administrators with an opportunity to target education and prevention programs. In addition, infected individuals can be placed under special supervision to ensure that they do not transmit the virus to others. Supporters of this policy argue that institutions must take action to

identify infected inmates and to prevent the spread of this virus or they will be held civilly liable. Finally, it is suggested that mass screening could provide a more accurate projection of how many cases of AIDS will eventually develop. This will enable correctional officials to plan more effectively and to seek an appropriate level of funding to meet future needs.

Critics of mass screening do not accept these rationale. They respond to the claim that education and prevention efforts be targeted by asserting that these programs must be directed to all inmates. It is argued that all prisoners should be encouraged to refrain from "high-risk" behavior, not those identified as seropositive.

Opponents of mass screening also argue that such a policy is not a wise expenditure of resources and that it will create a class of outcasts within the institution. Fear is expressed that not only will seropositive inmates be subjected to harassment, discrimination, and perhaps even violence within the prison, but that they will also encounter difficulties in obtaining employment upon release. There is also the question of how prisoners will respond to the knowledge that they are seropositive. Because institutions contain a substantial number of individuals with sociopathic personalities, it can be argued that inmates who learn they are carrying a deadly virus will be more likely, not less, to engage in predatory behavior.

Whatever policy is followed, institutions must ensure that the antibody status of infected inmates does not become known within the general prison population. However, despite the best efforts of correctional administrators, the identity of some infected individuals is still likely to become known. On occasion, inmates will disclose their HIV status to others. In other instances, the fact that an inmate has been denied the opportunity to participate in a particular activity or release program will serve as a "tip-off" for the institution's "rumor-mill." Finally, in cases where the individual has progressed to AIDS Related Complex, the physical manifestations of the disease may become obvious to other inmates. Therefore, educational programs, as part of their mission, must articulate the message that infected prisoners pose no danger to other individuals within the facility (as long as "high-risk" behaviors are avoided).

Other important decisions that correctional administrators must confront are the issue of condoms and the distribution of clean needles to inmates. Not only would the needle issue create a security problem, it would be a tacit admission that authorities are unable to stop the smuggling of illicit drugs into the institution. Not surprisingly, this step has not been considered by any correctional facility in the United States. Because condoms can reduce the risk of HIV infection, many educational campaigns outside the prison have emphasized the use of condoms as a means of avoiding exposure

to the virus. Such campaigns have often been controversial with critics, charging that they encourage people to engage in casual sexual activity. The debate over "safer sex" vs. abstinence is even more intense in the area of corrections. Although most correctional systems allow inmates to be provided with "safer sex" information (generally through outside speakers), only New York City, Mississippi, and Vermont actually make condoms available for use by inmates within the institution.

Advocates of condom distribution assert that homosexual behavior is a fact of life in many institutions and that officials should give inmates access to these devices as a means of protecting them from disease. It is asserted that such conduct will occur despite the best efforts of policymakers and administrators to eliminate sexual activity within the institution.

Critics of condom distribution note that sexual activity is prohibited within institutions and that many states have statutes that criminalize homosexual behavior. They argue that this step would imply tacit approval of such conduct by correctional administrators. There is also concern how the public might react and fear that inmates might use condoms to make weapons or conceal contraband.[14] Finally, there is the question of whether condoms actually offer significant protection against HIV infection during anal intercourse.[15]

It is apparent that the AIDS epidemic has generated a

great deal of discussion and controversy regarding the proper management of this disease within the nation's prisons and jails. Policymakers have been forced to wrestle with many of the same issues that have confronted the larger society. Some correctional systems have responded to this challenge by instituting mass screening for HIV and segregating inmates infected with the virus. Although these measures are measures that are viewed as inappropriate by most public health officials for dealing with AIDS, it is argued by others that the unique circumstances of the institution justify this response. On the other hand, we are now one decade into the AIDS epidemic, and three consecutive surveys of correctional institutions by the National Institute of Justice (NIJ) indicate not a single case of occupational transmission in the United States.[14] With thousands of seropositive inmates in correctional facilities, a rather compelling case can be made that if occupational transmission was a serious concern in prisons and jails, it would have manifested itself by now.

CHAPTER THREE

NOTES

[1] Allen F. Anderson, "AIDS and Prisoners' Rights Law: Deciphering the Administrative Guideposts," **Prison Journal** 69, no. 1 (Spring-Summer 1989): 14.

[2] Carl B. Clements, "AIDS and Offender Classification: Implications for Management of HIV-Positive Prisoners," **Prison Journal** 69, no. 2 (Fall-Winter 1989): 19.

[3] Ibid.

[4] J. Michael Olivero, "The Treatment of AIDS Behind the Walls of Correctional Facilities," **Social Justice** 17, no. 1 (Spring 1990): 113.

[5] Ibid.

[6] U.S. Department of Justice, Office of Justice Programs, **Correctional Populations in the United States, 1988** (Washington: Bureau of Justice Statistics, March 1991), 63.

[7] Theodore M. Hammett, "1988 Update, AIDS in Correctional Facilities," **National Institute of Justice: Issues and Practices** (Washington: GPO, June 1989), 7.

[8] Olivero, op. cit., 114-115.

[9] *Cordero v. Coughlin*. 606 F.Supp.9 (D.C.N.Y. 1984)

[10] Hammett, op. cit., 26.

[11] Ibid.

[12] *Coffin v. Reichard*. 143 F.2nd 443 (1944)

[13] Marrianne Takas and Theodore M. Hammett, "Legal Issues Affecting Offenders and Staff," **National Institute of Justice:**

AIDS Bulletin (Washington:GPO, May 1989), 2.

[14] "Inmates AIDS Test Challenge Reinstated by Appellate Court," **The Sacramento Bee**, 23 October 1990, B4.

[15] Ibid.

[16] Allen F. Anderson, "AIDS and Prisoners' Rights Law: Deciphering the Administrative Guideposts," in **AIDS: The Impact on the Criminal Justice System**, ed. Mark Blumberg (Columbus: Merrill Publishing Company, 1990), 213.

[17] Nancy Neveloff Dubler and Victor W. Sidel, "On Research on HIV Infection and AIDS in Correctional Institutions," **The Millbank Quarterly** 67, no. 2 (1989): 177-178.

[18] Ibid.

[19] Stefi Weisburd, "AIDS Vaccine: The Problems of Human Testing," **Science News** 131, no. 21 (23 May 1987): 329.

[20] Western Schools, **The Spectrum of HIV Infections and AIDS** (San Diego, 1989), 14:5-14:6.

[21] Carol Levine, "HIV Antibody Screening: An Ethical Framework for Proposed Programs," in **The AIDS Epidemic: Private Rights and the Public Interest** ed. Padraig O'Malley (Boston: Beacon Press, 1989), 175.

[22] Mark Blumberg, "Issues and Controversies With Respect To The Management of AIDS in Corrections," **Prison Journal** 69, no. 1 (Spring-Summer 1989): 11.

[23] Ibid., 8.

[24] Theodore M. Hammett, "AIDS in Correctional Facilities," **National Institute of Justice: Issues and Options**, 3rd ed.

(Washington: GPO, 1988), 92.

[15] Centers for Disease Control, "Condoms for Prevention of Sexually Transmitted Disease," **Morbidity and Mortality Weekly Report** 37, no. 9 (Mar. 1988): 136.

[16] Hammett, op. cit., 15.

CHAPTER FOUR

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

It is apparent that the AIDS epidemic has generated a great deal of discussion and controversy regarding the proper management of this disease within the nation's prisons and jails. Policymakers have been forced to wrestle with many of the same issues that have confronted the larger society. Some correctional systems have responded to this challenge by instituting mass screening for HIV and segregating inmates infected with the virus. Although these are measures that are viewed as inappropriate by most public health officials for dealing with AIDS, it is argued by others that the unique circumstances of the institution justify this response. On the other hand, we are now one decade into the AIDS epidemic, and three consecutive surveys of correctional institutions by the National Institute of Justice (NIJ) indicate not a single case of occupational transmission in the United States. With thousands of seropositive inmates in correctional facilities, a rather compelling case can be made that if occupational transmission was a serious concern in prison and jails, it would have manifested itself by now.

Continued expansion of the AIDS epidemic in the general population can be expected to lead to higher seroprevalence rates among incoming inmates. Thus, the potential for spread of HIV infection within prisons will be an increasing concern for corrections officials.

Summary

Prisons and jails are brutal institutions; they are designed to punish. They provide the setting for coercion and intimidation. Because of their nature and the history of abuse of prisoners in human experimentation, the federal regulations governing research on human subjects provide special protection to inmate populations. The regulations are necessary but not sufficient to protect inmates from abuse and provide them access to new promising therapies. Given the spread of HIV infection and AIDS, the high percentage of IV drug users among incarcerated populations, and the convenience of a correctional institution for gathering data, clear guidance and encouragement for investigators will be needed to facilitate the equitable and safe involvement of prisoners.

Data on HIV infection and AIDS in prison are potentially explosive. Inmates and officers alike fear the disease and have numerous myths and misconceptions about casual transmission of the HIV virus. Correctional officers have sometimes expressed concern that they will become infected with HIV as a result of various risks that they face on the job. It has been suggested that staff could become infected as a result of bites, being spat upon, by having bags of feces thrown at them by inmates, on in the course of breaking up fights between prisoners. However, an examination of the dynamics under which HIV is and is not transmitted indicates that all these modes of suggested transmission are highly

unlikely.

Epidemiological and physiological studies have suggested that HIV transmission occurs through specific behaviors and that becoming infected is quite difficult unless a person has had or is having intimate sexual contact or is sharing infected needles with an AIDS patient or someone at risk for AIDS.

Prisons and jails may provide an environment conducive to the spread of AIDS. Infected persons who continue to use intravenous drugs while incarcerated could transmit the virus to other prisoners, particularly through sharing needles. Data suggest that intravenous drug using inmates who do not engage in needle-sharing prior to incarceration in prison may adopt this behavior, given the scarcity of needles in prison. The lack of access to bleach for sterilization adds to the potential for transmission.

Conclusions

HIV is a very difficult virus to transmit. Studies of hospital workers who accidently prick themselves with HIV infected needles indicate that less than one percent of these individuals actually seroconvert. To date, there has not been a single case of HIV infection reported that resulted from either a bite or a spitting incident. Not only have laboratory tests revealed that HIV is present in the saliva of very few infected persons, it is found in such minute

quantities as to make transmission under these circumstances extremely improbable. In addition, the virus lacks the ability to pass through intact skin. For these reasons, seroconversion is not likely to occur under either of these circumstances. Assaults against staff that involve the throwing of bodily waste pose even less danger because HIV is not present in the feces of infected persons. Although it is theoretically possible for a corrections officer to become infected as a result of a cut received in the course of terminating a fight (if one of the participants is seropositive), the fact that this has never occurred suggests that the threat is more theoretical than real. In fact, staff members who consistently follow prescribed Center for Disease Control infection control procedures (i.e., insuring that open wounds are bandaged, wearing gloves when contact with blood or other body fluids is anticipated, ect.) face far less risk from AIDS than from stab wounds or other traditional risks associated with their job.

Not only is the fear of occupational transmission unwarranted, there is also little evidence to suggest that this virus is being sexually transmitted between inmates within the institution. Almost all prisoners diagnosed with AIDS have a history of intravenous drug use prior to entering the institution. In addition, seroprevalence studies indicate that few, if any, inmates who have been continuously confined since the beginning of the AIDS epidemic are infected. As

previously noted, the rate of AIDS cases is rising at a slightly slower rate in prisons and jails than in the general population. Taken together, this evidence suggests rather strongly that our correctional institutions have not become breeding grounds for this disease as was initially feared. In fact, for those inmates who have a history of intravenous drug use, the institution probably provides a more secure environment than they would encounter on the street where needle sharing among addicts is far more likely to occur.

Recommendations

Educating guards and prisoners regarding AIDS and its transmission may be crucial to eliminating fear and hostility about AIDS. Interventions to prevent the spread of HIV infection in prisons are warranted; using the following three-phase approach. First, at intake, all incoming inmates should be instructed on the modes of HIV transmission and on measures to protect themselves against infection. Voluntary HIV testing with pre- and post-test counseling may be an important adjunct to this educational process.

Second, while serving their sentences, inmates should receive periodic reinforcement of AIDS prevention messages. Additionally, prisons should maintain adequate substance abuse prevention and treatment services. The closed prison environment may afford an opportunity to provide substance abuse counseling and treatment for persons otherwise outside

the mainstream of the health care delivery system.

Third, upon discharge inmates should be reeducated in methods to protect themselves and their sexual partners from HIV transmission. Data suggest that persons with knowledge of needle sterilization techniques and access to bleach may be more likely to clean the needles they are sharing. Adoption of HIV-associated risk-reducing behaviors will make inmates less vulnerable to contracting the virus once outside of prison. In addition, inmates who know how to protect themselves against transmission may be valuable carriers of the AIDS prevention message to their families and friends.

Testing for and detection of HIV seropositivity in correctional facilities will also allow medical personnel to monitor the progress of the inmate's infection and render appropriate medical care. Periodic T-cell assessments of HIV-infected persons have become standard medical practice; infected inmates should undergo such tests to provide direction for appropriate clinical management.

In closing, the future prospects for prisoners with AIDS is quite poor. Neither the government nor the courts have stepped in to assure adequate treatment for infected prisoners. Infected prisoners face the possibility of being either isolated in a medical segregation unit, or worse, left without many of the privileges granted to the general population. In fact, they are confined in isolation without access to law libraries, outdoor exercise, or educational,

vocational, or work-release programs. In the end, it appears that prisoners with AIDS are in a precarious position. Further, it is clear that imprisoned racial and ethnic minority members, intravenous drug users, homosexuals, ect., are among the most unlikely to force society and the courts into adopting humane treatment standards within prisons.

BIBLIOGRAPHY

Abraham, Laurie. "AIDS Contact Tracing, Prison Testing Stir Debate." **American Medical News**, 8 July 1988, 4.

Abt, Clark C., and Kathleen M. Hardy, eds. **AIDS and the Courts**. Cambridge: Abt Books Inc, 1990.

Aggleton, Peter, Peter Davies, and Graham Hart, eds. **AIDS: Individual, Cultural and Policy Dimensions**. New York: The Falmer Press, 1990.

Anderson, Allen F. "AIDS and Prisoners' Rights Law: Deciphering the Administrative Guideposts." **Prison Journal** 69, no. 1 (Spring-Summer 1989): 14-26.

Andrus, Jon K., David W. Fleming, Catherine Knox, Robert O. McAlister, Michael R. Skeels, Robert E. Conrad, John M. Horan, and Laurence R. Foster. "HIV Testing in Prisoners: Is Mandatory Testing Mandatory?" **American Journal of Public Health** 79, no. 7 (July 1989): 840-842.

Baker, James N. "A Gentle Place to Live and Die." **Newsweek**, 29 July 1991. 42-44.

Baker, James N., Sue Hutchison, Nadine Joseph, Howard Manly, Daniel Pederson, Karen Springen, and Ned Zeman. "Learning To Live With AIDS In Prison." **Newsweek**, 13 Feb. 1989. 27-28.

Bigbee, Paul D., Prem S. Sarin, J.C. Humphreys, William G. Eubanks, Daisy Sun, D.G. Hocken, Arthur Thornton, Dwight E. Adams, and Michael G. Simic. "Inactivation of Human

Immunodeficiency Virus (HIV) by Ionizing Radiation in Body Fluids and Serological Evidence." **Journal of Forensic Sciences** 34, no. 6 (Nov. 1989): 1303-1310.

Blanchet, Kevin D. **AIDS: A Health Care Management Response**. Rockville: Aspen, 1988.

Blumberg, Mark, ed. **AIDS: The Impact on the Criminal Justice System**. Columbus: Merrill Publishing Company, 1990.

Blumberg, Mark. "Issues and Controversies With Respect to the Management of AIDS in Corrections." **Prison Journal** 69, no. 1 (Spring-Summer 1989): 1-13.

Bosarge, Betty B., ed. "CDC Funding Study To Measure The Spread Of AIDS In U.S. Prison Population." **Corrections Digest** 19, no. 11 (1 June 1988): 1, 5.

Bowker, Lee H. **Prison Victimization**. New York: Elsevier, 1980.

Bowser, Benjamin P., Mindy Thompson Fullilove, and Robert E. Fullilove. "African-American Youth and AIDS High-Risk Behavior: The Social Context and Barriers to Prevention." **Youth and Society** 22, no. 1 (Sept. 1990): 54-66.

Brauer, Shelley. "The HIV Infected Individual: Group Work As A Rite of Passage." **Smith College Studies In Social Work** 60, no. 3 (June 1990): 233-243.

Braun, M. Miles, Benedict I. Truman, Barbara Maguire, George T. DiFerdinando, Jr., Gary Wormser, Raymond Broaddus, and Dale L. Morse. "Increasing Incidence of Tuberculosis in a Prison Inmate Population." **Journal of the American**

Medical Association 261, no. 3 (20 Jan. 1989): 393-397.

Carroll, Leo. "Gender Differences In AIDS Knowledge Among Students In An Eastern University." **Sociology and Social Research** 74, no. 4 (July 1990): 212-221.

Centers for Disease Control. "Mortality Attributable to HIV Infections/AIDS - United States, 1981-1990." **Morbidity and Mortality Weekly Report** 40, no. 3 (25 Jan. 1991): 41-44.

Centers for Disease Control. "Recommendations for Prevention of HIV Transmission in Health-Care Settings." **Morbidity and Mortality Weekly Report** 36, suppl. 2 (21 Aug. 1987): 2-18.

Centers for Disease Control. "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus and Other Bloodborne Pathogens in Health-Care Settings." **Morbidity and Mortality Weekly Report** 37, no. 24 (24 June 1988): 377-382, 387-388.

Clements, Carl B. "AIDS and Offender Classification: Implications for Management of HIV Positive Prisoners." **Prison Journal** 69, no. 2 (Fall-Winter 1989): 19-28.

Cimons, Marlene. "Grim Anniversary: AIDS First Reported 10 Years Ago." **The Sacramento Bee**, 5 June 1991, A1.

Coffin v. Reichard. 143 F.2nd 443 (1944).

Connell, R.W., and Susan Kippax. "Sexuality in the AIDS Crisis: Patterns of Sexual Practice and Pleasure in a Sample of Australian Gay and Bisexual Men." **The Journal**

of Sex Research 27, no. 2 (May 1990): 167-198.

Connor, Steve. "Advisers Are Bitter At AIDS Ruling." **New Scientist** 118, no. 1607 (7 Apr. 1988): 17.

Conolly, Lisa, and Frances Potter. "AIDS Education in New South Wales Prisons." **Australian and New Zealand Journal of Criminology** 23, no. 3 (Sept. 1990): 158-164.

Cordero v. Coughlin. 606 F.Supp.9 (D.C.N.Y. 1984).

Curley, Martha Marie. "Establishing Relief For The Most Innocent Of All AIDS Victims: Liability For Perinatal Transmission of AIDS." **Journal of Family Law** 28, no. 2 (1989-90): 271-288.

DeVita, Vincent T., Samuel Hellman, and Steven A. Rosenberg, eds. **AIDS: Etiology, Diagnosis, Treatment, and Prevention**. Philadelphia: J.B. Lippincott Company, 1985.

Dorman, Steve M., M. Elizabeth Collins, and Rebecca A. Brey. "A Professional Preparation Course on AIDS/HIV Infection." **Journal of School Health** 60, no. 6 (Aug. 1990): 266-269.

Dubler, Nancy N., and Victor W. Sidel. "On Research on HIV Infection and AIDS in Correctional Institutions." **The Milbank Quarterly** 67, no. 2 (1989): 171-207.

Dugdale, David, and Ken Peterson. "The Prevalence of HIV Seropositivity and HIV-Related Illness in Washington State Prisoners." **Prison Journal** 69, no. 1 (Spring-Summer 1989): 33-38.

Feinberg, Harvy. "Public Health and Private Rights: Health,

Social and Ethical Perspectives." **Proceedings of AIDS International Symposium**. New York: Hummler Plenum Press, 1986.

"Finding On AIDS Transmission: Disease Can Enter Through Mucous Membranes, Researchers Say." **The Sacramento Bee Final**, 20 June 1991, A6.

Findlay, Steven. "If Your Doctor Has AIDS." **U.S. News and World Report**, 18 Feb. 1991. 66.

Garruto, Ralph M. "Biocultural Implications of AIDS and Other Retroviral Disorders." **American Journal of Human Biology** 2, no. 4 (1990): 343-345.

Gates, Daryl F., and Kenneth E. Lady. "Enhancing AIDS Awareness in Los Angeles." **The Police Chief** 58, no. 3 (March 1991): 44-47.

Gelman, David, and Anthony Duignan-Cabrera. "AIDS: Grin and Bear It." **Newsweek**, 15 April 1991. 58.

Gerbert, Barbara, Thomas Bleecker, Cara Miyasaki, and Bryan T. Mcguire. "Dentists Reactions to a Centers for Disease Control Report." **Journal of the American Medical Association** 265, no. 14 (10 Apr. 1991): 1845-1873.

Gido, Rosemary. "A Demographic and Epidemiological Study of New York State Inmate AIDS Mortalities, 1981-1987." **Prison Journal** 69, no. 1 (Spring-Summer 1989): 27-32.

Greenspan, Judy. "NPP Gathers Statistics on AIDS in Prison." **The National Prison Project Journal** 16 (Summer 1988): 5-9.

Hammett, Theodore M. "AIDS and HIV Training and Education in Criminal Justice Agencies." **National Institute of Justice: AIDS Bulletin**. Washington: GPO, Aug. 1989.

Hammett, Theodore M. "AIDS and the Law Enforcement Officer: Concerns and Policy Responses." **National Institute of Justice: Issues and Practices**. Washington: GPO, June 1987.

Hammett, Theodore M. "AIDS and the Law Enforcement Officer." **National Institute of Justice: Research in Action**. Washington: GPO, Nov./Dec. 1987.

Hammett, Theodore M., and Saira Moini. "Update on AIDS in Prisons and Jails." **National Institute of Justice: AIDS Bulletin**. Washington: GPO, Sept. 1990.

Hammett, Theodore M. "1988 Update: AIDS in Correctional Facilities." **National institute of Justice: Issues and Practices**. Washington: GPO, June 1989.

Hammett, Theodore M. "HIV Antibody Testing: Procedures, Interpretation, and Reliability of Results." **National Institute of Justice: AIDS Bulletin**. Washington: GPO, Oct. 1988.

Hammett, Theodore M. "Precautionary Measures and Protective Equipment: Developing a Reasonable Response." **National Institute of Justice: AIDS bulletin**. Washington: GPO, Feb. 1988.

Hammett, Theodore M., and Walter Bond. "Risk of Infection with the AIDS Virus Through Exposures to Blood."

National Institute of Justice: AIDS Bulletin. Washington: GPO, Oct. 1987.

Hammett, Theodore M., Harold Jaffee, and Bruce Johnson. "The Cause, Transmission, and Incidence of AIDS." **National Institute of Justice: AIDS Bulletin**. Washington: GPO, June 1987.

Herrell, Richard K. "HIV/AIDS Research and the Social Services." **Current Anthropology** 32, no. 2 (Apr. 1991): 199-203.

Holland, Janet, Caroline Ramazanoglu, and Sue Scott. "AIDS: From Panic Stations To Power Relations, Sociological Perspectives and Problems." **Sociology** 25, no. 3 (Aug. 1990): 499-518.

Hunsaker, Alan C. "Current AIDS Resources." **Hispanic Journal of Behavioral Sciences** 12, no. 2 (May 1990): 223-227.

Hunt, Dana Eser, Saira Moini, and Susan McWhan. "AIDS in Probation and Parole." **National Institute of Justice: Issues and Practices**. Washington: GPO, June 1989.

"Inmates AIDS Test Challenge Reinstated by Appellate Court." **The Sacramento Bee**, 23 Oct. 1990, B4.

Jarlais, Don Des, and Dana E. Hunt. "AIDS and Intravenous Drug use." **National Institute of Justice: AIDS Bulletin**. Washington: GPO, Feb. 1988.

Jones, Augusts. "Policy Making by the Lower Federal Courts and the Bureaucracy: The Genesis of a National AIDS Policy." **Social Science Journal** 27, no. 3 (1990): 273-

288.

Kantrowitz, Barbara. "Doctors and AIDS." **Newsweek**, 1 July 1991. 48-57.

Kenward, Michael, ed. "The Great Escape." **New Scientist** 121, no. 1650 (4 Feb. 1989): 21.

Kowalewski, Mark R. "Religious Construction of the AIDS Crisis." **Sociological Analysis** 51, no. 1 (Spring 1990): 91-96.

Krieaer, Nancy, and Glen Margo. "The Politics of Survival." **International Journal of Health Services** 20, no. 4 (1990): 583-588.

Lainer, Mark, and Belinda R. McCarthy. "Knowledge and Concern About AIDS Among Incarcerated Juvenile Offenders." **Prison Journal** 69, no. 1 (Spring-Summer 1989): 39-52.

Levine, Carol. "HIV Antibody Screening: An Ethical Framework for Proposed Programs." In **The AIDS Epidemic: Private Rights and the Public Interest**. Ed. Padraig O'Malley. Boston: Beacon Press, 1989.

Long, Robert E., ed. **AIDS**. The Reference Shelf, 59, no. 3. New York: H.W. Wilson Company, 1987.

MacDonald, Paul H. "AIDS, Rape, and the Fourth Amendment: Schemes for Mandatory AIDS Testing of Sex Offenders." **Vanderbilt Law Review** 43, no. 5 (Oct. 1990): 1607-1636.

McAuliffe, Kathleen. "Predicting Diseases." **U.S. News and World Report**, 25 May 1987. 64-69.

McLaughlin, Loretta. "AIDS: An Overview." In **The AIDS**

Epidemic: Private Rights and the Public Interest. Ed. Padraig O'Malley. Boston: Beacon Press, 1989.

Moini, Saira, and Theodore M. Hammett. "1989 Update: AIDS in Correctional Facilities." **National Institute of Justice: Issues and Practices**. Washington: GPO, May 1990.

Nacci, Peter L. and Thomas R. Kane. "The Incidence of Sex and Sexual Aggression in Federal Prisons." **Federal Probation** 47, no. 4 (Dec. 1983): 31-36.

Nelkin, Dorothy, David P. Willis, and Scott V. Parris. "A Disease of Society: Cultural Responses to AIDS." **The Milbank Quarterly** 68, suppl. 1 (1990): 1-9.

Olivero, J. Michael. "The Treatment of AIDS Behind the Walls of Correctional Facilities." **Social Justice** 17, no. 1 (Spring 1990): 113-125.

Olivero, J. Michael, and James B. Roberts. "The Management of AIDS in Correctional Facilities: A View from the Federal Court System." **The Prison Journal** 69, no. 2 (Fall-Winter 1989): 7-28.

O'Malley, Padraig, ed. **The AIDS Epidemic: Private Rights and the Public Interest**. Boston: Beacon Press, 1989.

"On The AIDS Barricades." **The Economist** 315, no. 7661 (30 June 1990): 79-81.

Patel, Konika K., Craig Hutchinson, and Dean G. Sienko. Sentinel Surveillance of HIV Infection Among New Inmates and Implications for Policies of Corrections Facilities." **Public Health Reports** 105, no. 5 (Sept.-

Oct. 1990): 510-514.

Petricciani, John C., and Jay S. Epstein. "The Effects of the AIDS Epidemic on the Safety of the Nations Blood Supply." **Public Health Reports** 103, no. 3 (May-June 1988): 236.

"Predicting A New Aids Toll." **U.S. News and World Report**, 13 May 1991. 17.

Rochman, Sue. "The Final Lockup: AIDS Reaches Crisis Proportions in America's Prisons." **Advocate**, Feb. 1991, 27-35.

Scheier, Ronni. "Inmates Learn About Safe Sex and AIDS." **American Medical News**, 10 Feb. 1989, 31-33.

Schwanberg, Sandra L. "Attitudes Towards Homosexuality in American Healthcare Literature, 1983-1987." **Journal of Homosexuality** 19, no. 3 (1990): 117-136.

Scrimshaw, Susan C.M., Manuel Carballo, Laura Ramos, and Betty A. Blair. "The AIDS Rapid Anthropological Assessment Procedures: A Tool for Health Education Planning and Evaluation." **Health Education Quarterly** 18, no. 1 (Spring 1991): 111-124.

Stoddard, Thomas B., and Walter Rieman. "AIDS and the Rights of the Individual: Toward A More Sophisticated Understanding of Discrimination." **The Milbank Quarterly** 68, suppl. 1 (1990): 143-177.

Stone, Deborah A. "The Rhetoric of Insurance Law; The Debate Over AIDS Testing." **Law and Social Inquiry** 15, no. 2 (Spring 1990): 385-407.

"Survey Shows One in 24 Inmates Infected with AIDS." **Corrections Today** 51, no. 7 (Dec. 1989): 165.

Takas, Marianne, and Theodore M. Hammett. "Legal Issues Affecting Offenders and Staff." **National Institute of Justice: AIDS Bulletin**. Washington: GPO, May 1989.

Taravella, Steve. "AIDS: A Complex Issue For Corrections Officers." **Modern Healthcare** 18, no. 24 (10 June 1988): 28.

U.S. Department of Health and Human Services. **AIDS Litigation Project**. Washington: GPO, 1990.

U.S. Department of Health and Human Services. **Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers**. Atlanta: Centers for Disease Control, 1989.

U.S. Department of Health and Human services. **National HIV Seroprevalence Surveys**. Atlanta: Centers for Disease Control, 1989.

U.S. Department of Justice Programs. **Correctional Populations in the United States, 1988**. Washington: Bureau of Justice Statistics, March 1991.

Vaid, Urvashi. "Prisons." In **AIDS and the Law: A Guide for the Public**. Ed. Burris Dalton. New Haven: Yale University Press, 1987.

Walsh, Mary [illegible]., and Roger Biback. "Developmentally-Based AIDS/HIV Education." **Journal of School Health** 60, no. 6

(Aug. 1990): 256-261.

Weisburd, Stefi. "AIDS Vaccine; The Problems of Human Testing." **Science News** 131, no. 21 (23 May 1987): 329.

Western Schools. **The Spectrum of HIV Infections and AIDS**. San Diego: Western Schools, 1989.

Whitman, David. "Inside an AIDS Colony." **U.S. News and World Report**, 29 Jan. 1990. 20-26.

Witt, Michael D., ed. **AIDS and Patient Management: Legal, Ethical and Social Issues**. Owings Mills: National Health Publishing, 1986.

Wooden, Wayne S., and Joy Parker. **Men Behind Bars: Sexual Exploitation in Prison**. New York: Plenum Press, 1982.