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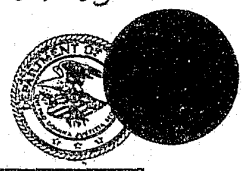

National Institute of Justice | ***Issues and Practices***

1986 Update: AIDS in Correctional Facilities

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James K. Stewart
Director

U.S. Department of Justice
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1986 Update: AIDS in Correctional Facilities

by

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with assistance from

Taylor McNeil

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Issues and Practices in Criminal Justice is a publication series of the National Institute of Justice. Designed for the criminal justice professional, each *Issues and Practices* report presents the program options and management issues in a topic area, based on a review of research and evaluation findings, operational experience, and expert opinion in the subject. The intent is to provide criminal justice managers and administrators with the information to make informed choices in planning, implementing and improving programs and practice.

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Foreword

Since its first appearance in 1981, AIDS — Acquired Immunodeficiency Syndrome — has become a major issue for public officials in all areas of the country and in all sectors of government. Today there is an enormous amount of uncertainty, fear, and misinformation about the origins and transmission of the disease. As a result, public health officials, school, hospital, police, and correctional administrators face a dilemma: how to develop effective and equitable policies that not only reflect the most current medical information available but also address the unique responsibilities of their professions.

For corrections agencies, the problem of AIDS is a formidable challenge. A substantial percentage of inmates fall within identified high-risk groups for AIDS. The presence — or potential presence — of AIDS within the prison is more than a simple health problem: correctional administrators are faced with tough decisions about prevention, institutional management, the best and most equitable means of identifying and treating inmates with AIDS, potential legal issues, and the costs of medical care.

Though much remains to be learned about AIDS, the National Institute of Justice recognizes that policymakers and corrections officials cannot afford to wait until medical science produces the ultimate answer. The problem must be addressed today, and to do so effectively, correctional administrators need the best and most current information available. This issues and practices report updates *AIDS in Correctional Facilities: Issues and Options* published in 1986. These studies could ¾not have been completed without the cooperation and assistance of numerous professionals in the fields of corrections and medicine.

While it is not appropriate at this time to prescribe any single course of action, this report describes the current range of correctional system practices related to AIDS, and discusses some of the advantages and drawbacks of each approach. In addition, it presents the basic facts on AIDS itself — how it is transmitted, how it can be prevented, and how widespread it is in both the general and correctional populations. With this knowledge, corrections officials will be in a stronger position to deal with the problem of AIDS through public education efforts, treatment, and reasonable and effective management policies.

James K. Stewart
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This project could not have been completed without the cooperation of several hundred correctional administrators, correctional medical directors, correctional legal counsel, physicians, researchers and others who responded to our questionnaires, answered our followup questions and provided other invaluable information. They were unfailingly gracious and patient.

Theodore M. Hammett
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1986 Update

Introduction

The first systematic research on AIDS in prisons and jails was done late in 1985, when the National Institute of Justice and the American Correctional Association jointly sponsored a report entitled *AIDS in Correctional Facilities: Issues and Options*. During the year since that research was done, even more attention has been focused on AIDS and there have been numerous significant research developments. This report updates the original study. It is based on survey responses received between October 1, 1986 and January 1, 1987 from all 50 state correctional systems, the Federal Bureau of Prisons, and 31 of the 33 large city and county correctional systems previously surveyed. As with the 1985 report, this update reviews significant medical research, policy issues, and legal implications associated with AIDS in the correctional setting. Current plans call for the report to be updated annually for the next several years.

Since the publication of the original report in April 1986, evidence against transmission of the AIDS virus through casual contact has become even more conclusive, but so has evidence of heterosexual transmission. The number of inmate AIDS cases in correctional institutions has increased, although at a slower rate than in the United States at large. The number of AIDS-related inmate lawsuits against correctional systems has significantly increased. Inmate and staff training on AIDS continue to be widespread, but there is still much room for improvement in format and content. Even fewer correctional systems than last year are screening all inmates for antibodies to the AIDS virus, but more are screening members of risk groups. Finally, fewer correctional systems are segregating inmates with AIDS-Related Complex (ARC) and those who are asymptomatically seropositive.

Medical Research Developments

Transmission of Human Immunodeficiency Virus (HIV) Infection

Heterosexual Transmission of HIV Infection

Recent research has yielded increasing evidence that the AIDS virus (now generally called human immunodeficiency virus, or HIV, instead of HTLV-III/LAV, the term used in 1985) can be transmitted through heterosexual contact, both male-to-female and female-to-male. However, disagreement continues on the current and projected scale of heterosexual transmission. Studies of stable, long-term monogamous heterosexual couples reveal that 5 to 37 percent of the steady sexual partners of HIV-infected individuals themselves become infected within a few years.[1]

Other evidence of heterosexual transmission comes from Africa. The sex distribution of African AIDS cases is nearly equal, in contrast to the male-dominated epidemiology seen in the United States. It should be noted, however, that African cultural factors might strongly inhibit the reporting of homosexual experiences, thus possibly exaggerating the apparent extent of heterosexual transmission. In any case, sexual activity seems the most likely means of transmission in Africa since almost all African cases are in the sexually active age range. Non-sexual modes of transmission, such as the use of unsterile needles in medical practice, would presumably produce many more cases than have been identified among persons in non-sexually active age groups. African studies also suggest that prostitutes are often carriers of HIV.[2]

A study of American military recruits discovered a male-to-female ratio among HIV seropositives of 3 to 1, although these data must be interpreted cautiously due to possible self-selection effects. The national average male-to-female ratio of AIDS cases is 13 to 1. The study also found a large number of married couples in which both partners were seropositive.[3] Finally, evidence of heterosexual transmission comes from the report that Australian women have seroconverted following artificial insemination with semen from an infected male.[4]

Despite evidence of heterosexual transmission of HIV infection, only a small and relatively stable percentage of AIDS cases in the United States have been attributed to heterosexual contact. This figure has increased only slightly to about 4 percent since the Centers for Disease Control (CDC) began compiling surveillance data on the disease. However, the past and current epidemiological profile of AIDS cases may not accurately predict the disease's future course. This is primarily because of the large number of asymptomatic carriers now in the population. Although there are probably far more infected men than infected women in the American population at present, heterosexual transmission has been demonstrated and must be considered a very serious potential problem in the United States.

Evidence Against Transmission by "Casual Contact"

Evidence continues to accumulate that HIV infection cannot be transmitted by casual contact. Altogether, studies of 437 family members of AIDS patients have identified no HIV seroconversions, despite long-term close contact with the patients. A recent study of hemophiliac and non-hemophiliac children in a French private school found that half of the former but none of the latter had seroconverted. All these children had had "close casual contact, some of them for several years." The only known case of seroconversion in a family setting was recently reported from Germany, where a 6-year-old sibling of an AIDS patient became infected.[5] The cause of this seroconversion is presently unknown. Except for a very small number of seroconversions in health-care workers attributed to accidental needlesticks cited in the 1985 report (3 of 666, or 0.5 percent), there continue to be no reports of HIV infection as a result of any occupational contact.

Evidence Against Transmission Through Body Fluids Other Than Blood and Semen and Through Biting Incidents

Despite the fact that contact with blood or semen continues to be the only known means of transmitting the AIDS virus, correctional staff have expressed concern that they might become infected by contact with body fluids other than blood or semen, or through biting incidents. All evidence continues to point to the extreme unlikelihood of viral transmission through such means.

One study which found the HIV virus in saliva has been criticized on the ground that the saliva samples were not drawn directly from the salivary glands, but from fluid already in the mouth, which may have contained blood. AIDS patients often have intraoral bleeding from gums and ulcers.[6]

Correctional officers and others who administer cardio-pulmonary resuscitation (CPR) may wonder why CDC recommends using masks or airways when performing CPR if saliva is not an efficient medium for HIV transmission and no cases of such transmission have been reported. The reason is that masks represent a reasonable precaution that also helps to prevent transmission of other infections.

Biting and spitting incidents may particularly concern correctional officers. Research findings on saliva should allay fears regarding the risk from spitting incidents. Biting may involve blood contact, but it should be emphasized that it is the individual doing the biting who comes into contact with the blood of the victim. The victim cannot be infected by the blood of the person committing the bite unless that person somehow has blood in his or her mouth that then comes into contact with the victim's blood. There have been no reports of HIV transmission through biting.

Other Research Findings

Relationship Between HIV Seropositivity and Development of Illness

With the passage of more time to track infected individuals, the estimates of the percentage who will become ill has increased. Recent studies of six groups of HIV seropositive persons in the United States and Denmark found that 8-34 percent developed AIDS within 3-5 years of infection. With the long and uncertain incubation period of AIDS, it is likely that the percentages of individuals in these cohorts who develop the disease will continue to rise.[7] A recent National Academy of Sciences report estimates that 25-50 percent of seropositives will develop AIDS within 5-10 years of infection. The report also notes that more than 90 percent of seropositive individuals show some immune system deficiency within 5 years of seroconversion.[8]

Complexity of HIV Infection

Recent research has stressed that HIV infection is extremely complex. While the typical elapsed time between infection and seroconversion is six to eight weeks, this period is extremely variable. There have been reported instances in which seroconversion has not occurred until eight months after infection.[9] This variability in timing may suggest longer followup periods for antibody testing following incidents in which HIV infection may have been transmitted.

The National Academy of Sciences report points out that persistent swollen lymphnodes, ARC and AIDS "cannot be considered simply as stages of an orderly progression in the spectrum of HIV infection."[10] For those individuals who do pass through these conditions sequentially, there is no standard rate or pace of progression. Some patients remain asymptomatic for long periods—perhaps indefinitely—while others quickly develop end-stage AIDS and die. What causes these wide variations in clinical history is not known.

Prospects for Vaccines and Cures

In the past year, scientists have made some significant progress in understanding the complex structure and

behavior of the HIV virus. Such knowledge is a prerequisite for developing an AIDS vaccine. However, the goal is extremely elusive and new knowledge about the virus as often frustrates as contributes to progress on vaccine development. The most recent scientific development, for example, is that there may be a second virus in addition to HIV that is a causative agent of AIDS.

Development of therapeutic drugs for AIDS has progressed in the past year. Several drugs, including azidothymidine (AZT) and ribovirin, are now undergoing clinical trials. At the same time, there have been some setbacks and some prematurely dramatic announcements of therapeutic success, which later had to be retracted or qualified.

In general, prospects for a vaccine or cure for AIDS remain less than promising for the immediate future. The National Academy of Sciences concludes that the probability of a vaccine becoming available in the next 5-10 years is "low". The report also concludes that "development of therapy for HIV infection will most likely be a difficult and long-term process with no presently available guarantees of success."[11] The poor prospects for vaccines or cures in the foreseeable future only serve to underline the importance of educational efforts. As many have already stated, education is our only available weapon against AIDS.

Safety of the Blood Supply

The HIV antibody test was originally developed to protect the blood supply, and it has been successfully used for that purpose. Several recent reports indicate that a small number of infected units of blood may have slipped through undetected, because the donor was only recently infected and antibodies had not had time to appear by the time the blood was donated. However, the Centers for Disease Control (CDC) estimate that only about 100 transfusion-associated infections will occur annually out of a total of 16 million units transfused. The recent National Academy of Sciences report on AIDS estimates the risk of transfusion-associated infection at fewer than 1 in 34,000 recipients of packed red blood cells.[12]

Incidence of AIDS in the United States

The dimensions of the AIDS problem continue to grow alarmingly. CDC figures through calendar year 1986 report over 28,700 adult AIDS cases in the United States. In addition, there have been over 400 pediatric cases. Thus far, almost 16,500 persons have died of AIDS in this country.[13]

New York State and California together account for 54 percent of the AIDS cases in the United States, while New Jersey, Florida and Texas collectively account for another 19 percent. Within these states, as elsewhere, cases are heavily concentrated in cities and major metropolitan areas. In addition to confirmed AIDS cases, the National Academy of Sciences estimates that there may be as many as 50,000 to 125,000 cases of AIDS-Related Complex and the Public Health Service estimates that there are 1-1.5 million asymptomatic HIV infected individuals. CDC believes 270,000 AIDS cases will have been diagnosed in the United States by the end of 1991.[14]

Ninety-three percent of all American AIDS cases have been in males and 89 percent of the adult cases have been in persons aged 20-49 years. The overall racial/ethnic distribution of adult cases has remained essentially the same since 1985: White—60 percent; Black—25 percent; Hispanic—14 percent; Other/unknown—1 percent. Blacks and Hispanics (11 percent and 6 percent, respectively, of the population 15 years of age and older) are disproportionately represented.[15]

Figure U.1
BREAKDOWN OF CONFIRMED AIDS CASES BY RISK GROUPS

Risk Group	% of all cases
Homosexual/bisexual males[a]	65%
Intravenous drug abusers	17
Homosexual male and IV drug abuser[a]	8
Transfusion recipients	2
Hemophiliacs	1
Heterosexuals with a partner in one of the above risk groups	4
Other/unclassified	3
TOTAL	100%

[a]At the time of the original report, CDC was combining the "homosexual/bisexual males" and "homosexual male and IV drug abuser" categories under "homosexual/bisexual males."

Source: CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987.

The most recent CDC breakdown of confirmed AIDS cases by risk group is shown in Figure U.1. There is an overlap of approximately 8 percent between the homosexual/bisexual and intravenous drug abuser categories. Thus, about 25 percent of reported AIDS cases are in persons with some history of intravenous drug abuse and about 74 percent of cases have been in homosexual/bisexual males.[16] The only change in the risk group distribution since 1985 was a 3 percent decrease in the "other/unclassified" category and a corresponding increase in the heterosexual partner category. Many epidemiologists believe the percentage

of cases attributed to intravenous drug abuse is likely to grow dramatically in the next few years. Moreover, they believe the greatest threat for significant spread of infection to the heterosexual population is through infection of the sexual partners of intravenous drug users.

The latest medical research and epidemiological data together show that AIDS is a very serious and growing problem, but also that the HIV virus that causes AIDS is transmissible only by unprotected sexual relations and blood-to-blood contact. In all settings, including correctional agencies, the response to AIDS should stress both these facts. Education and prevention programs which rationally address the real nature and extent of the risk should be implemented. It is equally dangerous to take a complacent or an alarmist approach to this problem.

Incidence of AIDS Among Correctional Inmates

As of October 1, 1986, there had been 1,232 confirmed AIDS cases among inmates in 58 responding federal, state, and local correctional systems. There had been 784 cases in 31 state and federal correctional systems—up 72 percent from the 455 cases reported as of November 1, 1985, the time of the original survey. Twenty-seven responding city and county jail systems reported 448 cases—up 44 percent from the 311 cases reported in the original survey eleven months earlier. Total AIDS cases in all responding correctional systems increased from 766 to 1,232—or 61 percent—in the eleven-month interval. This is a large increase in cases, but it is, in fact, smaller than the 79 percent national increase from 14,519 cases as of November 4, 1985 to 26,002 as of October 6, 1986.[17]

The figures above are *cumulative* totals—that is, all cases reported since the correctional systems began keeping records. Twenty-three state and federal systems reported 174 *current* cases of AIDS among inmates, while six responding city and county systems reported 29 current cases. State and federal systems report that a cumulative total of 463 inmates have died from AIDS while in custody; responding city and county systems report 66 inmate deaths. Of these total inmate AIDS deaths, 254— or 48 percent—have occurred since the 1985 survey was taken.[18]

More correctional systems now appear to be maintaining statistics on ARC than were doing so at the time of the 1985 survey. However, several of the jurisdictions with the largest numbers of AIDS cases still do not maintain figures on ARC. Thus, these statistics are still probably artificially low: 321 current ARC cases in 26 state and federal systems, and 28 current cases in 25 city and county systems.

The distribution of cumulative total AIDS cases across correctional systems is still highly skewed (Figure U.2). While 10 more systems than last year reported at least one case, the majority (35 of 51 state and federal systems—or 68 percent—and 18 of 33 city and county systems—or 54 percent) still have had fewer than four cases. At the other extreme, only three state and federal systems and one responding city or county system have had more than 50 cases. Three state systems (6 percent) account for 74 percent of the cumulative total AIDS cases, while two of the responding city and county systems (6 percent) contribute 73 percent of the cases.

Figure U.2
DISTRIBUTION OF CONFIRMED AIDS CASES AMONG INMATES, BY TYPE OF SYSTEM

Range of Total AIDS Cases	State/Federal Prison Systems							
	Original Survey: November 1985				Update Survey: October 1986			
	n systems	%	n cases	%	n systems	%	n cases	%
0	26	51%	0	0%	20	39%	0	0%
1-3	15	29	24	5	15	29	22	3
4-10	5	10	30	7	9	18	56	7
11-25	2	4	42	9	1	2	23	3
26-50	1	2	33	7	3	6	101	13
51-100	1	2	95	21	1	2	57	7
> 100	1	2	231	51	2	4	525	67
Total	51	100%	455	100%	51	100%	784	100%

Range of Total AIDS Cases	City/County Jail Systems							
	Original Survey: November 1985				Update Survey: October 1986			
	n systems	%	n cases	%	n systems	%	n cases	%
0	13	39%	0	0%	6	18%	0	0%
1-3	10	30	16	5	12	36	24	5
4-10	7	21	43	14	10[a]	30	60	13
11-25	1	3	12	4	3	9	39	9
26-50	1	3	40	13	1	3	40	9
51-100	0	0	0	0	0	0	0	0
> 100	1	3	200	64	1	3	285	64
Total	33	99%[b]	311	100%	33	99%[b]	448	100%

Source: NIJ/ACA Questionnaire Responses.

[a]Two systems in this category at the time of the original study failed to respond to the 1986 survey. Therefore, the numbers reported are from the 1985 survey.

[b]Due to rounding.

Figure U.3

REGIONAL DISTRIBUTION OF TOTAL AIDS CASES BY TYPE OF SYSTEM
(Federal Bureau of Prisons Excluded)

	State Prison Systems			
	Original Survey: November 1985		Update Survey: October 1986	
Region	n Cases	% of Total	n Cases	% of Total
New England[a]	16	3.7%	34	4.6%
Mid-Atlantic[b]	327	75.5	531	71.3
E.N. Central[c]	6	1.4	19	2.6
W.N. Central[d]	0	0.0	1	0.1
S. Atlantic[e]	49	11.3	88	11.8
E.S. Central[f]	1	0.2	5	0.7
W.S. Central[g]	12	2.8	28	3.8
Mountain[h]	2	0.5	2	0.3
Pacific[i]	20	4.6	37	5.0
Total	433	100.0%	745	100.2%[k]

	City/County Jail Systems			
	Original Survey: November 1985		Update Survey: October 1986	
Region	n Cases	% of Total	n Cases	% of Total
New England[a]	0	0.0%	0	0.0%
Mid-Atlantic[b]	222	71.4	307[j]	68.5
E.N. Central[c]	8	2.6	17	3.8
W.N. Central[d]	1	0.3	2	0.4
S. Atlantic[e]	24	7.7	27[j]	6.0
E.S. Central[f]	0	0.0	0	0.0
W.S. Central[g]	3	1.0	6	1.3
Mountain[h]	1	0.3	6	1.3
Pacific[i]	52	16.7	83	18.5
Total	311	100.0%	448	99.8%[k]

[a]Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut

[b]New York, New Jersey, Pennsylvania

[c]Ohio, Indiana, Illinois, Michigan, Wisconsin

[d]Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas

[e]Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida

[f]Kentucky, Tennessee, Alabama, Mississippi

[g]Arkansas, Louisiana, Oklahoma, Texas

[h]Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada

[i]Washington, Oregon, California, Alaska, Hawaii

[j]One system in this region failed to submit a follow-up questionnaire. We used the numbers reported on the original questionnaire.

[k]Due to rounding

The Middle Atlantic states still account for the vast majority of AIDS cases among correctional inmates (Figure U.3). Seventy-one percent of state systems' cases and 68 percent of cases in responding city and county systems have been in the Middle Atlantic region. However, it should be noted that correctional AIDS cases have increased in all regions since the original survey was taken. More and more correctional systems are likely to experience AIDS cases each year, although the overall distribution of cases will probably remain highly skewed across correctional systems and geographic regions.

The incidence rate of AIDS in the United States was 5.3 cases per 100,000 population in 1986,[19] up from 3.4 in 1985. Incidence rates for individual states range from 0 to 21, with most under 3. In state and federal correctional systems incidence rates ranged from 5 to 215 per 100,000, although two-thirds of the states have rates less than 25 and only three have rates over 100.[20] Rates in city and county jail systems vary from 15 to 148 cases per 100,000, although rapid jail population turnover makes these statistics extremely suspect.

Incidence rates are predictably higher in correctional systems than in the population at large because of the concentration in inmate populations of persons with demographic, racial/ethnic and behavioral characteristics closely associated with AIDS—young adult males; Hispanics and blacks; and intravenous drug abusers. Moreover, the method of calculating incidence rates per 100,000 population guarantees that a correctional system with a very small number of AIDS cases—the typical case—will have a somewhat higher rate than a much larger outside population with substantially more AIDS cases.

The wide range in incidence rates obviously reflects the uneven distribution of AIDS cases across correctional systems. The jurisdictions with the highest incidence rates continue to be in the Middle Atlantic region, where HIV infection is pervasive among intravenous drug users who are drastically over-represented in corrections institutions.

Characteristics of Inmate AIDS Cases

Though data on the characteristics of correctional AIDS cases are limited, a study of 177 inmate deaths from AIDS in the New York State correctional system reveals some striking demographic information. Ninety-seven percent were males, and 76 percent were between 25 and 39 years old. Fully 92 percent of these inmates *admitted* to intravenous drug abuse, 40 percent were Hispanic, 39 percent were black, and 86 percent came from New York City.[21]

Transmission of HIV Infection in Correctional Institutions

The extent to which HIV infection is transmitted within correctional institutions remains a controversial subject. The few systematic studies done suggest that transmission in prisons and jails has occurred infrequently. The Maryland study discussed in the 1985 report discovered a seropositivity rate of 1.5 percent among long-term inmates who volunteered to be tested. Seropositivity in an inmate continuously incarcerated for 7 years or more (i.e. since before the AIDS virus appeared in the United States) was assumed to mean that seroconversion occurred during incarceration.

New York State recently analyzed the periods of continuous incarceration of all of its correctional inmates with AIDS. The analysis revealed that none of the inmates had been continuously incarcerated for more than 7 years prior to their diagnosis, and only 5 inmates (2.3 percent) had been continuously incarcerated for 5-7 years prior to their diagnosis.

These figures also suggest low rates of transmission. However, as the New York report notes, "the long incubation period, the existence of the asymptomatic HIV carrier state, small number of long-term inmates and absence of data on antibody status make this finding inconclusive."[22] Firmer conclusions on HIV transmission in correctional facilities await systematic followup studies. At this writing, CDC is planning to sponsor such studies in several correctional systems.

AIDS Cases Among Correctional Staff

As with the original survey, the 1986 survey identified no cases of AIDS among correctional staff attributable to contact with inmates.

Education and Training for Inmates and Staff

Because prospects for an AIDS vaccine or cure are less than promising for the immediate future, education and training must continue to be the cornerstone of the response to AIDS in correctional facilities, as in the society at large. Training and education programs in correctional systems are widespread, but this survey shows that programs in most jurisdictions have not changed dramatically in format, frequency or content since last year.

The 1985 survey found that the vast majority of correctional systems were providing some type of AIDS education or training to both inmates and staff. (Education and training includes live training sessions, audio-visual programs, and distribution of written materials.) The 1986 numbers reveal slight increases in the ensuing year: two additional systems now provide education to inmates (raising the percentage from 83 percent to 86 percent), while one system added programs for staff (raising the percentage from 93 percent to 96 percent). Only ten responding correctional systems have no AIDS educational programs for inmates, while only three have no programs for staff.

A larger percentage of state/federal than city/county systems provide education for inmates (94 percent to 77 percent), a fact probably explained by the high inmate turnover in jails. However, education and training are possible—and necessary—no matter how rapid the inmate turnover. Indeed, they may be more important where turnover is high, because each inmate may come into contact with many other individuals in a relatively short period of time. Inmate training on AIDS serves important public health objectives, particularly where turnover is high and individuals quickly return to the greater society. Regardless of turnover rates, training of inmates also serves important correctional management purposes such as promoting institutional security, reducing medical care costs, and limiting potential liability exposure.

The 1985 report strongly recommended *live* training—lectures, discussion groups and seminars—on AIDS for both inmates and staff. These continue to be the most effective training formats if they are presented by persons knowledgeable about both the medical and correctional aspects of AIDS and if they allow inmates and staff to ask questions. The correctional systems most experienced in dealing with AIDS cases all present live training to both inmates and staff. Figures U.4 and U.5 show that the percentages of systems that provide live training to inmates or staff have increased slightly in the last year. Still, less than half the correctional systems surveyed currently provide this important type of training. Audio-visual programs have also found increasing use, but distribution of written materials remains the most popular form of AIDS education in all categories of correctional systems.

One new audio-visual program deserves special mention. "AIDS—A Bad Way to Die" is a videotape produced by and for New York State correctional inmates. It is an extremely effective presentation, based on extensive interviews with AIDS patients in the New York State correctional system. It shows the effects of AIDS in graphic detail and offers dramatic words of warning from inmates suffering from the disease.[23]

Figure U.4

MODES OF AIDS TRAINING PRESENTATION FOR INMATES

Modes of Presentation	State/Federal Prison Systems				City/County Jail Systems			
	Original Survey: November 1985 (n=51)		Update Survey: October 1986 (n=51)		Original Survey: November 1985 (n=33)		Update Survey: October 1986 (n=31)	
	n	%	n	%	n	%	n	%
• Live Training	16	31%	19	37%	8	24%	9	29%
• Audio-visual Programs	14	28	24	47	10	30	10	32
• Written Materials	28	55	33	65	15	45	16	52

Figure U.5

MODES OF AIDS TRAINING PRESENTATION FOR STAFF

Modes of Presentation	State/Federal Prison Systems				City/County Jail Systems			
	Original Survey: November 1985 (n=51)		Update Survey: October 1986 (n=51)		Original Survey: November 1985 (n=33)		Update Survey: October 1986 (n=31)	
	n	%	n	%	n	%	n	%
• Live Training	19	37%	23	45%	10	30%	14	45%
• Audio-visual Programs	17	33	24	47	12	36	16	52
• Written Materials	26	51	31	61	18	55	23	74

Figure U.6

HIV SCREENING/TESTING POLICIES FOR INMATES[a]

Policy Category	State/Federal Prison Systems				City/County Jail Systems			
	Original Survey: November 1985		Update Survey: October 1986		Original Survey: November 1985		Update Survey: October 1986	
	n	%	n	%	n	%	n	%
• Mass Screening (all or all new inmates)	4	8%	3	6%	0	0%	0	0%
• Screening of Risk Groups (including pregnant women)	2	4	11	22	7	21	6	18
• Testing *only* for Diagnosis, Incident Response or Epidemiological Studies	39	77	30	59	20	61	14	42
• Testing *only* on Inmate request	1	2	1	2	1	3	4	12
• No Testing	5	10	6	12	5	15	7	21
• No Update	—	—	0	—	—	—	2	6
TOTAL	51	101%[b]	51	101%[b]	33	100%	33	99%[b]

[a]Includes actual and planned policies. This is a hierarchical categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that do screening of all members of at least some risk groups, but no mass screening, are placed in the "screening risk groups" category regardless of whether they also do testing for diagnosis, incident response, or epidemiological studies.

[b]Due to rounding.

The 1985 survey found that most systems provided only infrequent training on AIDS. Yet, the 1986 follow-up survey revealed that only 14 percent of state/federal systems and 16 percent of responding city/county systems had increased the frequency of training or distribution of written materials to inmates. Thirty percent of state/federal systems and 26 percent of responding city/county systems had increased the frequency of training or materials distribution to staff. It should be re-emphasized that without regular doses of the truth about AIDS and how it is transmitted, misinformation may reassert its hold.

Less than half the correctional systems surveyed (42 percent of state/federal systems and 32 percent of responding city/county systems) had expanded or updated their training programs or written materials for inmates since the 1985 survey. Similarly, 46 percent of state/federal systems and 35 percent of responding city/county systems had expanded or updated staff programs or materials. Given rapid research developments, updating AIDS training and educational materials on a regular basis is extremely important.

Despite education and training efforts, inmate and staff concerns about AIDS have not dramatically increased or decreased between 1985 and 1986. Twenty-two percent of responding correctional systems believe inmate concern has increased in the last year, 26 percent believe it has decreased, and 52 percent believe it has remained the same. The analogous figures for staff concern are 24 percent, 37 percent, and 39 percent, respectively.

The 1986 survey suggests that there is still substantial room for improvement in correctional training on AIDS. More live training, more frequent training, and more regularly updated training are still necessary. As for content, the conclusion of the 1985 report holds true: AIDS training should carefully avoid the extremes of alarmism and complacency.

HIV Antibody Screening and Testing

Significant controversy continues to surround the use of the antibody test to screen people, as opposed to screening blood. Primary issues in the debate have been the test's utility in predicting the future course of infection, the difficulty of maintaining the confidentiality of test results, and the discrimination and other detrimental effects on individuals' lives if results are divulged.[24] Correctional management issues—in particular, what to do with seropositives once they are identified—must also be carefully weighed in any application of mass screening programs in prisons or jails. Probably as a result of some combination of all these factors, very few correctional systems have implemented mass screening programs. Several correctional departments have also rejected mass screening on the basis of CDC's recommendation against routine screening of the population at large. This seems to reflect the belief that mass screening is no more "productive or desirable" in correctional settings than in the larger society.[25] If and when therapeutic drugs such as AZT and Ribovirin are approved and become available, there may be better reason to screen inmates. This will be particularly true if such drugs prove effective in inhibiting the development of illness in asymptomatic seropositive individuals.

Figure U.6 reveals few significant changes in the screening and testing policies followed by correctional systems since the 1985 survey. None of the four jurisdictions that now collectively account for 70 percent of all inmate AIDS cases—New York State, New York City, New Jersey, and Florida—have implemented mass screening of inmates. New York State and New York City continue to follow a policy of no testing whatsoever, and Florida has maintained its policy of testing only when clinically indicated. New Jersey now tests all pregnant females believed to be at risk (e.g., intravenous drug abusers), and inmates with clinical indications of HIV infection.

The number of jurisdictions with mass screening programs has decreased from four to three. Two states dropped mass screening policies: Missouri has decided that mass screening is unnecessary and plans to screen risk group members only; Iowa discontinued screening after a prevalence study of about 800 inmates identified no seropositives. On the other hand, South Dakota instituted a mass screening policy during the last year. None of the responding city and county systems has instituted mass screening.[26] Most systems continue to test only when clinically indicated, in response to incidents, or for blind epidemiological studies. Michigan conducted anonymous screening of all inmates admitted to the state system during November 1986.

The most significant change reflected in Figure U.6 is the increase in the number of state and federal systems that screen all members of at least one risk group. All of the states with mass screening programs, and 76 percent of the jurisdictions with risk-group screening policies have had fewer than four cases of AIDS. Two of the systems with larger numbers of cases whose policies are classified as risk-group screening apply the policy only to pregnant women—a very small number of inmates. It appears that screening is more common

Figure U.7

RESULTS OF MASS SCREENING AND RISK-GROUP SCREENING PROGRAMS

A. Mass Screening

Jurisdiction	Number Tested	Inmate category(ies)	Number HIV Seropositive	% Seropositive
Colorado	2847	all new inmates	15	0.5%
Iowa	800	all new inmates (Jan.-Apr. 1986)	0	0.0
Nevada	2638	all new inmates	8	0.3
Nevada	3820	all current inmates (Aug. 1985)	96	2.5
South Dakota	427	all new inmates	1	0.2
South Dakota	1124	all current inmates (Jan.-Feb. 1986)	2	0.2

B. Epidemiological Studies

Michigan	457	All new inmates (Nov. 1986)	4	0.8

C. Risk-Group Screening

Alabama	301	unspecified risk groups	7	2.3%
New Hampshire	128	homosexuals and IV drug users	5	3.9
Orange County, CA	978	female prostitutes	28	2.9
Hennepin County (Minneapolis), MN	260	homosexuals and IV drug users	2	0.8

in low-incidence systems and in restricted applications where it is likely to identify relatively few seropositives, and thus pose fewer correctional management problems.

Thirty-three respondents provided aggregate results from their screening and testing programs. Most programs are small-scale, involving some combination of inmates with clinical indications, those in risk groups, and those who request testing. Data from such testing programs cannot be used to suggest seroprevalence because of the biases introduced in the selection process. However, four states reported the results of mass screening programs, and Michigan reported the results of its one-month epidemiology study. These are shown in Figure U.7.

Seroprevalence rates among new and current inmates in these jurisdictions were all very low—from 0 to 2.5 percent with all but one group under 1 percent. These are comparable to estimated seroprevalence rates in the population at large. Four other jurisdictions reported the results of large-scale screening of risk-group members—generally homosexuals and intravenous drug abusers—which are also shown in Figure U.7. In one county jail system, all female prostitutes were tested at intake. Seroprevalence rates in these risk groups were slightly higher than among all inmates— from 0.8 percent to 3.9 percent—but still quite low.

Figure U.8
HOUSING POLICY COMBINATIONS[a]

Policy Combination	State/Federal Prison Systems				City/County Jail Systems			
	Original Survey: November 1985		Update Survey: October 1986		Original Survey: November 1985		Update Survey: October 1986	
	n	%	n	%	n	%	n	%
• Segregate AIDS Cases; ARC Cases and Seropositives Maintained in General Population	3	6%	8	16%	3	9%	3	9%
• Segregate AIDS and ARC Cases; Seropositives Maintained in General Population	10	20	8	16	3	9	4	12
• Segregate All Categories	8	16	8	16	13	41	9	27
• No Segregation of any Categories	2	4	6	12	0	0	1	3
• No Policy	8	16	5	10	1	3	0	0
• Combinations involving case-by-case determination	16	31	14	27	10	30	12	36
• Other Policy Combinations	4	8	2	4	3	9	2	6
• No Update	—	—	0	—	—	—	2	6
Total	51	101%[b]	51	101%[b]	33	101%[b]	33	99%[b]

[a]For the purposes of this categorization, segregation means that the *basic* policy is to hospitalize (either within or outside the correctional system) or to segregate administratively the particular category of inmate, regardless of whether these inmates are returned to the general population when their symptoms subside. Single-celling is also included in segregation.

[b]Due to rounding.

Housing Policies for Inmates with AIDS, ARC and Asymptomatic HIV Seropositivity

Figure U.8 shows that there have been no dramatic changes in housing policies, but that these policies continue to be extremely diverse. The only changes of any significance are the decreasing percentage of city and county jail systems that segregate all three inmate categories (from 41 percent to 27 percent) and the increasing percentage of state and federal systems that segregate none of these categories (from 4 percent to 12 percent).

These figures seem to reflect a slight shift away from policies stressing segregation, particularly for inmates with ARC and HIV seropositivity. The majority of all systems (59 percent of state and federal systems and 76 percent of city and county systems) still hospitalize AIDS patients, but slightly smaller percentages than in the 1985 survey now hospitalize inmates with ARC and those who are asymptomatically seropositive. Seven (or 20 percent) of 34 systems whose policy at the time of the 1985 survey was to segregate all inmates with ARC had decided against segregation one year later; six of 21 systems (or 29 percent) had made a similar policy change for HIV seropositive inmates. In addition, 4 of 11 systems (or 36 percent) which originally reported no housing policy for inmates with ARC had decided on a no-segregation policy one year later; six of 13 systems (or 40 percent) had made a similar policy decision for seropositive inmates. Segregation policies for all AIDS-related inmate categories are still generally more common in city and county systems than in state and federal systems.

The trend away from segregating inmates with ARC and HIV seropositivity may reflect concern that segregation capacity will be insufficient to accommodate increasing numbers of such inmates. However, these policy changes undoubtedly also reflect a growing awareness that segregating inmates with ARC and HIV seropositivity may be unnecessary and inappropriate, and may lead to inmate lawsuits raising difficult legal issues.

Initial segregation policies may have been based primarily on a perceived need to protect HIV-infected inmates from physical harm at the hands of other inmates. However, at least in some correctional systems, this concern has turned out to be unfounded.

Moreover, CDC has issued strong regulations against such segregation in health care facilities. As with testing, correctional systems may be concluding that they should not deviate from policies considered appropriate for the society at large. For example, Michigan has determined that housing decisions should not be based on blanket AIDS-related categories but rather on each individual's security classification and medical needs. The state correctional department's protocol provides that "HIV-infected prisoners who do not require inpatient care will be eligible for general population housing at any institution which can meet their health care and security needs, and will also be eligible for any programming and work assignment which their health and behavior allows." As an alternative to inflexible segregation policies, Michigan has implemented an extensive program for identifying and monitoring high-risk behaviors and making timely housing and programming decisions for inmates exhibiting such behaviors.[27]

Medical and Psycho-Social Care for Inmates with AIDS, ARC and Asymptomatic HIV Seropositivity

The 1985 report emphasized the importance of quality medical care but also stressed the need for counselling and other psycho-social support services. A promising AIDS support group has been initiated at a state prison in Georgia. This support group has helped to address and ease the personal difficulties of inmates with AIDS and ARC, and raised the general level of information and awareness regarding AIDS among both inmates and staff. It thus serves not only to enhance care for AIDS and ARC patients but also to supplement educational programs.[28] Other correctional systems may wish to replicate this model.

Legal and Legislative Developments

In late 1985, most legal issues regarding AIDS in correctional facilities remained potential or theoretical; few actual cases had been filed at that time. In the past year, however, numerous inmate cases have been filed, and a few 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.

To date, very few AIDS-related cases have been instituted by correctional staff. This reflects the fact that there have been no cases of seroconversion, AIDS or ARC among correctional staff attributable to contact with inmates. This section summarizes legal developments in 1986 and discusses the status of state legislative initiatives on AIDS in correctional facilities.[29]

Inmate Legal Issues

Before summarizing the inmate cases, it should be emphasized that most are still pending. Obviously, anyone can file a suit for any reason. Many cases will undoubtedly be decided in favor of the correctional systems. The following discussion reflects the types of allegations that may be raised in inmates' AIDS-related lawsuits.

Equal Protection and Related Issues

This type of case generally involves inmates with AIDS, ARC or HIV seropositivity alleging that the conditions of their confinement violate equal protection standards and/or constitute cruel and unusual punishment. The leading case is *Cordero v. Coughlin*,[30] discussed in the original report, in which the court upheld the New York State Department of Correctional Services' policy of medical segregation for inmates with AIDS. In an Oklahoma case, *Powell v. Department of Corrections*, the court took a very similar position regarding segregation of a seropositive inmate. Although it did not cite *Cordero*, the court declared that the segregation policy furthered legitimate correctional objectives, namely prevention of the spread of disease and protection of the seropositive inmate from other inmates. Further, the court stated that inmates have no constitutional right to be in general population and that the inmate had not been denied equal protection since he had not been treated differently from other seropositive inmates—in fact, no other seropositive inmates had been identified in the Oklahoma prison system.[31]

In Colorado, by contrast, the Department of Corrections has eased its segregation policy for seropositive inmates. In motions filed under *Marioneaux v. Colorado State Penitentiary*, a broad correctional conditions case pending since the 1970s, seropositive inmates complained of being placed in a maximum security segregation unit next to death row, in violation of an objective classification system agreed to by the correctional department under *Marioneaux*. The state pleaded "special circumstances", but plaintiffs countered that the classification scheme contained no provision for special circumstances. Ultimately, the correctional department decided to move those seropositive inmates

who ordinarily would have been classified as medium security or lower to a medium security unit. The department also plans to hold a national conference of experts to discuss a comprehensive correctional AIDS policy.[32]

Two other cases involving segregation of seropositive inmates are still pending. In *Farmer v. Levine*,[33] a seropositive inmate in the Baltimore County Detention Center was isolated in a disciplinary unit and denied access to rehabilitation programs, the law library, and religious services. (The last two restrictions were removed after the suit was instituted.) The plaintiff also complained that guards routinely wore masks when entering his cell, left his meals at the opposite end of the cell rather than handing them to him directly, and subjected him to other forms of abuse. Farmer alleged that all of this constituted punishment without due process (i.e. that he was placed in the disciplinary unit without a hearing on any specific conduct), as well as denial of equal protection, right to privacy, and freedom of expression and association. The state, citing *Cordero*, responded that the isolation was not punitive but rather was in furtherance of a legitimate institutional objective—prevention of the spread of disease.

In a new Alabama case, an inmate alleges that his segregation and disqualification from work release programs due to his seropositivity are unconstitutional. As in the other cases, the state will respond that these restrictions are justifiable on the basis of institutional security and health.[34] The major difference between *Cordero*, on the one hand, and *Powell*, *Farmer*, and the Alabama case, on the other, is that the former involved inmates with confirmed AIDS while the latter involved asymptomatic seropositive inmates.

Finally, several recent cases in New York and Florida involve complaints from inmates with confirmed AIDS regarding the conditions of their confinement. The Florida case alleges cruel and unusual punishment associated with plaintiffs' illness. The inmates were isolated and prohibited access to the canteen and to recreational facilities; they also contend they were subjected to persecution and poor treatment by correctional officers. This case was recently dismissed on a technicality, but may be refiled. A recent New York case in which an inmate complained of denial of conjugal visits was decided in favor of the Department of Correctional Services. Following initiation of another New York suit, a correctional system policy was changed to permit HIV-infected inmates to receive visits from their children.[35]

Quality of Care and Related Issues

Typically, these are cases brought by inmates with AIDS alleging inadequate medical care or "deliberate indifference" to serious medical need. *Storms v. Coughlin*, another New York case discussed in the 1985 report, has been withdrawn. The plaintiffs' attorney reports that it became impossible to proceed in the absence of a measurable standard of adequate care for AIDS patients and without complete charting of their care while hospitalized.[36]

In Arizona, a case brought by the state prison system's only inmate with AIDS has been transformed by that inmate's death into a broader class action. The plaintiffs are seeking an injunction requiring development of a comprehensive correctional policy on care of inmates with AIDS, ARC, and HIV seropositivity.[37]

A class action in Nevada challenging a broad range of correctional conditions includes a complaint of inadequate attention to the medical needs of the state's seropositive inmates.[38] Finally, a wrongful death suit may soon be filed on behalf of a former Los Angeles County inmate who succumbed to AIDS and the parents of a Florida inmate who died of AIDS in 1983 have filed an intent to sue alleging that the correctional department provided inadequate care to their son.[39]

Failure to Protect Others from AIDS or HIV Infection

Numerous cases have now been filed by inmates alleging that correctional systems have not provided them adequate protection from HIV infection while in prison. The first case of this type was *La Rocca v. Dalsheim*,[40] discussed in the original report, in which New York State's policies were held to provide adequate protection. However, this case arose before the HIV antibody test became available and now a number of suits have been filed seeking antibody screening and other policies for the systematic identification and segregation of infected inmates. Many of these cases demonstrate that misinformation about AIDS still influences attitudes and actions in correctional institutions.

A North Carolina case seeking mass screening of inmates for antibodies to HIV, as well as an end to sharing of kitchen utensils, toilet facilities, clothing and bed linen with infected inmates, and steps to halt homosexual activity in prison was decided in favor of the correctional department. Another case on the same issues remains pending in North Carolina.[41]

In three pending Oregon cases[42] and a pending Florida case[43], inmates are seeking mass HIV screening in correctional institutions. Finally, an Arkansas case seeks not only mass screening, but also hospitalization of all inmates with AIDS, discharge of any staff who develop AIDS, removal of any seropositive correctional staff from contact with other staff and inmates, and systematic reporting of all AIDS cases to the correctional department and the state health department.[44] This case is still pending.

Two pending New Jersey cases allege failure to follow established administrative and medical screening policies and demand systematic identification and segregation of high-risk inmates and those with symptoms of HIV infection, as well as more and better inmate training on AIDS. These suits do not call specifically for mandatory HIV antibody screening, rather, they seek to have testing made available on a voluntary basis.[45]

In Arizona, a case seeking removal of an inmate with AIDS from the institution was dismissed, while another suit seeking damages for "severe emotional distress" as a result of being housed in the same unit with ARC inmates remains pending.[46] A group of pending Florida cases demands an end to homosexuals working in prison food service, and protection against homosexuals spreading HIV infection through assaultive and consensual sexual acts. One case alleges that inmates adulterated coffee with the blood of an AIDS patient.[47] Finally, in a Pennsylvania case an inmate seeks release from prison or elevation of the institution's conditions to a constitutional level. He alleges wanton neglect by being placed in population with inmates who have ARC or AIDS, thus endangering his life.[48]

No cases have been filed as yet by inmates seeking damages for allegedly contracting HIV infection or AIDS while in a correctional facility. Correctional systems have been required by courts to adhere to a standard of reasonable care in protecting inmates. Breaches of this standard may constitute cruel and unusual punishment.[49] In several cases, correctional systems and their officials have been held liable for damages resulting from homosexual rapes and other inmate-on-inmate assaults on the ground that inadequate supervision had been provided to prevent such incidents.[50]

However, correctional systems have not been held responsible for insuring the *absolute* safety of persons in their custody. In several cases, for example, courts have held that a correctional system could be liable for damages resulting from inmate-on-inmate assault only if its officials knew—or should have known—in advance of the risk to the particular inmate.[51]

In sum, law enforcement agencies perceive AIDS to pose serious potential legal problems. However, there have been no actual cases filed on these issues as yet and, with the exception of the police lockup scenario, there do not appear to be very strong grounds for suits alleging departments' liability for damages associated with HIV infection or AIDS either by officers or by members of the public.

Confidentiality and Other Issues

Several cases have been filed alleging improper disclosure, or seeking to halt disclosure, of AIDS-related information. In a pending New Jersey case, inmates allege that under current policies AIDS-related medical records might be seen by guards. They also ask to be tested for HIV antibodies but to be freed from any disciplinary action for engaging in needlesharing activities that might have led to their infection.[52] A Florida case alleges improper disclosure of antibody test results by the correctional department.[53] New Mexico has promulgated a comprehensive policy for maintaining the confidentiality of AIDS-related medical information on inmates that other systems may wish to consider. The policy provides for strict security of all HIV antibody test results, restrictions on use of the term "AIDS" on medical charts in the absence of a firm diagnosis, and disciplinary measures for persons divulging confidential information on patients with HIV infections.[54]

Several cases regarding AIDS-related information have been brought by inmates against the Federal Bureau of Prisons. In a recently dismissed case, a private attorney sued under the Freedom of Information Act for information on the number of AIDS cases, correctional management policies for inmates with AIDS, and training programs on AIDS.[55] In two other pending cases, inmates who had incidentally appeared in an AIDS training film allege that they have suffered damages because other inmates now believe they have AIDS.[56]

The sharp increase in the number of AIDS-related inmate lawsuits in the last year underscores the continuing importance of education, training, carefully considered housing policies, and maintenance of the confidentiality of medical information.

Staff Legal Issues

As noted above, thus far there have been very few AIDS-related suits filed by correctional staff. A

major reason for this is that there have been no cases of AIDS among correctional staff attributable to contact with inmates.

One staff-initiated case involved AIDS training. An informational memorandum circulated in a state prison contained the statement that "no one really knows the way AIDS is transmitted, so be careful. . . ." The actual training program stressed that the virus is not transmitted by casual contact. Nevertheless, a correctional officer refused to search inmates and was fired for disobeying an order. However, an arbitration board reinstated the officer on the ground that his fears had resulted in part from the misleading memorandum.[57] The lesson for correctional departments is unmistakable: be sure that all informational materials and training are clear and consistent regarding the means of transmission of the AIDS virus.

Another case involved a non-work-related case of AIDS in a correctional officer. After he informed his supervisor of the AIDS diagnosis, the officer was transferred to another position outside the institution. The officer filed an equal employment opportunity complaint seeking a return to his original position. However, a settlement was reached under which the individual's employment with the Federal Bureau of Prisons was terminated, but the FBOP agreed to continue paying for his health insurance.[58]

Although no cases of this type have arisen involving correctional officers, administrators should probably be aware of the controversy regarding whether AIDS is a protected handicap under Section 504 of the federal Rehabilitation Act of 1973.[59] If so, an employee could not be fired or otherwise discriminated against simply because he or she had AIDS. Several states and municipalities have passed laws and ordinances prohibiting discrimination against AIDS patients. By contrast, the U.S. Department of Justice issued an opinion last summer holding that measures taken to reduce the spread of AIDS could not be restricted under the Rehabilitation Act.

The U.S. Supreme Court has recently heard a case involving dismissal of a teacher for being susceptible to tuberculosis which addresses the same legal issues being raised under Section 504 in AIDS cases.[60] This case may begin to settle these key labor relations issues.

Legislative Developments[61]

During 1986 legislative sessions, bills on AIDS in correctional facilities were introduced in at least eight states. Three states considered and rejected bills that would have mandated HIV antibody testing in correctional facilities. Legislation filed in Arizona and Michigan would have required testing of all inmates, with an additional provision in Michigan for testing all individuals arrested and charged with prostitution. California's proposal would have required individual inmates to submit to testing in the presence of clinical indications. This would have overridden existing state law, which prohibits testing without written consent of the subject. An Alabama proposal to quarantine all inmates with AIDS was also rejected.[62]

Three states passed laws mandating studies of AIDS in correctional facilities. In Connecticut the study was to focus on education, training, and protection of correctional officers; in Pennsylvania, it was to assess the adequacy of the correctional department's policies and procedures on AIDS; and, in Virginia, it was to examine the feasibility of screening inmates for HIV, as well as the legal and ethical issues raised by such a program. Finally, pending New Jersey legislation would require a study of the extent of AIDS among inmates, the current correctional policies regarding the disease, and possible measures to control the transmission of HIV infection in correctional facilities.[63]

Conclusion

AIDS continues to present difficult and complex policy issues for correctional administrators. The incidence of AIDS is increasing in correctional institutions, although perhaps not as rapidly as in the society at large. Correctional systems' policies on AIDS are being challenged in increasing numbers of lawsuits. The 1986 survey reported here suggests a continuing need for expanding and improving education and training programs for inmates and staff and for careful attention to developing, evaluating, and refining policies regarding antibody testing, housing, medical care, and psycho-social services.

Footnotes

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2. R.J. Biggar, "The AIDS Problem in Africa," *Lancet* (January 11, 1986), 79-83; Deborah M. Barnes, "AIDS Research in New Phase," *Science* (July 18, 1986), 282.
3. "HTLV-III/LAV Antibody Prevalence in U.S. Military Recruit Applicants," CDC, *Mortality and Morbidity Weekly Report* (hereafter *MMWR*) 1986 July 4; 35:421-424; Barnes, "AIDS Research in New Phase," 283.
4. G.T. Stewart et al., "Transmission of HTLV-III by Artificial Insemination by Donor," *Lancet* 1985; 2:581-584.
5. G.H. Friedland et al., "Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis," *New England Journal of Medicine* 1986; 314:344-349; Peterman, Presentation at 10th NCCHC; *Lancet* (September 20, 1986), p.694. A. Berthier et al., "Transmissibility of HIV in Hemophiliac and Non-Hemophiliac Children Living in a Private School in France," *Lancet* (September 13, 1986), 598-601.
6. Nicholas Dello Russo, "Inaccuracies about AIDS Lead to Hysteria," Letter to the Editor, *Boston Globe*, November 12, 1986, p. 14.
7. Peterman, Presentation at 10th NCCHC; J.J. Goedert et al., "Three-year Incidence of AIDS in Five Cohorts of HTLV-III-Infected Risk Group Members," *Science* (February 28, 1986), 992-995.
8. *Confronting AIDS*, pp. 44, 91.
9. *Ibid.*, p. 45.
10. *Ibid.*, p. 46.
11. *Ibid.*, pp. 219, 229.
12. "Transfusion-Associated HTLV-III/LAV Infection from a Seronegative Donor— Colorado," *MMWR* 1986 June 20; 35:389-391; Peterman, Presentation at 10th NCCHC; *Confronting AIDS*, p.54.
13. CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987.
14. CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987; W.M. Morgan et al., "AIDS: Current and Future Trends," *Public Health Reports* 1986; 101:459-465; *Confronting AIDS*, pp. 69-70.
15. CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987. *MMWR* 1986 October 24; 35:664.
16. CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987.
17. CDC, AIDS Weekly Surveillance Report—U.S., November 4, 1985 and October 6, 1986. Responses to the original survey were received between November 1985 and January 1986. For the purpose of calculating change in the cumulative total cases, we considered the data current as of November 1, 1985.
18. For a demographic study of inmate deaths from AIDS in New York State, see New York State Commission of Correction, *Acquired Immune Deficiency Syndrome: A Demographic Profile of New York State Inmate Mortalities 1981-1985* (Albany, March 1986).
19. The incidence rate per 100,000 population is a standard measure used to facilitate comparisons. The incidence rates for the population at large were calculated as follows:

$$\text{incidence rate} = \frac{\text{Total number of cases reported to CDC in 1986 x 100,000}}{\text{Total population}}$$

20. The incidence rates for correctional systems were calculated as follows:

$$\text{incidence rate} = \frac{\text{Current AIDS cases in system x 100,000}}{\text{Current population of system}}$$

The reported number of *current* AIDS cases may slightly underestimate the total number of cases reported during 1986, but most correctional systems do not keep statistics on cases by year reported. Using the current number may slightly underestimate the real annual incidence rate in a correctional system.

21. *Demographic Profile of New York State Inmate Mortalities*, pp.12-18.
22. Bureau of Communicable Disease Control, New York State Department of Health, *AIDS Surveillance Monthly Update*, August 1986, pp. 3-5.
23. Copies of the videotape are available without charge by sending a blank VHS cassette with a self-addressed mailer to Charles Hernandez, Superintendent, Taconic Correctional Facility, 250 Harris Road, Bedford Hills, NY 10507, Telephone (914) 241-3010.
24. See Ronald Bayer et al., "HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs," *Journal of the American Medical Association* Oct. 3, 1986; 256:1768-1774.
25. Nebraska Department of Correctional Services, Administrative Regulations Number 115.28, "Medical Services: Acquired Immune Deficiency Syndrome," (March 16, 1986), p.2.
26. Lake County, Indiana, which is not in the survey sample, has implemented a mass screening policy (with informed consent) in its jail. Alfonso D. Holiday II and Debora Robinson-Watson, "Clinical and Cost-Effectiveness of HTLV-III Screening," Presentation at 10th National Conference on Correctional Health Care, Washington, D.C., October 30, 1986.
27. "Protocol for the Prevention and Management of HIV Infection in the Michigan Department of Corrections," (Revised October 1986) pp.9-11.
28. Don Wardrope (Psychiatric Nurse Consultant, Augusta Correctional and Medical Institution, Grovetown, Georgia), "An AIDS/ARC Support Group in a Correctional Institutional Setting: General and Specific Considerations," Paper presented at the 10th NCCHC, Washington, D.C., October 31, 1986.
29. For an introduction to some of the legal issues surrounding AIDS in correctional facilities, see William C. Collins, *Correctional Law 1986*, pp. 15-22.
30. 607 F Supp 9 U.S.D.C., (S.D.N.Y., 1984).
31. U.S.D.C., N.D. Oklahoma, Nos. 85-C-820-C and 85-C-816-B, dismissed February 20, 1986. A similar Oklahoma case, *Morse v. Meachum* (U.S.D.C., W.D. Oklahoma, No. CIV-86-1309-T), was decided in favor of the correctional department in late December 1986.
32. *Marioneaux v. Colorado State Penitentiary*, 465 F Supp 1245 (1979); interview with David Miller, Colorado ACLU.
33. U.S.D.C. Maryland, No. HM-85-4284.
34. Interview with T.L. Allen, Associate Commissioner, Alabama Department of Corrections.
35. *Saunders v. Wainwright*, U.S.D.C. Middle District, Florida, No. 85-677-CIV-J-16. Questionnaire response, New York State Department of Correctional Services.
36. Interview with Attorney Carol Kahn, White Plains, New York.
37. *Brown v. Arizona Department of Corrections*, (U.S.D.C., Arizona, No. CIV-85-2709-PHX-PGR [MM]); Interview with Attorney Cynthia Cheney, Phoenix, Arizona.
38. *Burns v. State of Nevada*, (U.S.D.C., Nevada, No. CV-S-86-366-HDM); Interview with Attorney Bruce Schup.
39. Questionnaire responses.
40. 120 Misc 2d 697 (NY, 1983).
41. *Wiedmon v. Rogers* (U.S.D.C., E.D., North Carolina, No. C-85-116-G); *Maberry v. Martin* (U.S.D.C., E.D., North Carolina, No. 86-341-CRT), pending.
42. *Herring v. Keeney* (U.S.D.C. Oregon, filed September 17, 1985); *Sheppard v. Keeney* (U.S.D.C. Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C. Oregon, filed October 11, 1985).
43. *Potter v. Wainwright* (U.S.D.C., Middle Dist. Florida, No. 85-1616-CIV-T15).
44. *Knight v. Henderson* (U.S.D.C. Arkansas, No. PB-C-86-16).
45. *Telepo v. Fauver* (U.S.D.C. New Jersey, Civil Action No. 85-1742 (HAA)); *Hook v. Fauver* (U.S.D.C. New Jersey, Civil Action No. 85-5962 (HAA)).
46. *Piatt v. Ricketts* (U.S.D.C. Arizona No. CIV-85-538-PHX); *Yates v. Lewis* (U.S.D.C. Arizona No. CIV-86-1538-PHX).

47. *Stalling v. Cave* (2d Circuit, De Leon County); *McCallum v. Staggers* (5th Circuit, Lake County, No. 85-1338-CAOI); *Bailey v. Wainwright* (8th Circuit, Baker County); *Lloyd v. Wainwright* (2d Circuit, De Leon County, No. 86-3144); notice of intent to sue, *Elliot v. Department of Corrections and Prison Health Services*.

48. *Fergley v. Faulconer* (Huntington County, PA Court).

49. See, e.g., *Doe v. Lally* 457 F. Supp. 1339 (U.S.D.C., Maryland, 1979); *Campbell v. Bergeron* 486 F. Supp. 1246 (U.S.D.C., Middle Dist. Louisiana, 1980), aff'd 654 F. 2d 719 (5th Cir. 1981); *Streeter v. Hopper* 618 F. 2d 1178 (5th Cir. 1980); *Rhodes v. Chapman* 101 S. Ct. 2392 (1981).

50. See, e.g., *Redmond v. Baxley* 475 F. Supp. 1111 (U.S.D.C. E. Dist. Mich. 1979); *Garrett v. United States* 501 F. Supp. 337 (U.S.D.C., N. Dist. Georgia 1980); *Saunders v. Chatham County* 728 F. 2d 1367 (11th Cir. 1982); *Kemp v. Waldron* 479 N.Y.S. 2d 440 (Sup. Ct. 1984); *Thomas v. Booker* 762 F. 2d 654 (8th Cir 1985).

51. See, e.g., *Mosby v. Mabry* 699 F. 2d 213 (8th Cir. 1982); *O'Quinn v. Manuel* 767 F. 2d 174 (5th Cir. 1985).

52. *Sheridan v. Fauver* (U.S.D.C. New Jersey, pending).

53. Notice of intent to sue, *Niosy v. Bowles*.

54. New Mexico Corrections Department, "Guidelines, Policies, and Procedures Relating to AIDS," (January 6, 1986), pp.21-22.

55. *Lewisburg Prison Project v. Federal Bureau of Prisons* (U.S.D.C. Middle Dist. Pennsylvania No. 86-1339).

56. *Torres v. James* (U.S.D.C., S.D.N.Y. No. 86-3112); *Wills v. Carlson* (U.S.D.C., S.D.N.Y. No. 86-6414).

57. *AFSCME and State of Minnesota Department of Corrections*, 85 LA 1185 (Gallagher, 1985); 24 Government Employee Regulations Reporter 187 (December 1985).

58. *Swinney v. Meese* (U.S.D.C., N.D. California).

59. 29 U.S.C. 794.

60. *School Board of Nassau County v. Arline*, No. 85-1277.

61. The information in this section was provided by Constance Thomas of the Intergovernmental Health Policy Project at George Washington University. We are grateful for her assistance.

62. Arizona—HB 2136; Michigan—HB 5247 and HB 5279; California—AB 3318, AB 3393, and SB 1513; Alabama—HB 25.

63. Connecticut—Public Act No. 86-421; Pennsylvania—House Resolution No. 168, Adopted January 22, 1986; Virginia—House Joint Resolution No. 125, Adopted March 6, 1986; New Jersey—AR 10 and AJR 37.

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