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STATEMENT OF

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BEFORE THE

SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL

U.S. HOUSE OF REPRESENTATIVES

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Mr. Chairman and distinguished members of the Committee, thank you for inviting the American Correctional Association (ACA) to discuss the topic of AIDS--Acquired Immunodeficiency Syndrome as it relates to intravenous drug abuse.

Let me begin by providing some background on the ACA. The ACA was formed in 1870 as an outgrowth of the American Prison Association. The purpose over the years has been to provide professional identification on a national level for those correctional workers nationally and internationally. Currently the ACA membership stands at more than 23,000 individuals in all components of adult and juvenile corrections. In our organization, corrections representation includes federal, state, and local workers in adult and juvenile facilities as well as community corrections including probation, parole, early diversion and pretrial services. Jails and detention facilities also comprise our network of representation. For more than a century, the ACA has worked toward a unified voice in correctional policies and goals. The ACA has been involved in continuing to develop a national correctional philosophy; in designing and implementing standards for correctional services and methods for measuring compliance; in conducting workshops that explore the latest problems and issues in the field and offer professional growth. The ACA publishes a great deal of professional information through its newsletters, magazine and books, and provides training and technical assistance.

There is growing nationwide concern among correctional professionals and federal, state, and local criminal justice officials regarding a proper criminal justice response to the extremely complex problem of AIDS. Reactions and techniques that develop in the public sector toward AIDS may not necessarily be the best responses for corrections to follow.

As recently as last week the nation's correctional chief executive officers met in Denver to discuss a number of concerns, including the growing phenomenon of AIDS, but the discussion did not lead to a consensus on how best to handle the problem within correctional institutions. One of the most hotly debated topics concerned mass screening or testing. Correctional professionals at this time do not see a correctional reason for mass testing; however, they are aware that there may be a political response or maybe even a public health response that is necessary.

At this very hour, about 50 sheriffs, correctional leaders and federal government officials from around Washington, D.C. are discussing the problem of AIDS at an ACA-sponsored meeting in College Park. The ACA is aware that new information is being generated by the Centers for Disease Control (CDC) in Atlanta and other medical groups quite rapidly. Because of this, we have called our colleagues together today to discuss the issues and search for unanimity in policy and procedures. While solutions may not be available, useful information will be exchanged. We will be happy, Mr. Chairman, to send to you and the Committee the results of today's meeting.

Although the ACA does not have a firm policy statement regarding AIDS, we began developing policy guidelines on AIDS in early 1985 with the significant help of three federal agencies: the Centers for Disease Control (CDC), the National Institute of Justice (NIJ), and the National Institute of Corrections (NIC). Several meetings sponsored by NIC were held nationwide, and two national surveys were conducted by NIJ and ACA to determine the extent of the AIDS problem in both correctional institutions and our nation's largest jails. NIJ published the results of those surveys; the first edition in April 1986 and the second edition in May 1987. A third edition will be published in the spring of 1988. We wish to thank the three federal agencies for their

professional response and their continued partnership in providing information to state and local correctional officials. Without the information, we probably would be significantly out of step on control issues.

Correctional officials throughout the nation now have more than 570,000 men and women in custody in state and federal facilities, and on any given day there are more than 250,000 men and women in our nation's jails and detention centers. However, more than 18 million people are processed through these jails and detention centers each year. These numbers are staggering, and each day a new record for correctional populations is being set.

For the past two years the correctional population has grown by more than 1,000 additional people each week. It is likely that the correctional population will continue its dramatic increase for the next 10 years or so.

Therefore, with the enormous number of persons being incarcerated, correctional officials cannot wait for a final answer on how to deal with AIDS victims. Lives are at stake now for both inmates and correctional officers and families of inmates who may be eventually paroled or complete their sentences. Science cannot produce a quick fix, nor is there a cure around the corner. So the slow and agonizing deaths will continue, and the health threat to other inmates and those who work with them will continue to loom ominously. Therefore, it behooves every federal agency and every correctional agency to be informed with all available information and to be constantly alerted to new options for care and custody of inmates with AIDS.

As a general summary as reported in the NIJ Report , AIDS in Correctional Facilities, Second Edition (May 1987), the following is significant:

> 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.

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.

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.

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 (Appendix A). 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.

The Middle Atlantic states still account for the vast majority of AIDS cases among correctional inmates (Appendix B). 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, 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. 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.

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." 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.

Although our 1986 figures indicated that the number of states using mass screening has decreased from four states to three, several states and systems have either legislated mass screening or ordered that AIDS screening be handled under the catagory of communicable disease.

Correctional professionals do not have a problem in deciding what to do with inmates who have AIDS and cannot function in the open environment of a correctional unit--they are either hospitalized within the institution or in a community hospital. The problem is what to do with those who test positive or have AIDS-Related Complex (ARC). We recently learned that the State of California Department of Corrections is beginning to separate those inmates

who test positive. They are currently using separate wings of the Vacaville medical facility.

Mr. Chairman, we are aware that your interest and that of the Narcotics Abuse and Control Select Committee is concerned with the implications of intravenous drug abuse and the subsequent condition of AIDS. Believe me, the entire criminal justice system is also alarmed at the implications as they present themselves to police, courts, and corrections. For whatever reasons, there are more AIDS victims in correctional institutions attributable to intravenous drug abuse through dirty needles than attributable to homosexual contact within the community or in correctional institutions.

Since an extremely high number of inmates use a variety of illegal drugs, the number of incarcerated intravenous drug abusers will probably continue to increase significantly over the next several years, provided there is continued pressure to get drug abusers off the streets.

There is an indication in a federal government study, yet to be released, that in New York City alone at least 2,000 arrested intravenous drug abusers per month will be seropositive. If this number continues, the consequences for the criminal justice system will be overwhelming.

On Monday I discussed the AIDS situation in the New York State Department of Corrections with Commissioner Tom Coughlin. The New York Department of Corrections has had 370 confirmed AIDS cases since they began counting, and all but one of the cases have been the result of intravenous drug use; the one was a combination of homosexuality and intravenous drug use. The great majority of persons with AIDS in the New York system today are from the Hispanic community. Commissioner Coughlin and the Department are still not planning to conduct mass testing of all inmates on a regular basis. However, beginning this month there will be a double-blind study conducted by the

Department of Corrections and the Department of Health for the next 2,000 new inmates to determine the incidence rate.

A drug prevention program of mass proportions must be established as soon as possible to decrease the number of cases that loom on the horizon. With no cure in sight, the prospect exists that correctional officials may be called upon to operate hospices rather than correctional institutions.

From each component of the criminal justice system there are enormous legal, medical, and, of course, political questions to be asked and proper answers to be sought. Let me highlight a few:

Police ask:

- Should there be mandatory testing of all arrestees suspected of AIDS?
- Should prosecutors be encouraged to seek maximum sentences for prostitutes with the AIDS virus?
- Should police handle every arrestee as if they had AIDS?
- What are the limits of police liability?
- How much education is necessary to prepare police officers?

Judges ask:

- Should all prostitutes who have AIDS or AIDS antibodies be imprisoned?
- Should longer sentences be given to defendants with AIDS?
- Should presentence reports require AIDS testing?

Probation agencies ask:

- Should probation officers maintain a screening program as part of supervision--should the results be confidential?
- Should a judge use probation for those who are infected?
- Should a judge send a convicted felon to prison because he/she has AIDS?

Prison Officials ask:

- Should they separate those inmates with AIDS antibodies?

- Should there be separate institutions for those inmates?
- Should men and women who work with AIDS patients be paid a premium?
- What kinds of persons do we recruit to do these jobs if, in fact, separation is mandated?
- Should a correctional staff be told of the results of AIDS testing?
- What are the legal liabilities?

Parole officials ask:

- Should parole boards delay release for those with AIDS antibodies or those who have AIDS?
- What level of confidentiality should be maintained? Should families, employers, or others in the community, such as medical authorities, be told of inmates who have AIDS antibodies?
- Should certain conditions be imposed on parolees with AIDS?

These are but a few of the enormously complex questions that criminal justice officials have and will be seeking answers for over the next several years.

Conclusion

Mr. Chairman, even though it appears that in correctional institutions the growth rate in the number of persons who have AIDS-related conditions is slower than that of the general public, the policies that are adopted by the public can have significant effects on corrections: Correctional agencies could be thrust into expensive screening programs that are not needed; eventually corrections might be used as a warehouse for AIDS victims. We suggest that the following ideas be given top priority by Congress and the administration.

1. Continue to appropriate significant funds to stop the use of illegal drugs in our society.
2. Continue to support education and awareness programs to help drug users come to terms with their plight.
3. Continue to support drug abuse treatment centers.
4. Help correctional agencies throughout the United States with the

enormous medical bills for testing and treating of inmates who have AIDS and require hospitalization. The American Correctional Association suggests that the cost of care should be borne by society as a whole through Medicaid funds. The current law forbids Medicaid funds to be used for any inmate in a correctional institution. We now believe the law should be amended to allow funds to be available for the care of AIDS victims.

The correctional community is quite concerned about its responsibility to public health. Some of the questions raised are so significant that it has been extremely difficult for correctional officials to find the proper answers. The ACA-sponsored meeting that is being held today in College Park is a step in that direction, Further, the ACA is in the process of establishing an AIDS task force to see if we can find the answers to some of these questions. We invite you to join with us in this effort.

I again thank the Committee for conducting this hearing and for allowing the American Correctional Association the opportuinity to offer comments on the impact of AIDS in corrections.

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.

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