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Update on AIDS in Prisons and Jails

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Acquired immunodeficiency syndrome (AIDS) remains one of the country's most difficult and complex public health problems. Over 130,000 cases have been reported in the United States since AIDS was first identified in 1981, with 50,000 cases diagnosed in the past 2 years.

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

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

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

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

In response to the needs of correctional administrators for up-to-date information, the National Institute of Justice has sponsored five annual reports on *AIDS in Correctional Facilities: Issues and Options*. These reports summarize the latest medical information on AIDS, present statistics on the prevalence of HIV infection and AIDS in correctional facilities, and enumerate key choices facing administrators as they formulate policy responses. This *AIDS Bulletin* summarizes the major findings and conclusions of the 1989 update.

Essential medical information

HIV disease is now viewed as a continuum from asymptomatic infection to end-stage AIDS. Transmission of the virus appears to be possible at any point along the continuum. The year 1989 has brought some new optimism to the battle against AIDS. There have been important advances in the development and testing of therapeutic drugs; scientists' understanding of the natural history of HIV infection; the accuracy, interpretation, and meaning of HIV antibody test results; the development of vaccines; and epidemiologic knowledge of several HIV transmission factors.

However, AIDS continues to grow as a worldwide public health and fiscal concern. In the United States, the face of the HIV epidemic is changing. While the number of total AIDS cases among IV drug users is still substantially smaller than the number among homosexual and bisexual men, the comparison is misleading and probably not predictive of the future course of HIV infection.

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The number of cases among IV drug users is now increasing at a much faster rate than among homosexual and bisexual men. This may be due in part to the antiviral drug AZT, which has been shown to retard the progression from asymptomatic HIV infection to active disease and is generally more accessible to gay men than to intravenous drug users.

Cases among IV drug users have rapidly multiplied, particularly since 1987. Many public health officials believe that while HIV transmission through homosexual contact may be leveling off or declining, IV drug use represents the second wave, and associated heterosexual transmission the third wave, of the epidemic.

One-half of all adult/adolescent AIDS cases attributed to heterosexual contact are specifically linked to sex with IV drug users. A growing number of infants are being born with HIV infection. These are generally the offspring of women who are HIV-infected IV drug users or sexual partners of IV drug users.

Public health officials anticipate that AIDS cases in all categories associated with IV drug use will continue to increase sharply, at least over the next few years.

Accumulating evidence continues to reinforce the conclusion that HIV is transmitted in three ways—through sexual contact, blood-to-blood (or blood-to-mucous membrane) exposure, and perinatally—but not transmitted through any form of casual contact, by insects or in any other manner.

Studies show that, with adherence to strict quality control, the available HIV antibody tests can virtually eliminate false positives, even in populations at low risk of infection. However, several other studies suggest that false negatives may continue to present problems in high-risk populations.

The year 1989 saw great progress in the medical treatment of HIV disease and its opportunistic infections. AZT remains the only anti-HIV drug with full FDA approval. It has been shown to be effective, to varying extents, among infected individuals at different points along the HIV infection continuum, including asymptomatic individuals.

Several other promising drugs, including ddC, ddI and soluble CD4, are still undergoing clinical trials for safety and efficacy in humans. The most recent developments emphasize the importance of early identification, regular medical monitoring, and early intervention for infected individuals.

Important scientific strides were also made with regard to HIV vaccines in 1989. However, for a number of reasons, including medical and ethical obstacles to clinical trials of vaccines among humans, an effective AIDS vaccine is not likely to be available for at least 5 to 10 years.

In spite of medical progress, AIDS remains a fatal disease. Although periods of survival vary considerably, no one has ever recovered from the disease. At least 80 percent of patients whose cases were diagnosed before 1987 have died. In the absence of a therapeutic breakthrough, it is still believed that virtually all people infected with HIV will eventually develop AIDS.

HIV infection and AIDS in the correctional population

The 1989 NIJ study included the Federal Bureau of Prisons, all 50 State correctional systems, and 31 large U.S. city and county jail systems as well as 11 Canadian correctional systems. Responses to the NIJ study reveal that, as of October 1989, a cumulative total of 3,661 AIDS cases have been confirmed among inmates in 45 State/Federal correctional systems. In addition, 30 large city and county jail systems reported a cumulative total of 1,750 cases of AIDS among inmates. In sum, the survey revealed a total of 5,411 correctional AIDS cases.

Among Canadian inmates, the survey revealed a cumulative total of 57 reported AIDS cases. In both Canada and the United States, no job-related cases of HIV infection or AIDS among correctional staff have been reported.

Cumulative total inmate AIDS cases in the United States have increased by 600 percent since the first NIJ study in 1985 and by 72 percent since the fourth survey in 1988. Between 1988 and 1989, for the first time since the NIJ surveys were initiated in 1985, the percent increase in total U.S. correctional cases (72 percent) exceeded the increase in cases in the population at large (50 percent).

This change appears to be a result of a reduced rate of increase among cases in the population at large (due to a leveling off in homosexual contact cases not yet compensated for by the increase in IV drug use-associated cases). The increase in correctional cases may also reflect improved reporting and recordkeeping in several correctional systems.

These figures represent cumulative total cases from when the responding jurisdictions began keeping records. As for current cases, as of October 1989, there were 1,351 among State/Federal inmates in 39 systems, 158 among city and county inmates in 22 large systems, and 7 in 3 Canadian systems.

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Data from the 1989 NIJ survey on demographics and exposure categories of AIDS cases are incomplete. However, studies performed by individual correctional systems suggest that demographic and risk-factor patterns among prisoners with HIV infection and AIDS have remained stable. Inmate cases are primarily male, blacks and Hispanics are overrepresented relative to the outside population, and, in some cases, to the correctional population as well, and IV drug use is the predominant exposure category.

The distribution of cumulative total AIDS cases throughout U.S. correctional systems remains quite skewed (Table 1). While two more systems than in 1988 reported at least one case, almost half of all responding systems still have had 10 or fewer cases. At the other extreme,

Table 1

Distribution of cumulative total inmate AIDS cases, U.S., November 1985 and October 1989

State/Federal prison systems

Range of total AIDS cases	November 1985 (N=51) Number of systems	%	Number of AIDS cases[a]	%	October 1989 (N=51) Number of systems	%	Number of AIDS cases[a]	%
0	26	51	0	0	5	10	0	0
1–3	15	29	24	5	7	14	82	0.4
4–10	5	10	30	7	12	23	155	2
11–25	2	4	42	9	10	20	143	4
26–50	1	2	33	7	6	12	227	6
51–100	1	2	95	21	4	8	278	8
> 100	1	2	231	51	7	14	2,906	79
Total	51	100	455	100	51	101[b]	3,661	99[b]

City/county jail systems

Range of total AIDS cases	November 1985 (N=33) Number of systems	%	Number of AIDS cases[a]	%	October 1989 (N=32) Number of systems	%	Number of AIDS cases[a]	%
0	13	39	0	0	2	6	0	0
1–3	10	30	16	5	6	19	10	1
4–10	7	21	43	14	6	19	40	2
11–25	1	3	12	4	10	31	186	11
26–50	1	3	40	13	3	9	115	7
51–100	0	0	0	0	2	6	104	6
> 100	1	3	200	64	3	9	1,295	74
Total	33	99[b]	311	100	32	99[b]	1,750	101[b]

[a] The figures in this table represent the *minimum* number of correctional AIDS cases to date, since the NIJ survey does *not* include every U.S. county jail system.

[b] Due to rounding.

Source: NIJ questionnaire responses.

only 11 State and Federal systems and 5 city and county systems have had more than 50 cases. Seven State-Federal systems (14 percent) and 3 of the city and county systems (9 percent) accounted for more than three-quarters of the cumulative total AIDS cases in such systems.

AIDS incidence rates are predictably higher in the correctional setting than in the population at large because of the higher concentration among inmates of individuals with histories of high-risk behavior, particularly IV drug use. The incidence rate of AIDS for the entire U.S. population was 14.65 cases per 100,000 people in 1989. The aggregate incidence rate for State/Federal correctional systems was 202 cases per 100,000 inmates. Incidence rates range widely among correctional populations, reflecting the uneven distribution of cases across systems.

HIV seroprevalence rates among inmates in most correctional systems are still 1 percent or lower, according to available data. It should be noted, however, that most high-prevalence States have not undertaken mass screening of prisoners for HIV antibodies, but some of these jurisdictions have undertaken epidemiologic studies. (Mass screening is the mandatory testing of all inmates, all new inmates, or all releasees in the absence of clinical indications.)

Higher seroprevalence rates, mostly between 2 and 4 percent, are found in correctional systems covering jurisdictions with larger numbers of AIDS cases in the outside population. A blind epidemiologic study among incoming New York State prisoners in late 1987 and early 1988 found an HIV seroprevalence rate of 17 percent.

Although substantial debate continues, little hard data exist on the extent of transmission of HIV within correctional institutions. Data from several jurisdictions suggest low rates of transmission. Logic and common sense indicate, however, that even in the best-managed correctional facilities, at least some transmission of the infection is occurring among inmates. Systematic studies of in-prison transmission are underway.

Correctional policy issues and options

The major policy areas involved in the correctional response to HIV are education and training; HIV antibody testing and notification; medical care and psychosocial services; housing and correctional management issues; and legal issues. Trends and issues in these areas are summarized in the following sections.

Education and training. While the original crisis atmosphere seems to be dissipating, a number of AIDS studies in individual correctional systems reveal continued and substantial concern. Education and training programs still represent the cornerstone of efforts to prevent transmission of HIV infection in prisons and jails, as well as in the population at large. In fact, the actual and potential role of education affects decisions on virtually all of the other AIDS issues and policy options in correctional facilities.

For example, the effectiveness of educational programs may play a major role in determining both inmate and staff attitudes on whether inmates with AIDS or asymptomatic HIV infection should be segregated.

Most correctional administrators feel strongly that AIDS education and training are not options but absolute requirements. Virtually all responding jurisdictions currently offer or are developing some AIDS training or educational materials for staff and inmates (Tables 2–3). However, there remains some unevenness in the provision of AIDS education. Two-thirds of prison or jail systems provide AIDS education to staff at all institutions. About two-thirds of prison systems and less than half of jail systems provide it to inmates at all institutions.

Many correctional systems have mandatory AIDS training for staff, and about half of the prison systems have at least some mandatory education for inmates. However, probably as a result of logistical problems posed by high inmate turnover, very few jail systems make inmate education compulsory. Because the high turnover may present the risk of transmission both within and outside institutions, some form of mandatory education for every jail inmate, possibly as part of orientation or medical screening, is particularly important.

AIDS education has two basic objectives: to foster behavior change, reducing HIV transmission, and to allay concerns regarding casual transmission of the virus. Coaxing changes in firmly entrenched social, sexual, and addictive behaviors poses serious challenges for AIDS educators and policymakers. However, the effort is worthwhile, since AIDS education has been effective in changing behavior among IV drug users and gay men in the community.

Ideally, AIDS education and training should occur before widespread concern takes hold and be repeated periodically so that timely, updated information can be presented and new staff and inmates quickly reached. Programs should be mandatory for both inmates and staff. Inmates and staff should be involved in the development of educational programs and in the delivery of training to peers. The use of peer trainers along with knowledgeable and approachable professionals will help to build credibility, a critical element in the success of AIDS training.

AIDS education should be geared to the specific concerns of the audience, focusing on specific risks and precautionary measures for inmates and staff. It should be appropriate to the educational levels, racial and ethnic composition, and special needs of the population, and avoid extremes of alarmism and complacency. Finally, all training and education should be

documented so that their provision can be proven in the event of future lawsuits.

As knowledge about AIDS education increases, educational strategies become more sophisticated. Some correctional systems are moving to develop and implement more comprehensive educational strategies, which may involve counseling, HIV antibody testing, ongoing support groups, drug treatment opportunities, and other components. Several examples exist of consortia of organizations that are

Table 2

Live AIDS education for inmates, October 1988 and October 1989

	U.S. State/Federal prison systems				U.S. city/county jail systems				Canadian systems			
	October 1988 (N=51)		October 1989 (N=51)		October 1988 (N=28)		October 1989 (N=31)		October 1988 (N=12)		October 1989 (N=11)	
Live education[a]	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%
Provided[b]	48	94	46	90	19	68	21	68	9	75	9	82
In all institutions	39	77	34	67	18	64	15	48	7	58	7	64
Mandatory	37	74	23	45	4	14	1	3	3	25	3	27
Sometimes voluntary and sometimes mandatory	—	—	20	39	—	—	4	13	—	—	1	9

[a] Live education involves the participation of a trained leader in some substantial part of a session.

[b] Includes programs in operation and under development.

Source: NIJ questionnaire responses.

Table 3

Live AIDS education for correctional staff, October 1988 and October 1989

	U.S. State/Federal prison systems				U.S. city/county jail systems				Canadian systems			
	October 1988 (N=51)		October 1989 (N=51)		October 1988 (N=28)		October 1989 (N=31)		October 1988 (N=12)		October 1989 (N=11)	
Live education[a]	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%
Provided[b]	49	96	48	94	25	89	24	77	10	83	10	91
In all institutions[c]	42	82	32	63	19	68	19	61	9	75	8	73
Mandatory	47	94	26	51	16	7	11	35	4	33	5	45
Sometimes voluntary and sometimes mandatory	—	—	19	37	—	—	10	32	—	—	2	18

[a] Live education involves the participation of a trained leader in some substantial part of a session.

[b] Includes programs in operation and under development.

[c] Figures include systems that specified centralized training for staff.

Source: NIJ questionnaire responses.

successfully working with correctional administrations to bring such programs to inmates. Drug treatment programs are a particularly important component of a comprehensive correctional response to AIDS.

For additional information on education and training, readers may wish to consult the AIDS Bulletin "AIDS and HIV Education and Training in Criminal Justice Agencies," NCJ 115904, available from the NIJ AIDS Clearinghouse.

HIV antibody screening and testing. Advances in treatment regimens for HIV infection have resulted in an increasing emphasis on early identification and intervention. Therefore, in the world outside correctional institutions, testing is now viewed more and more as an integral part of medical treatment.

The situation is not quite the same in correctional facilities, where testing is still considered by some to be an infection control tool. But many correctional systems are now offering voluntary or on-request testing. This trend is at least in part responsive to the movement toward early therapeutic intervention.

The major applications of HIV-antibody testing in correctional inmate populations are mass screening, "risk-group" screening, testing in response to potential transmission incidents, voluntary testing, testing on request, testing in support of blind epidemiological studies, and testing in the presence of clinical indications or symptoms. Testing of staff may also occur in limited instances—such as in response to possible transmission incidents. Mass screening of inmates continues to be a controversial testing application.

Correctional policies on HIV-antibody testing. The trend toward mass screening evidenced in correctional facilities between 1986 and 1987 has ceased. As of October 1989, 15 State systems and the Federal Bureau of Prisons—but no city-county or Canadian systems—had mass screening policies (Table 4). Table 5 shows that this represents a net increase of only one system since 1988, with a few systems joining the list but others leaving it.

The majority of jurisdictions currently conducting mass screening are in small States with few inmate AIDS cases. Those State systems that have discontinued mass screening policies have done so for a number of reasons, including funding shortages and the realization that mass screening was creating more problems than it was intended to solve.

Because of the recent findings regarding medical intervention for asymptomatic HIV-infected inmates, the importance of offering voluntary and on-request testing has increased. About three-quarters of prison systems and nearly all (90 percent) jail systems make such testing available to inmates through various arrangements with local public health departments and other agencies.

There is evidence that voluntary testing of inmates serves the needs of both inmates and correctional systems. Results of some carefully controlled studies show that voluntary testing can capture a significant percentage of IV drug users and seropositive inmates.

Policymaking regarding the confidentiality and disclosure or notification of an inmate's HIV status remains a controversial and difficult issue for correctional systems. Many States have laws protecting the confidentiality and

Table 4

Correctional systems conducting mandatory mass screening of inmates, October 1989

U.S. State/Federal prison systems (N=51)	U.S. city/county jail systems (N=31)	Canadian systems (N=11)
Federal Bureau of Prisons	None	None
Alabama		
Colorado		
Georgia		
Idaho		
Iowa		
Michigan		
Missouri		
Mississippi		
Nebraska		
Nevada		
New Hampshire		
North Dakota		
Oklahoma		
Utah		
Wyoming		

Mandatory mass screening is defined as *mandatory* HIV antibody testing, generally identity-linked, of all new inmates, all releasees, and/or all current inmates, regardless of whether they do or do not show clinical indications of HIV infection. In terms of correctional policy, this type of testing differs in purpose and method from blind epidemiological studies. These studies are anonymous (*not* identity-linked) screenings intended to assess seroprevalence rates in a particular population.

Source: NIJ questionnaire responses.

anonymity of individuals tested for HIV antibodies. While almost all prison and jail systems notify the inmate and attending physician or health-care worker of an inmate's test results, only a small fraction of systems have official policies of notifying correctional officers.

However, it is apparent from lawsuits filed by inmates that news of a particular inmate's positive test results or seropositive status travels rapidly through an institution. Breaches of confidentiality are alleged to occur frequently.

Continued staff education on the low-risk nature of most staff-inmate contacts and training on following universal precautions is necessary. It eases staff concerns about transmission, which prompt demands for widespread disclosure of inmates' HIV status. Such disclosures may, in fact, lull correctional officers into a false sense of security, leading them to believe that all infected prisoners have been identified.

False negatives do occur on the antibody tests, and because of the sometimes long "window" period between infection and appearance of antibodies, no testing program can guarantee the identification of all HIV-infected prisoners. Since disclosure has potentially serious consequences, it is essential that

Table 5

HIV antibody testing of inmates, mutually exclusive categorization, October 1988 and October 1989

	U.S. State/Federal prison systems				U.S. city/county jail systems				Canadian systems			
	October 1988 (N=51)		October 1989 (N=51)		October 1988 (N=28)		October 1989 (N=31)		October 1988 (N=12)		October 1989 (N=11)	
Procedure[a]	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%
Mandatory mass screening (all incoming inmates, current inmates and/ or inmates at release)	15	29	16	33	0	0	0	0	0	0	0	0
Screening of "high risk groups"	8	16	12	22	5	18	13	42	2	17	6	55
Voluntary/inmate request testing	6	12	7	14	8	28	10	32	3	25	2	18
Testing if clinical indications[b], involvement in incident or for epidemiologic studies	22	43	15	29	13	46	8	26	4	33	3	27
No testing/policy unknown	0	0	1	2	2	7	0	0	3	25	0	0
Total	51	100	51	100	28	99[c]	31	100	12	100	11	100

[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 screen identifiable inmates with histories of high-risk behaviors, but do no mass screening, are placed in the "screening of high-risk groups" category regardless of whether they also do testing for diagnosis, incident involvement, or epidemiologic studies, and so on.

[b] In this table, clinical indications include lowered CD4 (T4) counts, opportunistic infections, and TB positivity or active TB.

[c] Due to rounding.

Source: NIJ questionnaire responses.

correctional systems adopt and enforce clear policies on the issue.

For additional information on HIV antibody testing, readers may consult the AIDS Bulletin "HIV Antibody Testing: Procedures, Interpretation, and Reliability of Results," NCJ 114206, available from the NIJ AIDS Clearinghouse.

Medical care, psychosocial services, housing, and correctional management issues

In responding to the problem of AIDS, correctional administrators must address both medical and psychosocial considerations and complex management factors, such as housing and precautionary measures.

Medical care. Costs of medical care have escalated dramatically in recent years and represent a major budget item for correctional systems. In many correctional systems, the increasing numbers of prisoners with HIV infection and AIDS have rendered medical care costs an even more severe financial strain than was already the case. In these constrained circumstances, correctional systems are, and will continue to be, under pressure to contain medical care costs. However, cost containment should not come at the expense of reducing standards of care for HIV-infected prisoners.

The significant recent advances in medical treatment of HIV-infected persons include findings regarding the effectiveness of AZT in delaying disease progression in asymptomatic HIV-infected patients and of aerosolized pentamidine in preventing and treating *pneumocystis carinii* pneumonia. These and other therapeutic advances have prompted optimism that in many patients HIV infection may be manageable as a chronic disease and that life expectancy for AIDS patients may increase.

Virtually all (90 percent) of prison systems and three-quarters of jail systems provide AZT to inmates with AIDS. However, only a small fraction of correctional systems are providing AZT to asymptomatic HIV-infected inmates, even after the release of data in 1989 showing the drug's effectiveness in asymptomatics. Nearly a quarter of prison and jail systems do not provide AZT to *all* inmates meeting their own eligibility criteria. Because AZT is an expensive drug, it may represent a serious budgetary strain for many jurisdictions.

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

Psychosocial services. It is increasingly well established that there is a close link between psychological and physiological health in HIV-infected persons. Therefore it is critical that they be provided with a range of supportive services. Correctional and public health officials, as well as AIDS advocacy groups, have established programs of supportive services for HIV-infected prisoners in several jurisdictions. Inmates in a few systems have initiated innovative peer support services.

Inmates with HIV infection and AIDS who are about to be released into the community also require important services. First, they need intensive counseling on their responsibility to notify their sexual partners of their medical status and to avoid any behavior that may transmit infections to others. Second, prerelease planning should include notifying and referring inmates to all government benefit programs for which they may be eligible—such as Medicaid and Supplemental Security Income (SSI). Of course, prereleasees should also be referred to appropriate sources of hospice care, hospitalization, outpatient care, counseling, and other support services in the community.

Housing and programming policies. It appears that the trend in presumptive housing policy in many systems is away from blanket segregation of HIV-infected prisoners toward "mainstreaming"—that is, maintaining all categories of HIV-infected inmates in the general population. Many other systems are following a policy of case-by-case determination of housing, basing decisions on the specific medical or security needs of individual infected inmates. These housing policies are more in accordance with offender classification schemes, which may be overridden when systems decide to base housing decisions solely on HIV status.

The changes in housing policy reflect a combination of factors, varying from system to system. These factors include a less fearful and more compassionate attitude on the part of inmates and staff towards individuals with HIV infection or AIDS, increased costs of hospitalizing inmates, and class action lawsuits filed by segregated inmates.

Segregated prisoners generally have only severely restricted, if any, access to institutional programming and recreational activities. However, most HIV-infected persons, and even many with AIDS diagnoses, are able to lead perfectly normal lives for long periods. It can be very damaging psychologically to be isolated from one's peers.

Less restrictive housing for inmates at all stages of HIV disease also follows the realization among correctional systems that, due to the increasing numbers of inmates with HIV infection or AIDS, segregation or separation may be impractical and unfeasible. Mainstreaming and case-by-case approaches attempt to address some of these issues.

Table 6 summarizes housing policies according to mutually exclusive combinations and shows how these policy combinations have changed since 1985. Sixteen State and Federal systems still segregate or separate all AIDS patients. However, almost two-thirds of prison systems now make housing

decisions for HIV-infected prisoners based on presumptive mainstreaming or case-by-case determination. Some jail systems are reviewing the option of case-by-case determination policies.

Precautionary and preventive measures. Correctional systems continue to face the challenge of protecting their staff and inmates from HIV infection without raising suspicions or exacerbating fears through extreme precautionary measures. To address the issue, correctional agencies have instituted a wide range of precautionary measures to control the spread of AIDS within institutions.

Table 6

Combinations of housing policies for inmates with AIDS, ARC, and asymptomatic HIV infection, November 1985 and October 1989

	U.S. State/Federal prison systems				U.S. city/county jail systems				Canadian systems			
	October 1985 (N=51)		October 1989 (N=51)		October 1985 (N=33)		October 1989 (N=31)		October 1987[c] (N=12)		October 1989 (N=11)	
Housing policy combination	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%	Number of systems	%
Separate/segregate AIDS cases, ARC cases,[a] and asymptomatics maintained in general population[b]	3	6	9	18	3	9	2	7	0	0	1	9
Separate/segregate AIDS and ARC cases; asymptomatics maintained in general population[b]	10	20	1	2	3	9	2	7	0	0	0	0
Separate/segregate all three categories	8	16	4	8	13	41	1	3	3	25	1	9
No separation/ segregation of any category	2	4	18	35	0	0	4	13	0	0	1	9
Combinations involving case-by-case determination (for at least one category)	16	31	15	29	10	30	16	52	9	75	7	64
Other policy combinations, no policy, or policy unknown	12	24	4	8	4	12	6	19	0	0	1	9
Total	51	101[d]	51	100	33	101[d]	31	101[d]	12	100	11	100

[a] The category ARC is no longer used by some correctional systems. This year's NIJ survey presented the category as "ARC or a lesser form of *symptomatic* HIV disease."

[b] In this categorization, "separate/segregate" means that the basic policy is to hospitalize or administratively segregate, regardless of whether clinically ill inmates are returned to general population when their symptoms subside. This categorization is mutually exclusive.

[c] October 1987 was the first year Canadian systems were included in the NIJ survey.

[d] Due to rounding.

Source: NIJ questionnaire responses.

While most systems have instituted infection control measures to help staff and inmates protect themselves, only a handful have taken the much more controversial step of making condoms available to inmates in institutions.

In 1989 CDC released guidelines for the prevention of HIV transmission to health care and public safety workers, including correctional officers. These encourage institutions to tailor their infection control procedures to their unique needs, within the framework of "universal precautions"—i.e., treating all persons as if they are infected.

Precautionary measures should always be commensurate with the risk involved. Obviously, correctional personnel cannot predict with certainty when they will encounter blood or body fluids in the course of their duties. Many situations involve the potential for such contact. Staff members must exercise their professional judgment in using gloves, airways, infectious waste receptacles, or other protections.

Precautionary measures addressing very rare or casual modes of contact, even if implemented in a good faith effort to reduce the fears of staff and inmates, may ultimately increase those fears by encouraging the view that HIV infection is transmitted by unusual or casual contact. Such a conflict between educational messages and practical measures may not only increase fear within the institution, but also foster suspicion of the correctional system for, in effect, saying one thing about the transmission of HIV but doing something else. Hence, correctional systems should be extremely cautious in adopting precautionary measures beyond those recommended by CDC.

The issue of condom availability in correctional institutions continues to evoke argument. Five correctional systems, one more than in the previous year, currently make condoms available to inmates, either through medical staff (with counseling) or at institutional canteens. Many correctional officials believe that making condoms available, in effect, condones conduct that is prohibited by correctional regulations and, perhaps, by State law as well. The systems which have instituted condom availability policies counter that they are not condoning the conduct, but rather acknowledging that it occurs, and taking what they believe to be a reasonable step to help inmates protect themselves against a deadly disease.

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

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

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

Two major AIDS-related lawsuits have recently been concluded. *Harris v. Thigpen*,[1] brought by Alabama inmates, challenged that State's policies of mass screening and segregation of seropositives and alleged that the medical care provided to prisoners with HIV infection and AIDS was inadequate. In January 1990, the case was decided in favor of the correctional department.

The court held that the State's policies represented reasonable measures taken in pursuit of a legitimate penological interest and that the right of uninfected prisoners to be protected from potential exposure to HIV-infected prisoners outweighed the claims of the latter group to be free from discrimination on the basis of their HIV status.

A California case, *Gates v. Deukmejian*,[2] challenged the State's policy of segregating all HIV-infected prisoners in a locked unit at a correctional medical facility. A settlement has been negotiated and approved by the judge, under which a 1-year pilot project has been established for 20 to 30 HIV-infected inmates to live in a separate but not closed unit of the institution and participate with general population inmates in all programs and activities.

Prisoners and staff have initiated both civil and criminal actions arising from incidents, such as biting, in which transmission of HIV could allegedly occur. As yet, however, there have been no cases in which a plaintiff asserted that he or she became infected with HIV as a result of the incident. Several cases seeking expanded testing, disclosure of results, and restrictions on HIV-seropositive prisoners are pending.

Many correctional systems are justifiably concerned about their potential liability should HIV infections occur among inmates while incarcerated and among staff while on the job. Such cases would face serious proof problems given the difficulty in linking infection with a particular episode. However, the most important actions correctional systems can take to minimize potential liability and maximize safety in their institutions would be to intensify efforts to prevent sexual victimization of inmates and provide all inmates and staff members with clear and complete education and training on how to avoid becoming infected with HIV.

AIDS continues to pose complex and difficult problems for correctional systems. The only certainty is that these problems will not go away. With accumulating experience and information, many correctional systems seem to be developing fair and reasonable policy responses to AIDS. But this is an evolutionary process. The information on policy options provided here and in the full report is designed to help correctional administrators continue the refinement and improvement of their AIDS policies.

Notes

1. *Harris v. Thigpen* (U.S.D.C., M.D. Alabama) CA–87–V1109–N, opinion dated January 4, 1990.

2. *Gates v. Deukmejian* (U.S.D.C., E.D. California) CIVS 87–1636, adopted as a court order March 8, 1990.

For additional information on legal issues, readers may wish to consult the AIDS Bulletin "Legal Issues Affecting Offenders and Staff," NCJ 114731, available from the NIJ AIDS Clearinghouse.

NCJ 124549

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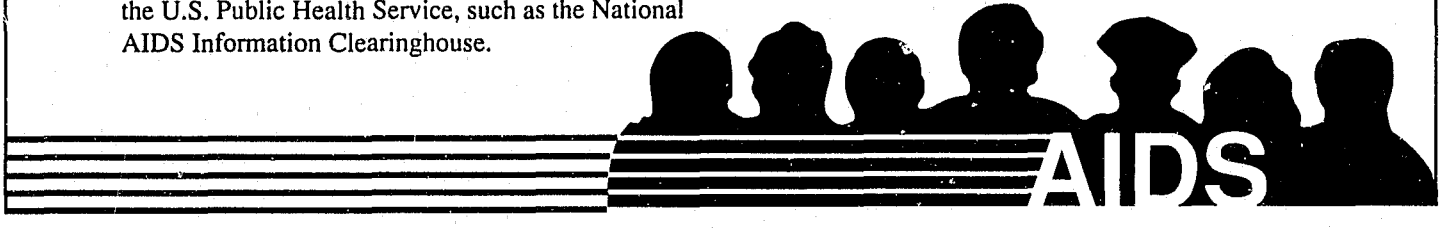

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