Federal Probation

JUNE 1990

Federal Probation

A JOURNAL OF CORRECTIONAL PHILOSOPHY AND PRACTICE

Published by the Administrative Office of the United States Courts

VOLUME LIV JUNE 1990 NUMBER 2

This Issue in Brief

Community Service: Toward Program Definition.—Over the past two decades, community service work order programs have been established at various points in the adult and juvenile justice systems. On the basis of detailed study of 14 community service programs, authors Joe Hudson and Burt Galalway describe a detailed community service program model. Key elements of program structure are described, including inputs, activities, outputs, and outcomes, along with their linking logic. According to the authors, preparation of this type of program model is a necessary prerequisite for sound management practices, as well as for developing and implementing program evaluation research.

Identifying the Actual and Preferred Goals of Adult Probation.—The field of adult probation has undergone considerable change over the last 10 years, reflecting a perceived public sentiment which emphasizes enforcement and community protection. As a result, the goals of probation have shifted. Based on a survey of adult probation professionals in two midwestern states, author Thomas Ellsworth confirms the existence of a dual goal structure in probation, encompassing both rehabilitation and enforcement. Further, the study results reveal that probation professionals prefer a dual goal structure in administering probation services.

Sharing the Credit, Sharing the Blame: Managing Political Risks in Electronically Monitored House Arrest.—For the last several years, electronically monitored house arrest has been the topic of extensive commentary in the literature. Scant attention, however, has been paid to the political environment in which such programs must exist. Using a brief case study of one county in Ohio, author James L. Walker suggests a four-part implementation strategy aimed at reducing the risks to the political actors involved in these programs. He concludes that only if political considerations are properly managed will efficient and legitimate use of electronic monitoring programs be likely.

CONTENTS

AIDS in Prisons—Administrator Policies, Inmate Protests, and Reactions From the Federal Bench

BY DANIEL L. SKOLER AND RICHARD L. DARGAN*

SINCE THE AIDS crisis descended upon the nation, the prison setting has been a major area of concern—perhaps less for actual incidence and contagion than the perceived "worst case" potential of closed institutional systems peopled by residents drawn from social strata arguably more vulnerable to infection than the population-at-large. The most current incidence figures (1,351 AIDS cases as of October 1989 in a total state and Federal prisoner population of approximately 600,000 and a cumulative total of over 3,661 confirmed AIDS state/Federal prisoners since 1985) are high but less than for major metropolitan trouble spots (e.g., New York City and San Francisco) and even below national increase figures for the overall population.

Those who administer correctional institutions have had to react to the threat of this fatal disease in an environment of initial ignorance and at times bewildering change in theories of cause, connection, and risk of infection. This was a no-choice "inaction means action" situation for prison administrators where uncertainty and public alarm permitted no moratorium. Issues such as segregation, screening, diagnosis, treatment, inmate fears, population tension, etc. had to be dealt with as the nation moved toward better understanding and the correctional apparatus toward sound public health concepts in coping with the threat and the realities of HIV infection, AIDS-related complex, and full blown AIDS within correctional populations.

The current model—and one being adopted by many systems across the nation—largely parallels the Federal Bureau of Prisons policy approach (cited by the Presidential Commission on the Human Immunodeficiency Virus Epidemic in its 1988 report). That consists of (i) recognition that there is virtually no risk of exposure to the HIV virus from normal living and working with infected persons (provided one does not absorb an infected person's blood, sexual fluids, or milk), (ii) a bias toward use of the least restrictive measures necessary for orderly institutional management and towards mainstreaming most HIV-positive cases in the general population, (iii) emphasis on confidentiality, counseling, and education vis-a-vis infected persons, (iv) testing for presence of HIV antibodies only for modest samples of new inmates, those who request testing, those exhibiting clinical signs of HIV infection, those displaying predatory or promiscuous behavior, and all inmates prior to release, (v) an assumption of small rates of sero-conversion or change in HIV status during confinement, (vi) hospitalization of those requiring acute care and regular monitoring of HIV-positive inmates to detect changes in status, and (vii) recourse to isolation only when promiscuous and predatory behavior is displayed (in which case the infected inmate is placed in administrative detention).

Most state systems are pursuing comparable policies although a number (about a dozen) still test all new inmates and opt for some form of isolation for HIV-positive residents. Guidelines adopted by the American Correctional Association (ACA) in 1988 are not inconsistent with the Bureau of Prisons' approach and are tied into prevention and control procedures of the Centers for Disease Control and treatment protocols of the Food and Drug Administration. However, they permit a more flexible approach to management of AIDS and would allow mandatory testing for medical management or "prevalence" determination and for segregation of infected inmates (although conceding that the latter is not necessary except for "medical management goals" and "sound security threat justification"). The ACA standards place a high premium on training staff and offenders, confidentiality of test results, and adapting to the constant change in AIDS prevention and control technology.

Early approaches to AIDS infection in prisons were less well informed and somewhat more alar-

*The authors are both with the Federal Judicial Center's Division of Continuing Education and Training—Mr. Skoler as director and Mr. Dargan as judicial/legal education specialist. Any views expressed or implied in this article are those of the authors and not of the agency or the Federal Government.

mist than the current concepts of progressive custody outlined above. As might be expected, inmates alarmed with the AIDS threat and infected inmates subject to unyielding isolation policies have reacted in ways not unknown to such groups, i.e., the initiation of litigation. The first AIDS-related prison litigation to reach Federal courts arose in 1984. However, the pace has accelerated markedly since the mid-1980's. To date, there have been over 20 AIDS-related opinions in Federal court prisoner lawsuits, nearly three-quarters of which were handed down in the past 3 years. These cases have primarily arisen in state correctional systems, initiated by inmates employing the Civil Rights Act as the vehicle for Federal jurisdiction. Indeed, more than 80 percent of the reported Federal cases decided through January 1990 are Section 1983 actions asserting violation of constitutionally protected rights of prisoners "under color of state law." As will be noted, the success rate has been low, and almost all cases have been disposed of without full trial on motions to dismiss complaints for failure to state a cognizable claim or on motions for summary judgment.

The chief kinds of lawsuits seen so far are (i) actions by infected inmates challenging confinement in isolated or segregated facilities or in hospital facilities earmarked for AIDS, ARC, or HIV-positive patients, (ii) actions by general population inmates seeking testing and isolation of infected inmates, and (iii) actions by seriously ill prisoners (or their families) seeking damages or other relief from inadequate or negligent care by institutional medical personnel.

Isolated cases have also raised issues such as (a) failure to protect inmates from physical attack by diagnosed HIV-positive inmates, (b) right to release from confinement where system custody and hospital facilities are inadequate for proper treatment of advanced AIDS victims, (c) liability for unnecessary disclosure of infected status, (d) alleged conspiracy by prison officials to spread infections among prisoners in custody, and (e) special criminal liability for assaultive behavior of a character which might operate to transmit or spread AIDS infection. Both the major and isolated claim categories evidence a clear recognition of administrator dilemmas and merit further discussion.

Protests Against Segregation and Isolation

Almost every prisoner lawsuit brought in Federal court challenging segregation, isolation, or transfer of AIDS or HIV-positive inmates has been decided in favor of the prison systems and their officials—and this has been done without full trial (e.g., *Judd* v. *Packard, Powell* v. *Dept. of Corrections, Cordero* v. *Coughlin*, and *McDuffie* v. *Rikers Island Medical Dept*). That is, courts, with only one exception, have decided the cases on motion to dismiss the complaint or on summary judgment (without trial but with affidavits of evidence and facts expected to be established), determining either that constitutionally protected civil rights such as procedural due process, access to courts, privacy, protection against cruel and inhuman punishment, free expression and association, or liberty interests in proper application of prisoner regulations, were not infringed.

Federal lawsuits thus far have involved the Alabama, Colorado, Maryland, New York, and Oklahoma correctional systems. Only one reported case arose at a Federal facility (*Muhammad* v. *Carlson*). The decisional principles that have guided court analysis in these cases include (i) the notion that since prisoners are not a "suspect class," the administration's action and policies will be upheld if rationally related to the goals of disease diagnosis, treatment and control, and the maintenance of inmate safety, (ii) decisions to isolate or transfer, when based on good faith medical reasons, are not subject to the procedural due process protections (notice, hearing, etc.) that would apply to administrative (i.e., disciplinary) segregation, (iii) ordinary negligence in diagnosis and resulting decisions to isolate do not rise to a civil rights violation unless they involve either gross error or deliberate indifference or malicious intent, and (iv) some deference to administrator discretion is warranted in view of the lack of sound knowledge of the disease in the early eighties, the general seriousness of the AIDS epidemic, and prevailing legal doctrine that prisoners have no inherent rights to particular kinds or modes of confinement so long as conditions of custody are within the purview of sentences imposed and any restrictions are not for punitive reasons.

The limited exceptions to the more or less uniform upholding of prison system actions are (i) a New York case (*Doe* v. *Coughlin*) in which the court issued an injunction against involuntarily placing a prisoner in a special dormitory at Coxsackie, New York, used for diagnosis and treatment of HIV-positive inmates as violative of the prisoner's constitutional privacy rights, especially when there were inexpensive and convenient options for not stigmatizing the prisoner until the necessity or his willingness for special dormitory

custody could be determined, and (ii) a second New York case (*Baez* v. *Rapping*) in which the court, although dismissing a complaint against prison medical staff for issuance of a "medical precaution sheet" against dealing with an HIV-positive inmate's bodily fluids as a proper exercise of official functions which cloaked them with qualified immunity, refused to do so for the county warden (where it appeared that the inmate's segregation was for disciplinary rather than medical considerations). In the latter case, the prisoner was found to have a protected interest in notice and hearing for the segregation action (which he did not receive) and there was an allegation of malicious discrimination against the plaintiff inmate which was a question of fact that the inmate had a right to establish at trial.

As a cautionary note, none of these adverse rulings was a final trial determination but rather preliminary rulings that refused to support administrator judgment without a fuller review of inmate contentions. The cases may well have been settled or closed without full trial. Indeed, in the only fully tried case, testing virtually every constitutional claim imaginable against mandatory testing and segregation policies, the validity of a state mandatory testing statute, the curtailment of access by infected prisoners to regular treatment programs such as work release and even to law library facilities, and the applicability of Federal handicapped discrimination statutes to prison inmates, the court held for the prison administration in every claim (*Harris* v. *Thigpen*). Recognizing the legitimacy of plaintiff inmate rights in all of these areas, but also considering and balancing the interests of non-infected prisoners and staff and the reasonableness of restrictions imposed in light of the deadly threat of AIDS, the decision found all of the impositions to be reasonable and defensible and very much matters "best left in the hands of prison officials with the help and advice of their medical staffs."

Complaints About Failure to Segregate Infected Prisoners

Four Federal decisions have been issued involving complaints brought by prisoners in the general population, all challenging the failure of prison administrators to segregate HIV-positive prisoners or to test all inmates for AIDS or presence of the virus. In dismissing three of the cases outright (which originated in the Indiana, Arkansas, and Illinois prison systems), the courts found a failure of the plaintiffs to show or allege that the absence of segregation or comprehensive screening created a risk of contracting AIDS so great as to implicate constitutional rights (*Jarrett* v. *Faulkner, Glick* v. *Henderson,* and *Traufler* v. *Thompson*). They found no requirement for prison officials to respond to "unsubstantiated fears or ignorance regarding the transmission of AIDS" and one opinion noted no implication in medical guidelines to suggest that wholesale testing or segregation was necessary.

The fourth case in this category (originating in the Pennsylvania system) reached the same conclusion as to no need for routine testing and segregation of symptomatic AIDS patients or HIV-positive residents. However, the court found that the prison administration's refusal to test requesting inmates might be a "punishment which includes the unnecessary and wanton infliction of pain" by failing to relieve inmate anxieties. Consequently, that issue was allowed to go forward to proof while the general challenge to prison policies was dismissed (*Feigley* v. *Fulcomer*).

Thus, courts have recognized no right for inmates or others to require prison systems to routinely test for infection and segregate HIV-positive prisoners, a position very much in line with current knowledge about AIDS transmission and progressive institutional medical policy. However, a fifth case involved the unique circumstance of non-infected prisoners within the defendant state system joining forces as a class with prison administrators in successful defense of the mandatory testing, segregation, and program restrictions for HIV-positive inmates adopted by that system (*Harris* v. *Thigpen*). To this extent, it can be said that general population protests to "mainstreaming" have been considered and upheld in at least one significant court case.

Damages for Inadequate Medical Care

Three Federal cases have dealt with claims of inadequate treatment. In one of these, arising out of the Georgia system, the court found no "deliberate indifference" or violation of constitutional rights in denying access to private physicians and to experimental drugs (many of which were not FDA-approved) for HIV-positive prisoners. The court granted summary judgment for defendant prison officials, pointing out that mere negligence in treatment was not enough to establish a constitutional violation, that reasonable treatment and drug administration policies followed by the system were sufficient even if disagreed to by the plaintiff inmates, and that there was a valid security interest in restricting inmate drug use

(*Hawley* v. *Evans*).

The second case (*Maynard* v. *New Jersey*), was brought by the parents of an incarcerated son who died as a result of undiagnosed and untreated AIDS. While the court dismissed claims against the state on 11th amendment grounds (i.e., no Federal judicial power over suits against states by foreign subjects or citizens of another state), it denied similar action against the prison doctor and nurse who failed to either diagnose or properly treat the inmate's condition.

In the third case (*Botero Gomez* v. *U.S.*), the petitioner was in an advanced state of AIDS and asserted that the Federal prison authorities could not provide adequate medical attention at his confinement facility (even where this included regular referral to a hospital outside the institution). The court agreed and granted the prisoner's petition for release while awaiting determination of a post-conviction habeas corpus petition. It placed the petitioner on house arrest, coupled with electronic monitoring (which was currently being piloted in the petitioner's Federal judicial district in Florida).

Objections to Mandatory Testing

Prisoner lawsuits challenging mandatory AIDS-testing policies and legislation have not met with success in Federal lawsuits. In the two cases where this issue was raised, the courts held that non-consensual AIDS testing violated neither first amendment privacy rights nor fourth amendment search and seizure rights even conceding that risks of contagion in prison were no greater than in the general population. The legitimate interest of administrators in identifying HIV-positive inmates in order to meet agency treatment responsibilities, as well as the more remote (but not arbitrary or irrational) goal of preventing the spread of AIDS, was found to justify and outweigh expectations of prisoner privacy. Thus, mandatory testing based on administrative policies in the Oklahoma (*Dunn* v. *White*) and Colorado prison systems and a direct statutory mandate to test new inmates in the Alabama system (*Harris* v. *Thigpen*) were upheld and would probably fare similarly in other jurisdictions.

Restricted Participation in Employment and Training Programs

Courts have generally upheld correctional agency policies or actions limiting participation in work and rehabilitation programs by HIV-positive inmates. In the one Federal case directly on point (*Williams* v. *Sumner*), a Nevada system inmate brought a civil rights action for an injunction and damages when, after testing positive, he was removed from employment at a conservation camp under a "community trusty" work program. The court, in dismissing the inmate's complaint, found that (i) there was no independent constitutional right of state prisoners to employment of this kind and (ii) state laws providing for offender employment programs in prison and the community were not sufficiently mandatory in character (i.e., placed clear discretion in administrators to select and exclude participants) to create a protected interest on the part of inmates denied participation.

A few of the Federal "isolation" lawsuits brought by infected inmates alleged restricted access to work and training programs as part of the harm suffered in denial of alleged constitutional rights. These either found reasonable efforts by the correctional institution to compensate for such restrictions or accepted the exclusions as an offshoot of justified non-punitive actions to segregate HIV prisoners for institutional medical and security reasons. Some state court decisions have reached contrary results as to exclusion from work release programs although state courts seem to have consistently upheld denials of participation in conjugal visitation programs to HIV-positive inmates or inmates with AIDS.

Damaging Disclosure of Infected Status

The one area where Federal courts have shown an inclination in favor of prison official legal accountability has been the casual disclosure of HIV-positive status to inmates or individuals without a medical need-to-know. Thus, in a civil rights case arising out of the Wisconsin system (*Woods* v. *White*), the court found a retained constitutional right on the part of HIV-positive prisoners to confidentiality against unwarranted disclosure of medical records, especially in an area so personal and with such connotations of deviancy as AIDS infection. It also found that the casual conveying of such information by facility medical service personnel to non-medical staff and other inmates, without any claim of counterveiling public interest in so doing, could in no way be interpreted as within the scope of "discretionary function" of such personnel so as to support a qualified immunity defense.

Similarly, in a New York county jail case (*Baez* v. *Rapping*), although the court found immunity and no liability on the part of state prison and medical officials for alerting jail staff of the complaining inmate's HIV-positive status and suggest-

ing precautions, it refused to grant judgment against the county warden where it appeared that the casual disclosure of the plaintiff's status had been undertaken and segregation imposed without notice or hearing.

Also, in Connecticut, a Federal court, in a series of pretrial motions to a lawsuit challenging state system handling of inmates with AIDS, recognized that HIV-positive inmates had a privacy interest in non-disclosure of their identities and in certain medical and mental health records (*Doe* v. *Meachum*). Through the use of protective orders, that court limited disclosure to those with a legitimate need to know. The court also allowed the inmates to testify using fictitious names and, if desired, to wear physical disguises. However, it required testimony in open court (in recognition of first amendment public trial rights) and not in chambers or on tape as requested by the complaining inmates with AIDS.

Violence By and Against Infected Inmates

It is not surprising that AIDS-related or AIDS-aggravated tensions would give rise to violent episodes in confinement facilities. Indeed, the nature of prisons and the character of their occupants hardly require this complication as a trigger to violent conflict. Although the incidence of violent and predatory behavior with some AIDS-nexus is undoubtedly much greater than suggested by occasional lawsuits growing out of such incidents, two Federal cases pinpoint the kinds of issues and case resolutions to be expected in this area.

In one case (*Cameron* v. *Metcuz*), an inmate in the Indiana system sought to hold the officials of a state prison, (i.e., the superintendent, medical services director, and general services director) liable for failure to protect him from a biting attack by an HIV-positive inmate. After dismissing all claims against the defendants in their official capacities on 11th amendment grounds, the court found the prisoner's allegations could not support claims of deliberate indifference or gross negligence in preventing the fight that was necessary to sustain eighth amendment ("cruel and inhuman punishment") claims nor did general state legislation on reporting and preventing communicable diseases create a "liberty interest" in the complaining inmate to have officials isolate or otherwise restrict his HIV-positive attackers so that the biting incident could not occur.

The second Federal case in this area (*United States* v. *Moore*), establishes that an AIDS-infected inmate's deliberate infliction of a deep bite wound on two Federal correctional officers could give rise to criminal liability for "assault with a deadly weapon or dangerous weapon." Here, both the district and circuit court upheld a jury conviction for such assault (the dangerous weapon being the "mouth and teeth" of the infected inmate), finding that the issue of whether the human mouth and teeth are a deadly or dangerous weapon was a proper determination for the jury to make under the evidence of the case. The court emphasized, however, that such evidence was insufficient to establish the transmittability of AIDS through biting.

Conclusions

Five years of legal experience with AIDS control policies in prisons suggest that prison systems and their officials have been granted leeway and deference in measuring their management initiatives and policies against inmate civil rights. By and large, administrator actions have been sustained against inmate challenges on issues such as whether to segregate or not, whether to test or not, what kinds of medical treatment and prisoner protection policies are warranted, and even the extent to which participation in work and educational programs can be restricted for health and security management purposes.

The two areas in which Federal courts, faced with prisoner assertions of Federal constitutional and statutory rights violations, have shown a disposition to recognize the potential validity of such claims relate to (i) careless or unnecessary breaches of confidentiality as to HIV or AIDS status of prisoners and (ii) gross negligence, misdiagnosis, or mistreatment by medical personnel of inmates with the disease. Certainly correctional agencies should work to minimize these kinds of gaps in care as well as respond to the Presidential HIV Commission's injunction that "rights regularly accorded to all inmates. . . should not be abridged solely on the basis of HIV infection."

Beyond legal prodding, more needs to be done right now to bring correctional institutions in line with ACA guidelines and Presidential Commission recommendations, to move toward the Bureau of Prisons' approach to management of the AIDS problem, and to garner the resources necessary for proper care and treatment of HIV-positive inmates. Further developments in disease prevention technology may well narrow and sharpen perspectives on optimal and permissible institutional policies and practices. Thus far, however, it appears that both correctional administrators and the courts, working in a context of burgeoning

inmate population and heavy system overload, have taken their respective obligations seriously and moved responsibly, albeit not always unerringly, in attempting to address this serious threat to the stability of correctional institutions and the health of their public charges. May such endeavors be met with increasing success as the present resolves into the future and today's gaps in knowledge yield to tomorrow's insights.

Cases Cited

Judd v. *Packard*, 669 F. Supp. 741 (D.Md. 1987).
Powell v. *Department of Corrections, State of Oklahoma*, 647 F. Supp. 968 (N.D.Okl. 1986).
Cordero v. *Coughlin*, 607 F. Supp. 9 (D.C.N.Y. 1984).
McDuffie v. *Rikers Island Medical Department*, 668 F. Supp. 328 (S.D.N.Y. 1987).
Muhammad v. *Carlson*, 845 F.2d 175 (8th Cir. 1988).
Doe v. *Coughlin*, 697 F. Supp. 1234 (N.D.N.Y. 1988).
Baez v. *Rapping*, 680 F. Supp. 112 (S.D.N.Y. 1988).
Harris v. *Thigpen*, 727 F. Supp. 1564 (M.D.Ala. 1990).
Jarrett v. *Faulkner*, 662 F. Supp. 928 (S.D.Ind. 1987).
Glick v. Henderson, 855 F.2d 536 (8th Cir. 1988).
Traufler v. *Thompson*, 662 F. Supp. 945 (N.D.Ill. 1987).
Feigley v. *Fulcomer*, 720 F. Supp. 475 (M.D.Pa. 1989).
Hawley v. *Evans*, 716 F. Supp. 601 (N.D.Ga. 1989).
Maynard v. *New Jersey*, 719 F. Supp. 292 (D.N.J. 1989).
Batero Gomez v. *U.S.*, 725 F. Supp. 526 (S.D.Fla. 1989) (on appeal to 11th Circuit).
Dunn v. *White*, 880 F.2d 1188 (10th Cir. 1989).
Williams v. *Sumner*, 648 F. Supp. 510 (D.Nev. 1986).
Woods v. *White*, 689 F. Supp. 874 (W.D.Wis. 1988).
Doe v. *Meachum*, 126 F.R.D. 437, 442, 444, 450, 452, 456, 459 (D.Conn. 1989).
Cameron v. *Metcuz*, 705 F. Supp. 454 (N.D.Ind. 1989).
U.S. v. *Moore*, 846 F.2d 1163 (8th Cir. 1988), *affirming*, 669 F. Supp. 289 (D.Minn.1987).

Note: Statistics cited on the first page of the article were derived from *AIDS in Correctional Facilities: Issues and Options, 1989 Update* published by the National Institute of Justice.