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AIDS in Jail

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INTRODUCTION

One of the first institutions to feel the effects of the AIDS epidemic was America's jails. These institutions hold a high percentage of at-risk individuals, and have been forced to confront the AIDS epidemic before the general awareness of this tragedy occurred in the rest of American society. Accordingly, American jails served as a testing ground for institutional responses to the AIDS epidemic. The response of America's jails discussed in this article may be informative in shaping and reviewing the responses of other institutions to this tragic epidemic. Among the major issues which have been raised, and to some extent litigated, regarding AIDS and jails are: 1) mandatory testing or testing on demand, 2) segregation of HIV-positive or AIDS individuals, 3) the right to medical treatment including the use of experimental drugs, 4) privacy rights, 5) programs and services, 6) sentencing issues and enhancement problems, and 7) employment-related issues. These issues and the existing case law in this area will be discussed in this article.

I. JAIL DEFINED

This article addresses the AIDS related problems of America's jails as opposed to other correctional institutions.[1] For the purposes of this article, a jail is defined as a short-term holding facility, usually

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1. America has approximately 3500 local jail facilities ranging in size from those with a few beds, to the Los Angeles County area 23,000 prisoner system. AMERICAN CORRECTIONAL ASSOCIATION, NATIONAL JAIL AND ADULT DETENTION DIRECTORY (5th ed. 1990).

locally run and/or supervised.[2] Typically jails hold prisoners awaiting trial and those sentenced to no more than one year in custody. Although variances exist in this model,[3] to date, jails have not been used as long-term holding facilities. The transient nature of the jail population creates special problems for jail administrators in dealing with prisoners with special medical needs. The typically short stay of these prison populations further compound this problem.[4] Jails are generally the first point of entry into the criminal justice system for most individuals charged with crimes and often hold a substantial number of individuals in AIDS at-risk populations, including intravenous drug users and prostitutes. It is not unusual for jails to serve as revolving door institutions for such individuals because the total jail population may "turn over" five or more times each month. Jail officials are then working with relatively unknown clients whose stay in their institution will ordinarily be brief. These clients' medical conditions and degrees of dangerousness are often difficult if not impossible to assess during the individual's brief time in jail.

In recent years, the number of HIV-positive individuals entering America's jails[5] has vastly increased. Not surprisingly, therefore litigation involving "these special needs" prisoners has risen drastically.

II. LITIGATION IN GENERAL

Although a substantial amount of litigation has now occurred regarding the rights of prisoners with AIDS, few if any of these

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2. Most jails are run by the local county sheriffs, although a more modern trend is to have an independent county corrections department. Some are run privately, and two are state-run (Connecticut and Rhode Island) systems. *See* F. JANSEN AND R. JOHNS, MANAGEMENT & SUPERVISION OF SMALL JAILS (1978); ISSUES IN CONTRACTING FOR THE PRIVATE OPERATION OF PRISONS AND JAILS (U.S. DEPT. OF JUSTICE, NATIONAL INSTITUTE OF JUSTICE 1988, 1ST ed).

3. Some state legislatures have extended the possible length of stay in local jails to as long as 8 years (Tennessee) as a means of dealing with prison overcrowding. TENN. CODE ANN. §§ 40-20-103, 40-35-104, 40-35-314 (1991). This is likely to be a growing trend with similar legislation proposed in Texas and Florida in the past several years.

4. In an efficient criminal system, it is not unusual for the average length of stay in jail to be no more than a few days. Even in the most inefficient system, many detainees will be released within 48 hours. ANAY HAU & AWAN HENRY, Alleviating *Jail Crowding: A Systems Perspective*, N.I.J. (1985).

5. For the most reliable data on the numbers of such individuals see Theodore M. Hammett, *AIDS in Correctional Facilities: Issues and Options,* NAT'L INTS. JUST./ ISSUES AND PRACTICES 23-33 (3d ed. 1988); Theodore M. Hammett, *1988 Update: AIDS in Correctional Facilities,* NAT'L INST. JUST./ISSUES AND PRACTICES 14-17 (1989). This volume and its update are the basic U.S. Government officially sanctioned source books in this area.

lawsuits have been successful from the prisoners' point of view. Scott Burris, a lecturer at the University of Pennsylvania Law School, pointed out in his testimony before the National Commission on AIDS, that the nature of the law in this area severely limits the possibility of positive litigation results for prisoners. Mr. Burris suggested that prisoner rights are negative at best. For example, prisoners have a right *not* to be abused rather than in the positive right *to* good treatment or special conditions of confinement. He further noted that the courts have generally been weak in enforcing even these negative rights, in large part based upon the presumption of validity of the acts of jail officials.[6] If anything is clear from the modern trend of cases in this area, it is deference to the acts of professional administrators by the courts whenever possible.

At least since *Bell v. Wolfish*,[7] an almost unbroken string of cases have rejected any form of judicial activism in this area. Mr. Burris finally suggested that "truth," is difficult to find in a jail situation, making proof in these lawsuits particularly difficult and leading to the conclusion that, at least for now, any real change in the treatment of HIV-positive prisoners in an institutional setting will only come as a result of political, rather than administrative, decision making.[8]

III. Standards Relating to Jails and AIDS

Despite the lack of success in jail litigation (or perhaps because of it), this area has become one of considerable interest and commentary from a wide variety of sources. The American Bar Association, the American Jail Association, the National Prison Project of the American Civil Liberties Union, and others have adopted standards[9]

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6. *See e.g.*, Jarrett v. Faulkner, 662 F. Supp. 928, 929 (S.D. Ind. 1987). (In denying a prisoner AIDS suit, the court held that "[t]raditionally, federal courts have adopted a broad hands-off attitude towards problems of prison administration" (quoting Procunier v. Martinez, 416 U.S. 396 (1974)).

7. Bell v. Wolfish, 441 U.S. 520 (1979).

8. Testimony of Scott Burris, Staff Attorney, AIDS and Civil Liberties Project (ACLU of Pennsylvania) before the Nat'l Commission on Acquired Immune Deficiency Syndrome, Problems in Using the Federal Courts to Promote an Effective and Humane Response to HIV in Prisons (Aug. 17, 1991). In particular see Mr. Burris's "six remedies" listed on p. 4-5 of his testimony. Mr. Burris is also co-editor of *AIDS and the Law: A Guide for the Public* (1987).

9. *Policy on AIDS and the Criminal Justice System*, ABA HOUSE OF DELEGATES, resolution C (adopted February 7, 1989) [hereinafter ABA

regarding the treatment of HIV-positive or AIDS prisoners. Each of

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Recommendations]:

RECOMMENDATIONS CONCERNING CORRECTIONAL FACILITIES

1. Appropriately funded training and educational programs regarding HIV should be instituted in all correctional facilities.
2. Inmates in correctional facilities should be afforded appropriate medical care for the full range of HIV infections and should be afforded appropriate counseling services.
3. A prisoner should not be segregated from the general population of the correctional facility or be placed in other special areas solely because of the prisoner's known or perceived HIV status. Consequently, mass HIV-antibody testing should not be done for the purpose of segregating inmates in special areas or cells.
4. Unless an inmate consents, information about his or her HIV status should not be disclosed except to the warden, key supervisory staff who have a legitimate need for the information, or medical staff for purposes of care and treatment. Correctional authorities should draft, promulgate, and enforce specific rules governing who may have access to such information and who is responsible for the release of the information.
5. A prisoner should not be denied parole or temporary release, or barred from participating in other community release programs, solely because of the prisoner's known or perceived HIV status.
   (a) Where discretionary, temporary release is permitted by law, authorities may require pre-release disclosure of HIV positive test results to spouses and similarly situated persons as a condition of release.
   (b) Although parole or discharge should not be conditioned upon disclosure of HIV test results, prisoners scheduled for discharge should be encouraged to disclose their HIV status to their spouses or any similarly situated persons. Where a prisoner fails to do so, correctional authorities may notify appropriate public health authorities.

American Jail Association Resolutions, AMERICAN JAILS, Sept.- Oct. 1990, at 94. (approved by Board of Directors, April 30, 1989)[hereinafter AJA Resolutions].

AIDS

WHEREAS,AIDS is recognized as a serious health problem, and

WHEREAS,AIDS poses significant and special problems in a jail setting, and

WHEREAS,It is recognized that health care, testing, specific treatment methods and education related to AIDS are subject to constant change;

THEREFORE BE IT RESOLVED that the American Jail Association support the following guidelines and procedures with respect to AIDS in all jail settings:

A. Infection control and health precautions should follow the U.S. Public Health Service/Center for Disease Control "universal precaution" infection control procedures. These guidelines are based on an assumption that no person's blood or body fluids are safe.
B. Training of all corrections staff and prisoners is a critical, essential part of the management of health care. Training should be updated with current knowledge and should be recurring for staff and prisoners.

these standards calls for compassionate treatment of prisoners with respect to their special needs.[10] Further, much has been written to help jail staff and prisoners in dealing with AIDS. Available materials include a National Prison Project primer on AIDS[11] for inmates and officers as well as internal policy and procedure manuals for jails in dealing with AIDS in prisons.[12] These internal policy and procedure

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Ordinarily, training should be provided to prisoners upon admission and/or release from custody. Training should be varied, with the opportunity for questions to be answered by knowledgeable staff.

C. Jails should adopt procedures for HIV antibody testing. Such test procedures should reflect current public standards and legal constraints. Testing may be adopted to pursue effective medical management goals and to pursue inquiries into management questions about prevalence of the disease in the population. Confidentiality of testing results must follow current public health and legal standards. Ordinarily, disclosure of test results is limited to those with a need-to-know, based on medical, legal, and security concerns.

D. Treatment protocols should follow those issued by the Food and Drug Administration. Counseling for patients, and in appropriate circumstances for those in close relationship to them, is an important part of the treatment.

E. Management of AIDS requires a policy for housing those prisoners who are symptomatic and those who are asymptomatic. Prisoners who are HIV positive need not be separated unless medically indicated or unless there is a sound security or health-threat justification. Jails should have procedures and practices established to handle risk-situations such as body-fluid spills, altercations, CPR, and biting incidents. In addition to training, these may require special equipment and precise directions for handling these situations.

See also, ACLU Policy #268, Communicable Diseases and AIDS: AIDS in Institutions, April 11-12, 1987.

10. *See*, ABA Recommendations, *supra* note 9, recommendations 1-3, at 2; AJA Resolutions, *supra* note 9, resolutions B,D,E at 94-95. For example, in the area of medical care, both the ABA and AJA recommend appropriate medical care and counseling. *See* ABA Recommendation 2; AJA Resolution D. Segregation of . . . to prevent security or health risks. *See* ABA Recommendation 3; AJA Resolution E. Training and education . . . definite priority. *See* ABA Recommendation 1; AJA Resolution B.

11. ACLU NATIONAL PRISON PROJECT, AIDS & PRISONS: THE FACTS FOR INMATES AND OFFICERS (3d ed. 1990).

12. Broward County Florida Sheriff's Department Policy on AIDS in Jails (1989) (Internal Policy Manual). This policy is based on prisoner self identification at the initial jail medical interview and identifies AIDS as a chronic medical problem. "Asymptomatic prisoners are placed in general populations as are those with treatable symptoms unless segregation is required for prisoner safety. Those with severe symptoms are placed in the medical unit for treatment. The AIDS protocol lists specific treatment to be offered including the use of AZT if certain criteria are met

manuals have included policies on medical treatment, segregation and condom distribution,[13] to name a few.

IV. Specific Legal Issues Relating to AIDS and America's Jails

A. EMPLOYMENT ISSUES

A growing, but as yet largely untested area of AIDS litigation and concern is that of employment-related issues for jail staff. These issues include the perceived "dangers" of working with HIV-positive prisoners and the standards of employment for HIV-positive officers. In both cases, a balancing test must be applied contrasting the right to work (and to work in a safe environment) with employee safety and medical concerns.

As of this date, ten San Francisco Sheriff's deputies have died from the AIDS infection while in the employment of the Sheriff's Department. This fact has forced the San Francisco Sheriff's Department to confront this tragic and delicate reality in dealing with HIV-positive employees. The Sheriff's Department has adopted a policy in accordance with the basic tenets of the generalized right to continue work for all employees. In addition to this "right to work" issue, other issues confronting government employees regarding employees with AIDS are: 1) mandatory pre-employment testing, 2) on-going testing of existing employees, and 3) the right to medical treatment for this illness which has a considerable effect on insurance availability and rates.

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including positive HIV tests, a history of P.C.P. and a T.4 lymphocyte count of less than 200 per cubic mm."

The Sheriff's Department of San Francisco under the enlightened leadership of Sheriff Mike Hennessey has taken the national lead in establishing a comprehensive and humane policy for dealing with AIDS in a jail setting. This policy which deals with AIDS as one of many communicable diseases, specifically identifies procedures for: Communicable disease control, "all persons, sharp objects, and body fluids will be considered capable of transmitting a communicable disease"; San Francisco Sheriff's Department Policy on Communicable Disease Control, *Exposure Reporting and Management; and the Requesting (and Confidentiality) of Medical Information.* Sheriff Hennessey and Lt. Jan Dempsey of his staff were most helpful in providing information, advice and support to the author of this article.

13. Both New York and Georgia have rejected condom distribuiton proposals for prisons. *See* Bruce Lambert, *Albany AIDS Panel Assails Ban on Condoms to Inmates*, N.Y. Times, Sept. 16, 1989, at 30, sec. A, col. 5; Ron Taylor, *AIDS Panel Pleads for Condoms; Prisons Say No*, Atlanta Journal, Oct. 17, 1987, at 1, sec. B, col. 2.

San Francisco has taken the lead in the employment area by adopting a policy of treating HIV-positive employees as they would any employee with a long-term chronic illness (such as cancer).[14]

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14. The Civil Service Commission of the City and County of San Francisco Policy on AIDS adopted on May 2, 1988 reads as follows:

> It is the policy of the City and County of San Francisco Civil Service Commission to prohibit discrimination in the compensation, terms, conditions and privileges of employment on the basis that any employee or applicant for employment with the City and County:
>
> has, is perceived as having or has a history of having the conditions known as Acquired Immune Deficiency Syndrome (AIDS), Acquired Immune Deficiency Syndrome Related Complex (ARC), Human Immunodeficiency Virus Infection (HIV infection) or any medical signs or symptoms related thereto.
>
> The Civil Service Commission finds that AIDS, ARC and HIV infection are national and local health concerns not confined to any single community, the effects of which cut across all communities, impacting all arenas of life, including that of the employment setting. To provide assistance to City departments in managing this concern in the employment setting, the Commission establishes the following policy guidelines:
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> 1. The current and best medical evidence is that AIDS, ARC and HIV infection do not pose a threat of contagion or transmission from worker to co-workers through everyday contact common in the work environment;
> 2. AIDS, ARC and HIV infection are life threatening illnesses, which may be regarded as handicaps under prevailing local, state and federal law. Each individual responds differently to the illness in terms of ability to work. On this basis, as with all other handicaps, departments are required to make reasonable accommodations to facilitate the ability of employees with AIDS, ARC or HIV infection to continue working as long as they desire and are able to perform the essential functions of the job with accommodation;
> 3. Like all other medical information and records, the conditions of AIDS, ARC or HIV infection in an employee or applicant are subject to privacy protection and all employees have a right to the confidentiality of medical information. Departmental personnel having access to an individual's medical records or those having knowledge of a medical condition have a duty to preserve the privacy and confidentiality of the information. To that end, it is imperative that such information not be shared without the express and prior written permission of the individual having the condition;
> 4. In that employees with AIDS, ARC or HIV infection do not pose a threat of contagion to co-workers through everyday work place contact, the refusal by co-worker(s) to work with an individual having or perceived to have AIDS, ARC or HIV infection can be considered insubordination, subject to due process disciplinary action in consideration of the specific facts and circumstances of the refusal. Similarly, members of the public

Recognizing that modern medical treatment has resulted in extending the life of AIDS patients[15] and treating AIDS as a chronic, manageable disease which may for a long period of time remain dormant, the Sheriff's Department has ruled out any special treatment of generally healthy, HIV-positive deputies. Although some accommodation is made for those suffering from more serious manifestations of AIDS-related diseases, the Sheriff's Department policy is to treat these employees as unexceptionably as possible. In general, employees are kept in their typical position when identified as HIV-positive. Among the issues raised by this policy are the danger of exposure to other employees and prisoners and the danger of undue risk to HIV-positive employees by assignment to areas of the jail where they may be put in contact with individuals suffering from opportunistic diseases to which HIV-positive individuals may be susceptible. As a minimum, the Sheriff's Department requires officers identified as HIV-positive

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with AIDS, ARC or HIV infection pose no threat of contagion to City employees providing common public services and the refusal of any City employee to provide public service on this basis can be grounds for disciplinary action;

5. Departments must treat AIDS, ARC and HIV infection as they would any other life threatening illness and must therefore apply and comply with all Civil Service Commission rules which govern employee health, including but not limited to leaves of absence, disability transfers and medical examinations. Under no circumstances shall an employee or applicant be required as a condition of pre-employment or employment to undergo any tests to detect the presence of the HIV antibody, antigen or virus;
6. Employees who are affected by any life threatening illness should be treated with compassion and understanding. Department personnel should provide support and encouragement and foster, by example, an attitude of sensitivity to the needs of chronically ill colleagues, recognizing that continued employment and interaction in the work environment can be physically, mentally and emotionally beneficial. Similarly, such compassion should be shown to employees who have a family member or significant other who has AIDS, ARC or HIV infection;
7. Given that fears that AIDS, ARC and HIV infection often inspire, the most effective way to avoid disruption and discrimination in the work place is to prepare and educate all employees. In fostering a rational, compassionate and non-discriminatory understanding of AIDS, ARC and HIV infection in the work place, departments should implement educational programs. These programs should be based on the best available medical knowledge, resources for employee support and City and County policies and rules which apply to the issues of AIDS, ARC and HIV infection in the work place.

15. *See* Laurie Garret, *AIDS: Managing Infections*, N.Y. NEWSDAY, Sept. 4, 1990, (Discovery), at 3.

to provide the Sheriff's Department with the following information: (1) if their personal physicians are aware of their condition and employment and (2) if their physicians approve of their current work assignment. The Sheriff's Department, with the permission of the employee, will send the individual employee's physician a list of job tasks to determine if the tasks are consistent with the medical needs of the individual. It is the formal and reasonable policy of the Sheriff's Department to allow the employees to work in their positions as long as their health permits.

Problems which have arisen from this policy include the reality that many of these individuals will not be completely truthful with the Sheriff's Department and the considerable cost of hiring and maintaining the employment of HIV-positive employees due to the exceptional medical needs of these individuals.

Although there has been little significant litigation specifically related to AIDS and jail employees, the general tenets of labor law and labor arbitration undoubtedly apply as suggested by a Law Review article by Dean Roger Abrams at Nova University which considers the areas of universal new employee testing for AIDS, annual physical testing, suspect employee testing, insurance coverage, employee discharge, and reassignment and other employee complaints in this area.[16]

Although the trend to-date for litigation in the area of AIDS and jails has been prisoner litigation, it is certain that the next few years will find employee litigation regarding these previously mentioned issues.

B. TESTING

The short-term nature of jail population currently makes testing an unattractive and a probably worthless option for most jails. Typically, the length of time from testing to receiving accurate results exceeds the average length of stay in jail[17] and, accordingly, only voluntary testing appears to make any sense in a jail setting. Voluntary testing serves a public health function for those prisoners desiring to know their HIV-positive status as well as assisting in the identification of HIV-positive individuals and attempting to direct those individuals to appropriate counseling and treatment upon release. For a few

16. *See* Roger L. Abrams and Dennis R. Nolan, *AIDS in Labor Arbitration*, 25 U.S.F. L. REV. 67, 92 (1990) (discussing the evolving mediation role in dealing with HIV-positive employees).

17. The currently most used confirmatory test (the Western Blot) requires about a two week turnaround time and costs about $120 per test.

sentenced prisoners, as well, voluntary testing may provide valuable information for jails and prisoners to use. Most progressive jail systems and Departments of Health, following San Francisco's lead, have rejected mandatory testing and have identified individuals for testing on a case-by-case basis. Testing has been typically applied only to those showing definite symptoms of HIV-positive related illness.

In *Davis v. Stanley*,[18] a 1987 Alabama case, an inmate sued for damages under 42 U.S.C. § 1983 alleging "callous and deliberate indifference" to his health and well-being by "negligently plac[ing] the plaintiff in a cell with another inmate who was later diagnosed as having the disease known as Acquired Immune Deficiency Syndrome (AIDS). The complaint alleges that the defendant [sheriff] was negligent by not requiring all in-coming inmates to undergo physical examinations and tests before being placed in the jail populations."[19] The plaintiff went on to state that he had "shared a coffee cup and cigarettes with his infected cellmate."[20] Rejecting his claim, the District Court held the complainant "fail[ed] to state a legally sufficient ground for liability under 42 U.S.C. § 1983. . . . § 1983 liability may not be predicated merely upon a 'lack of due care.'"[21] The court pointed out "the plaintiff's own complaint, . . . alleges that the sheriff was unaware that the . . . cellmate had AIDS . . . . [T]he Sheriff . . . is in the best position to evaluate the need to test and screen incoming inmates for the presence of AIDS."[22] The ironic result of this decision is that the sheriff who practices benign neglect and chooses not to test is risking less liability than the sheriff who decides to test all inmates. The district court further pointed out, rather naively, that strict rules against homosexual activity and intravenous drug use will obviate the need for "the expensive process of screening and testing."[23]

Although the motivating philosophy behind a demand for universal testing was to segregate HIV-positive prisoners, such segregation seems to be falling into disfavor with most jail administrators. Further, the use of extensive testing can place a significant burden on the local facility, requiring extraordinary medical treatment for those

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18. 740 F. Supp. 815 (N.D. Ala. 1987).

19. *Id.* at 816.

20. *Id.* at 817.

21. *Id.*

22. *Id.* at 818.

23. *Id.* at 818-19. Not surprisingly in prison suits the decision to test or not to test has been left to professional administrators. *See*, Harris v. Thigpen, 727 F. Supp. 1564 (M.D. Ala. 1990)(global AIDS case *upholding* the use of mass testing).

prisoners so identified. (Conversely, this is also probably the best argument for upholding mandatory AIDS testing of *all* incoming and discharged prison inmates.) However, the expense and efficacy of short-term treatment, such as treatment with AZT,[24] leaves one to question the medical and economic viability of such universal testing. Tests themselves tend to be expensive, with basic ELISA tests running about twelve dollars a test and the Western Blot confirmatory test running as much as $120 a test, requiring about two weeks for turnaround time.

In the area of testing, although state laws regarding confidentiality and mandatory testing[25] may control, the courts have upheld almost any reasonable practice of professional jail administration, including mandatory, selective testing for high-risk individuals or absence of all testing.[26]

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24. Treatment for an AIDS infected prisoner may run $80,000-100,000 per year with a daily dose of AZT costing an average of $20.00 per day.

25. Johnetta J. v. Muncipal Court, 267 Cal. Rptr. 666 (1990).

Proposition 96 was enacted in the November 1988 California general elections and applies to three areas of possible AIDS transmission: 1) victims of sex crimes; 2) assaulted peace officers, firefighters or emergency medical technicians; and 3) employees of custodial facilities. *Id.* at 668.

In *Johnetta J.* a woman inflicted a deep bite wound to the arm of a deputy who was physically removing the woman from a child dependency hearing. The woman was ordered to submit to a blood test pursuant to Proposition 96. *Id.*

The constiutionality of Proposition 96 was challenged as an unreasonable search and seizure and an invasion of privacy. *Id.* at 674-75, 683. The court concluced that Proposition 96 did not violate the Fourth Amendment since the electorate of California recognized a special need for AIDS testing under certain circumstances which justified the minimal intrusion of blood testing. *Id.* at 680.

As to the privacy issue, the court stated that "the California right of privacy is 'not absolute' and may be subordinated to a compelling state interest. . . . Here the electorate has enacted a statute that finds public safety officers at risk from anxiety and fatal infection in the course of their duties." *Id.* at 683. In conclusion, the court held the state interest was sufficiently compelling to overcome a privacy interest. *Id.*

26. For examples of court holdings in prison testing cases *see* Jarrett v. Faulkner, 662 F. Supp. 928 (S.D. Ind. 1987) (a failure to test case deferring to the professional prison administrator); Feigley v. Fulcomer, 720 F. Supp. 475 (M.D. Pa. 1989) (a failure to test case *found* not to be deliberate indifference — interestingly this case raised the possibility that failure to test and a universal demand for good cause might under some circumstances be eighth amendment "punishment" and "unnecessary cruelty"); Dunn v. White, 880 F.2d 1188 (10th Cir. 1989) (a forced testing case alleging violation of religious convictions upheld testing — deferring to prison administrator absent substantial evidence that the administrators had overstepped their authority — and also rejected privacy argument. But note prisoner did not make a very good case for his religious opposition to testing); LaRocca v. Dalsheim, 467 N.Y.S.2d 302 (1983) (one of the first failure to test cases which denied relief because no known test for detecting AIDS was available at the time).

C. SEGREGATION

The segregation of HIV-positive prisoners is again an area in which the courts have deferred to the actions of professional administrative officials in determining whether or not individuals should be segregated based upon their medical condition.

Two cases upheld the segregation of HIV-positive and AIDS prisoners in jail facilities. The first, *Baez v. Rapping*,[27] a case arising in the Westchester County Jail, involved the isolation of Vitini Baez based upon a positive AIDS test. The U.S. District Court for the Southern District of New York upheld the action, finding qualified immunity for the medical staff. It commented, "[t]he Supreme Court has held that administrative segregation, segregation imposed for administrative and generally not punitive reasons, 'is something of a catchall' and is 'the sort of confinement that inmates should reasonably anticipate at some point in their incarceration.'"[28]

A 1987 case, *McDuffie v. Riker's Island Medical Dept.*,[29] likewise deferred to the judgment of the medical staff of the Riker's Island Jail in New York City. In this case, the prisoner sued for segregation resulting from the misdiagnosis of an AIDS-related ailment. Despite the fact that he was placed in segregated housing for five months, the court found that given the state of medical knowledge at the time of segregation (1982), the Riker's Island staff had not been shown to have behaved with "deliberate indifference to serious medical needs on the part of the defendants."[30] As previously noted by the court, "[t]he right of prison administrators to segregate inmates with AIDS has been upheld against challenges based upon the First, Eighth and Fourteenth Amendments."[31]

A tragic result of this segregation issue was the reputed initial placement of HIV-positive prisoners in the medical facilities in several jails. In these jails the prisoners were put in closest contact with other prisoners suffering from opportunistic diseases such as tuberculosis and therefore were exposed, albeit inadvertently, to the worst possible medical conditions, in light of their HIV-positive condition.

It is now universally medically accepted that relatively healthy HIV-positive prisoners pose little or no danger to general jail population. Absent some compelling reason for such segregation (for

27. 680 F. Supp. 112 (S.D.N.Y. 1988).
28. *Id.* at 115 (citing Hewitt v. Helms, 459 U.S. 460 (1983)).
29. 668 F. Supp. 328 (S.D.N.Y. 1987).
30. *Id.* at 330.
31. *Id.* at 330, (citing Cordero v. Coughlin, 607 F. Supp. 9 (S.D.N.Y. 1984)).

example, past violent behavior) there seems to be little justification for the segregation of AIDS or HIV-positive prisoners. The key issue in the decision-making process for a jail administrator is whether the HIV-positive individual is likely to do something which will place himself or other prisoners at risk. A positive decision in this area will provide, it seems, legitimate grounds to segregate these prisoners. Otherwise, placement in general prison populations makes medical and correctional sense.[32]

Obviously those individuals who are ill and in need of medical treatment should be placed in isolation, as well as being isolated from those with transmittable disease. It is possible that there may be liability for placing asymptomatic, HIV-positive prisoners with other prisoners who may be suffering from tuberculosis or other opportunistic diseases. In short, the most enlightened policy on segregation is to segregate HIV-positive inmates *only* for diagnostic or treatment reasons or out of concern for security purposes, but not based upon punitive desires or a generalized fear of AIDS. Even these segregated prisoners must, of course, be provided with approximately the same facilities as non-segregated inmates.[33]

Segregation may also result in the limitation of the prisoners' work assignment, denying HIV-positive prisoners the right to prime work assignments in the jail and the possibility of good and gain time for participation in those assignments. In particular there has been

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32. For two prison cases upholding administrators' positions on segregation *see* Muhammad v. Carlson, 845 F.2d 175 (8th Cir. 1988), which upheld the seven month segregation of a prisoner shown to be "Pre-ARC", referring to the prison administrator's decision in this case and holding that no liberty interest existed to be placed in any specific quarters in prison. *Accord*, Powell v. Dept. of Corrections of the State of Oklahoma, 647 F. Supp. 968, 970 (N.D. Okl. 1986), the United States District Court for the Northern District of Oklahoma upheld the segregation of an AIDS-positive prisoner, stating, a prisoner "does not have a Federal constitutional right to be placed in the general prison population . . . [a]s long as the conditions or degree of confinement is within the purview of the sentence imposed on him and is not otherwise violative of the Constitution, the Due Process clause does not subject an inmate's treatment by prison authorities to judicial review [citation omitted]. The decision to segregate Plaintiff from other inmates was based upon legitimate objectives to prevent the possible spread of a deadly infectious disease and to protect the Plaintiff from assault by other inmates."

33. *See*, Judd v. Packett, 669 F. Supp. 741 (D. Md. 1987), upholding the segregation of a prisoner for testing, diagnostic and treatment purposes. The court in *Judd* took notice of the fact that AIDS poses a threat to public health and correctly pointed out the danger of homosexual activity and drug use in prison, finding a legitimate government interest in segregating AIDS-positive prisoners for medical treatment and diagnostic purposes.

considerable unreasonable fear of HIV-positive inmates involved in food preparation and service. This fear, like many others surrounding AIDS, is not rationally based and should not be a factor in work assignments.[34] However, in some institutions at least, the danger of other prisoners' responses, including riot, to such placement has resulted in prisoner exclusion from food handling work assignments. The San Francisco Sheriff's Department has adopted a policy that all prisoners should be able to fill any work assignment roles within the institution, subject to their skills and medical fitness for that assignment.[35]

D. MEDICAL

The area of medical treatment for HIV-positive jail prisoners, which inevitably includes the right of privacy (and confidentiality) of

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34. *But see*, Farmer v. Moritsugu, 742 F. Supp. 525, 527 (W.D. Wis. 1990). A prison case upholding the denial of food service work assignment to a prisoner who had tested HIV-positive. Although the United States District Court for the Western District of Wisconsin pointed out that "[t]here were no reported cases of restaurant or hospital employees contracting the [AIDS] virus through casual contact with infected co-workers. . . ." and AIDS is "not transmitted through casual contact", the court upheld the prison administrator's decision to deny Farmer the right to a kitchen work assignment, "the decision . . . forbidding inmates who have tested positive for HIV from working in food service . . . is a classification that results in unequal treatment." However, this classification is rationally related to a legitimate governmental purpose. The purpose is to maintain security and order in the institution. "If inmates knew that an inmate who tested positive for HIV was working in food service . . . they might become concerned for their health or wellbeing. These inmates could either cause a disruption because of their fear or refrain from availing themselves of necessary services. Either of these outcomes threatens the order and security of the institution. . . ." *Id.* at 527-28. The purpose for the defendant's decision was not to prevent the transmittal of the disease but to maintain the security and order of the institution. *Id.* at 27. "Security and order are threatened by the inmates' fear of the transmittal of the disease and their actions based on this fear." *Id.* at 28. It is interesting to point out that the court's decision in this case is based upon the irrational fear of other prisoners rather than requiring the education of these misinformed prisoners.

35. For other segregation cases *see* Lewis v. Prison Health Services, No. 88-1247 (E.D. Pa. Nov 22, 1988)(LEXIS, Genfed library, Dist. File) (HIV-positive prisoners were housed in the prison infirmary and not allowed to eat, exercise, or attend religious ceremonies with the general prison population — Segregation upheld on the basis that no due process rights were violated); Brickus v. Frame, No. 89-2498 (E.D. Pa. July 24, 1989) (LEXIS, Genfed library, Dist. File) (The court held that inmates with AIDS were subject to administrative segregation from the general prison population. The equal protection clause was held not to apply because AIDS prisoners are not similarly situated to the general prison population and "there is no fundamental right of a prisoner to reside in the general prison population.").

these prisoners, is one of the few areas in which prisoner lawsuits have been partially successful.

Although there is no absolute right to a particular medical treatment, in general, all prisoners should enjoy the right to adequate medical treatment. Some cases suggest that there is a right to accepted medical treatment, now including AZT.[36] This right exists when the treatment has been recognized as effective by an appropriate authority such as the Centers for Disease Control. Treatments with drugs such as AZT are expensive, and there is some question as to their efficacy.[37] However, at the very least, medical care which avoids the standards of deliberate indifference is required[38] for jail prisoners.

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36. *See* Wilson v. Franceschi, 735 F. Supp. 395, 400 (M.D. Fla. 1990), which upheld the denial of AZT to a prisoner based upon a lack of knowledge of its effectiveness at the time of the lawsuit. In this case the court held that "it is the rare case in which a court should venture forth to establish medical procedures and guidelines in an area where the medical profession has not yet been able to ascertain what they should be," (citing Glick v. Henderson, 855 F.2d 536, 541 (8th Cir. 1988)). However, the court also said "intentionally denying or delaying [of] access to medical care [manifests a deliberate indifference as well as intentional interference with prescribed treatment]," (citing Estelle v. Gamble, 429 U.S. 97, 104-05 (1976)). In *Wilson* the court stated that the lack of knowledge regarding the effectiveness of AZT was determinative in its outcome in this case and its decision might well have been otherwise had the Centers for Disease Control recognized AZT as effective in the treatment of AIDS, something which occurred during the pendency of this lawsuit. Based upon this CDC ruling, it is quite likely that denial of AZT by jail authorities today will undoubtedly be found to be deliberate indifference on the part of jail administrators.

37. Elinor Burkett, *The Queen of AZT*, MIAMI HERALD (Tropic section), Sept. 23, 1990 at 8, col. 1. This article suggested that the basic testing on the efficacy of AZT as a treatment for AIDS may be fatally flawed by the primary researchers' desire for fame and financial gain being the motivating factor of the research. This article which discusses the enormous profit to be made from the sale of AZT also questions the close relationship of the primary researcher to the developer of this medication, Burroughs-Wellcome.

38. *See* Estelle v. Gamble, 429 U.S. 97 (1976) for the most comprehensive review of the right to medical treatment by incarcerated individuals. This 1976 U.S. Supreme Court case makes it difficult for prisoners to successfully maintain a § 1983 lawsuit for denial of medical care, absent outrageous conditions. In *Estelle* the Court concluded:

> that deliberate indifference to serious medical needs of prisoners constitutes the 'necessary and wanton infliction of pain' [citation omitted] proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury

However, this is one area in which it is likely there will be more and possibly even successful litigation. One New York state study[39] found that HIV-positive prisoners live as much as three times longer outside of correctional settings. This no doubt relates to both psychological and medical components. However, the failure to provide medical care adequate to meet the prisoners' needs, which may result in premature death, certainly can be seen as cruel and unusual punishment and deliberate indifference, providing jail management with the potential for considerable liability in this area.[40]

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states a cause of action under § 1983.

Id. at 104, 105.

However, the Court went on to say that:

> this conclusion does not mean . . . that every claim by the prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment . . . .
>
> Similarly, in the medical context, an inadvertent failure to provide adequate medical care cannot be said to constitute 'an unnecessary and wanton infliction of pain' or to be 'repugnant to the conscience of mankind.' Thus a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend 'evolving standards of decency' in violation of the Eighth Amendment.

Id. at 105-06.

39. Michael Wiseman, Staff Attorney, The Legal Aid Society, Testimony of Prisoners' Rights Project of the Legal Aid Society of the City of New York before the National Commission on AIDS (Aug. 17, 1990). Mr. Wiseman found that of the 400 deaths in the New York City jail system since 1981, the leading cause of death was AIDS. He went on to state of "120,000 prisoners who pass through the city's jails each year, estimates hold that 15,000 of them are seropositive." Because medical care for these infected prisoners beyond the ability and willingness of the city and the state to fund, Mr. Wiseman argues that it is criminally inhumane to continue incarceration of these individuals. He goes on to state, at 12, "because of the nature of HIV-related illnesses, even if adequate resources were available . . . many would still be consigned to die horrible and painful deaths in prison . . . it is imperative that the New York State Legislature enact some form of early release for dying prisoners with AIDS." He argues that early release of these prisoners would not only save significant sums of money for the state but also "would show the measure of our compassion as a society . . . State prisoners are sentenced to a term of years in prisons. For those thousands who are infected with HIV, their term of years often becomes a death sentence. It is both wasteful and cruel to force people to die in prison."

40. *See* Maynard v. New Jersey, 719 F. Supp. 292 (D.N.J. 1989), where the

V. PRIVACY

Related to the right to medical treatment is the right of privacy. The general dissemination of the prisoners' status by way of record notation, the assignment of a particular color uniform, or prison grapevine all deny a prisoner's basic right to privacy and are one of few areas which will clearly give rise to liability for jail administrators.

In *Doe v. Borough of Barrington*,[41] the court found a violation of the right of privacy of both the individual in question and his family members. When the prisoner was initially arrested, he told police that he tested HIV-positive and the officers searching him should be careful because of his current medical condition. In questioning neighbors, the local police revealed this information and advised the neighbors to "wash with disinfectant." Eventually this information became generally known in the local community and the patient sued claiming harassment, discrimination and humiliation: in short a violation of his right to privacy. The court held[42] that the local police had ignored all of the available information on the spread of AIDS and although finding that an individual's privacy interest in medical information was not absolute, the "government's interest in disclosure here does not outweigh the substantial privacy interests involved."[43] "Disclosure of . . . confidential information did not advance a compelling governmental interest preventing the spread of the disease." The court, finding an absence of proper training for police officers, which gave rise to liability, denied defendant's motion to dismiss the plaintiff's lawsuit, finding that the city had violated the context of the plaintiff's "constitutional right to privacy and the defendant's arrival under § 1983."[44]

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court partially upheld a cause of action for failure to provide medical treatment. *See also* Hawley v. Evans, 716 F. Supp. 601 (N.D. Ga. 1989) (HIV-positive prisoners who sought updated medical treatment or the right to be seen by a private physician were denied such requests because the prisons' medical policy was constitutionally acceptable and the medical care provided to a prisoner is not required to be perfect or the best obtainable); Gomez v. United States, 899 F.2d 1124, 1126-27 (11th Cir. 1990) (AIDS prisoner seeking habeas corpus relief for inadequate medical treatment would not be entitled to release from prison, rather the most relief that would be given would be an injunction against any practices found to be violative of the Eighth Amendment).

41. 729 F. Supp. 376 (D.N.J 1990).

42. *Id.* at 381-82.

43. *Id.* at 385.

44. *Doe*, 729 F. Supp. at 383 (citing Woods v. White, 689 F. Supp. 874, 876 (W.D. Wisc. 1988)) ("[T]he court held that prison officials who discussed the fact

It should be clear that an individual identified as HIV-positive has a strong right to privacy as to this information. The dissemination of this information should be only to those with absolute need to know, such as jail senior administrative staff and medical personnel. Nothing should be done to identify these individuals as HIV-positive to the general staff or prisoner population.[45]

One other interesting if untested issue with regard to confidentiality of medical information is whether prison officials have a duty to warn the public, spouse or employer when releasing an HIV-positive individual. At least one state has held that jail personnel can inform the wife but not others of this condition. However, one need only think of the case where psychiatrists have been sued for the violent actions of their patients to consider the potential for liability in this area. There must, of course, be a balancing between the right to privacy and the medical needs of the public and specifically-identified individuals.[46]

VI. EDUCATION

Perhaps the most effective tool in dealing with the challenge of HIV-positive prisoners is the education of staff and prisoners regarding this disease.

The San Francisco Sheriff's Department has developed an extensive staff training program regarding HIV-positive prisoners. All staff are given four hours of entry level training on AIDS before employment with the Sheriff's Department. The training describes AIDS and other infectious diseases, the prevention of these diseases and universal precautions against them. In addition, particularized training based

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that plaintiffs had tested positive for AIDS with nonmedical prison personnel and with other inmates violated the inmate's constitutional rights and could be held liable under § 1983. The court recognized the plaintiff's privacy interest in the information. The court stated that, to define the scope of the right to privacy in prison information, it must balance the individual's right to confidentiality against the governmental interest in disclosure . . . The Court noted that information about one's body and state of health is particularly sensitive and that such information has traditionally been treated differently from other types of personal information.")

45. *Contra* Harris v. Thigpen, 727 F. Supp. 1564 (M.D. Ala. 1990).

46. Price, *Between Scylla and Charybdis: Charting a Course to Reconcile the Duty of Confidentiality and the Duty to Warn in the AIDS Context*, 94 DICK. L. REV. 435 (1990); Heath, Jr., *A Hospital's Dilemma: The Legal Implications of Promulgating Guidelines Concerning HIV*, 23 U. RICH. L. REV. 39 (1988); Piorkowski, *Between a Rock and a Hard Place: AIDS and the Conflicting Physicians' Duties of Preventing Disease Transmission and Safeguarding Confidentiality*, 76 GEO. L.J. 169 (1987).

upon the tasks of specific jobs are developed and offered to the detention officers. Policies and procedures have been adopted for the staff to identify appropriate behavior and institutional needs.

Further, staff members are given an annual update along with their CPR training. In addition, supervisors are provided with personalized training in this area and updated on policies and procedures, and all officers are provided with training on special needs, such as the safe searching of prisoners.

Further, in San Francisco all prisoners are provided with education on AIDS, including at-risk behavior patterns, and safe sex. (As previously mentioned, condoms are provided by the Health Department for the prisoners in the jails.[47]) Additionally, information is provided for prisoners on proper cleaning techniques for needles and an extensive library of films, most of which are quite graphic. Finally, upon release from the jail, prisoners are provided with "graduation packets," including referral phone numbers, condoms and bleach solutions.

While some may shy away from such graphic and realistic treatment of the needs of prisoners, it could be argued that anything less would be a criminal abrogation of responsibility given the lifestyles of individuals found in and being released from America's jails.

VII. RESOURCES

AIDS in jails has long been recognized as an important problem. A significant amount of resources is available to those interested in developing informed policies in this area. In fact, there is so much information now that one is overwhelmed by the information. For example, the National Institute of Justice has published a series of volumes on AIDS in correctional facilities as well as on other individual topic areas relating to this issue.[48] These publications, which are updated annually, provide significant information on testing, medical correctional management and litigation, labor relations, housing, correctional management, policies, precautions, at-risk populations and education.[49]

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47. Condoms are provided one at a time and individuals are counseled as to appropriate behavior before provided with condoms. City and County of San Fransisco, Department of Public Health Forensic Services, *Policy and Procedure Manual*, XXV-25 (May 30, 1989).

48. Theodore M. Hammett, *AIDS in Correctional Facilities: Issues and Options*, NAT'L INTS. JUST./ISSUES AND PRACTICES (3d ed. 1988).

49. *See Research in Action*, a bi-monthly publication of the National Institute of Justice.

The American Civil Liberties Union's National Prison Project has also published a substantial number of publications in this area, including the 1990 prison bibliography which discusses prison and jail issues involving AIDS, including: confidentiality, segregation, testing, medical care, consent decrees, staff issues, work release, and family visits, which list state legislative policies in this area as well as educational materials on AIDS.[50] Numerous law reviews,[51] newspaper articles,[52] and publications by groups including the National Lawyers Guild and National Gay Rights Advocates[53] and the ABA Judicial Administration Division[54] have addressed these issues as well.

SUMMARY

Although HIV-positive jail prisoner litigation in areas other than privacy rights has been quite limited and mostly unsuccessful to date, advancements in medical treatment may eventually affect even the

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50. *See generally* the National Prison Project Journal, a quarterly publication of the American Civil Liberties Union Foundation, Inc.

51. Tanya L. Banks & Roger R. McFadden, *Rush to Judgment: HIV Testing Reliability and Screening*, 23 TULSA L.J. 1 (1987); Lynn S. Branham, *Opening the Bloodgates: The Blood Testing of Prisoners for the AIDS Virus*, 20 CONN. L. REV. 763 (1988); Thomas A. Coughlin, *AIDS in Prisons: One Correctional Administrator's Recommended Policies and Procedures*, 72 JUDICATURE 63 (1988); Larry Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health and Civil Liberties*, 49 OHIO ST. L.J. 1017 (1989); Irene Lambrou, *AIDS Behind Bars: Prison Responses and Judicial Deference*, 62 TEMPLE L. REV. 327 (1989); Note, Thomas R. Mendicino, *Characterization and Disease: Homosexuals and the Threat of AIDS*, 66 N.C. L. REV. 226 (1987); Wendy E. Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53 (1985); David Robinson, *AIDS and the Criminal Law: Traditional Approaches and a New Statutory Proposal*, 14 HOFSTRA L. REV. 91 (1985); Rubenstein, Book Review, 98 YALE L.J. 975 (1989); Richard H. Sinkfield and Terry L. Nouser, *AIDS and the Criminal Justice System*, 10 J. OF LEGAL MED. 103 (1989).

52. *See generally*, Time Out; Staff, *AIDS Units Lie Empty,* TIME OUT, Sept. 26, 1990, at 9, col. 3; Catherine Pepinster & Denis Campbell, *Behind Closed Doors,* TIME OUT Oct. 3, 1990, at 12, col. 1; N.Y. Times News Service, *$875 million AIDS-care bill would include San Juan*, SAN JUAN STAR, Aug. 5, 1990, at 10; Paul Marcotte, *New Disabilities Law*, A.B.A. J., Nov. 1990, at 21, col. 2.

53. PAUL ALBERT, ET AL., AIDS PRACTICE MANUAL: A LEGAL AND EDUCATIONAL GUIDE, National Gay Rights Advocate and The National Lawyers Guild, (2d ed. 1988).

54. C.C. Torbert, Jr., *The Challenge AIDS Poses to the Courts*, JUDGES' J., Spring 1990, at 2; Richard T. Andrias, *Shed Your Robes: Three Reasons for Aggressive Judicial Leadership with the HIV Epidemic*, JUDGES' J., Spring 1990, at 4.

courts most reluctant to intrude on the area of professional correctional administration.

However, even without litigation, intelligent and humane jail management require an awareness of the issues relating to HIV-positive prisoners and attention to the special medical needs of this population group. Few jails in America are unaffected by this compelling problem, and the adoption of enlightened and humane standards and policies can allow an informed and proactive approach to dealing with this tragedy of epidemic proportions.