MANAGEMENT OF HIV INFECTION IN NEW YORK STATE PRISONS

New York State Department of Health - AIDS Institute

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MANAGEMENT OF HIV INFECTION IN NEW YORK STATE PRISONS

Introduction and Summary

The scourge of AIDS, like other miseries, is intensified and magnified in prison. Currently in New York State's prisons over 200 inmates per year die of AIDS related illnesses. Prisoners with AIDS appear to constitute a disproportionate percentage of the prison population; they receive less care and seem likely to die sooner than comparable groups outside. This epidemic has underscored dramatically, and made more urgently unacceptable, the pre-existing deficiencies in medical care in prison. The principles that must guide us are clear. Winston Churchill, never inappropriately tender, observed that the quality of our civilization is shown by the way we treat our prisoners. The Supreme Court has decreed that basic, decent medical care in prison is commanded by the Constitution. The recommendations in this report are informed by these precepts and are meant to assist the State's responsible officials in their challenging task of implementing them.

I. The Provision of Services Generally

We recommend that the Department of Correctional Services (DOCS) remain charged with the provision of health care services in the prisons and we appplaud, as vitally necessary, the appointment of an outstanding physician as Chief Medical Officer and Deputy Commissioner for Health Services. At the same time, there is a central role for the Department of Health (DOH) -- to

assist, evaluate and monitor the process of change and improvement. The two departments should collaborate in designing and implementing a strong quality assurance program.

Recognizing the nearly insuperable problem of recruiting and keeping well-qualified professionals as prison medical staff, we recommend that prison health services rely primarily on outside contractors. Here, again, cooperation of DOCS with DOH is essential for setting standards and monitoring medical providers.

Decent medical care calls for adequate funding. New York appears to lag in this respect when compared with such states as California and Illinois. The State must appropriate and spend for its rapidly growing inmate population amounts sufficient to ensure decent care for all stages of HIV infection as well as other medical disorders.

II. Acute Care and Long-Term Care

To serve the increasing need, we recommend that DOCS create two new secure hospital wards, one in New York City and one upstate, to be administered by existing medical centers. These facilities should be approved by the Joint Commission for the Accreditation of Health Care Organizations. In addition, to project and provide for long-term needs, DOH and DOCS should conduct a suitable study or studies of incidence and prevalence.

To allocate resources effectively, maximum care facilities should not be misused for inmate patients requiring less intensive care. For such inmates DOCS should establish both Skilled Nursing Facilities and Health Related Facilities.

While it is likely that most bed capacity in the foreseeable future will be employed for cases of illness caused by HIV infection, we recommend that neither long-term care nor acute care facilities be AIDS specific. This is in line with our opposition to segregation of prisoners with AIDS.

III. Interagency Collaboration

In addition to the recommended collaboration between DOCS and DOH, there is need for cooperative work of both these agencies with the Department of Mental Health. Among the goals of such inter-agency cooperation should be the encouragement of providers to take on treatment of a disfavored population and the setting of suitable standards and rates of reimbursement for such treatment.

IV. Integration

We recommend generally against the creation of, or any attempt to create, segregated facilities for HIV positive inmates. Recognizing that non-segregation entails its own problems, we note the attendant needs for appropriate counseling, testing and education as well as the training of medical staff to identify early symptoms.

V. Clinical Trials

We recommend that prisoners be eligible for clinical trials. With the blurred line between treatment and research in the swiftly changing understanding of AIDS, denial of such access is punitive and unjustifiable. The problem of informed consent is, of course, profoundly difficult in prison. But neither this concern nor any other warrants exclusion of people in prison.

VI. Release of the Terminally Ill

Without limiting it to AIDS, it is our recommendation that all terminally ill inmates, if they pose no danger to society, should have opportunities for release so that they may die outside of prison. Provisions for such release call for sensitive judgments as to life expectancy as well as potential danger, but these are obviously manageable. On the other hand, prisoners for whom there is no other place to go should be able to spend their last days in conditions of reasonable dignity and minimal discomfort. We recommend the creation of a hospice or hospices in prison for this purpose.

VII. Substance Abuse

We recommend the establishment of drug treatment centers under the Prison Health Service in all state prisons. The close connections between HIV infection and drug abuse are well known. Given this fact and the nature and accessibility of the prison

population, there is compelling reason to reach and treat the drug abusers in this population. Many of them are likely to be receptive. Conquering addiction is a crucial need if they are to have a future outside. The opportunity to serve that need should not be neglected.

VIII. Mental Health Needs

HIV or AIDS brings with it an array of mental health needs, aggravated by incarceration. We recommend that suitable programs and personnel be available for psychiatric consultation as well as appropriate staff training to understand and deal with the mental health problems.

IX. Women with HIV Infection

Women in prison have a number of special problems connected with HIV infection. We recommend appropriate attention to such problems, including education about perinatal transmission and the effects of substance abuse during pregnancy. An array of other measures are required -- for example, to deal with gynecological disorders and the varied concerns attending pregnancy, childbirth and abortion for female prisoners.

X. Condoms in Prisons

Much, and perhaps excessively, discussed, the question of giving or allowing condoms to male prisoners undoubtedly calls for consideration and resolution. We recommend that the Commissioner

of Health determine whether transmission of HIV infection is in fact occurring in the prisons. If the answer is yes, condoms should be made readily available, preferably as government issue, or at least as items legitimately mailable to prisoners. Other jurisdictions, here and abroad, have allowed distribution or receipt of condoms without visible adverse consequences.

XI. Autonomy in Medical Decision-Making

Respect for the autonomy of patients, only recently highlighted for lay people generally, is a particularly acute need in prison. Recognizing the many obstacles to voluntary free choice for prisoners, we recommend that special attention be paid to creating conditions for autonomous decisions by prisoners, including decisions on the acceptance or rejection of medical care. Appropriate procedures and people must be found to ensure as nearly as may be that such decisions are indeed voluntary, a condition that may not be readily discerned in a prison setting.

XII. Education and Prevention

We recommend that DOCS provide HIV education for both staff and inmates that is culturally appropriate, accurate and intelligible. Intelligibility requires at a minimum that communications be available in Spanish as well as English. The education must cover all means of HIV transmission.

XIII. Prisoner Involvement in Education

While the ultimate responsibility for education is that of DOCS, prisoners should be engaged in developing curricula, in the teaching process and in peer counseling programs. The AIDS Counseling and Education (ACE) program at the Bedford Hills prison for women exemplifies the high potential of prisoner-inititated programs of peer counseling and training.

XIV. Educating Correction Officers

We recommend that DOCS and DOH organize programs of education, counseling and testing for correction officers and their families. The officers have acute needs to understand how HIV is <u>and is not</u> transmitted; how to protect themselves and avoid unfounded fears; how to respect rights of confidentiality; and, broadly, how to understand and deal with the medical and emotional needs of prisoners exposed to or afflicted with HIV infection.

XV. Counseling and Testing

Recognizing the constraints and limits of the prison environment, we recommend that confidential and anonymous counseling and testing be made available to prisoners to the maximum feasible extent. The creation of suitable procedures and record-keeping systems is a daunting task. We urge that every effort be made nevertheless to serve the interest of inmates and society as a whole in effective counseling and testing.

XVI. Conjugal and Family Visits

We recommend that HIV positive persons should be permitted to participate in conjugal and family visits, and that all participants in these programs should be provided with education about HIV infection.

The Problem in Broad Outline

AIDS, the last stage of a spectrum of disease caused by the human immunodeficiency virus (HIV), is an infection without precedent in contemporary society. Especially in the New York State prison system, this is an epidemic with possibly catastrophic consequences. AIDS was first recognized as a distinct disease complex in 1981. Within the New York State prison system the first cases were diagnosed also in 1981. As of July 1989, 966 inmates had been diagnosed in the New York State prison system. This number may represent 1/2 to 1/3 of the actual incidence.

Anonymous blind seroprevalence studies, conducted by the New York State Department of Health (DOH) on male inmates mainly from the New York City area entering the system in December 1987 - January 1988, and on all women entering the system in September - December 1988, indicated a 17.4% seropositivity rate among males and 18.8% among females. This is probably not an accurate reflection of entering serology status in 1989, which is inferred to be significantly higher.

An informal projection done at the request of this committee by the Division of Epidemiology of the New York State Department of Health projects 553 new cases of AIDS in the year 1992, with a cumulative incidence by that year of 2856. Dr. Robert Greifinger, the newly appointed Deputy Commissioner for Health Services and Chief Medical Officer for the Department of Correctional Services (DOCS), estimates that in the fall of 1989 approximately one inmate per day was dying of AIDS related illnesses.

The problems with health care delivery in DOCS preceded HIV infection. AIDS has magnified these deficiencies, as a population which previously appeared relatively healthy (but was even before AIDS significantly less well than a matched unincarcerated cohort), with a very high percentage of IV drug users (variously estimated at 50 to 80%), begins to develop symptoms of HIV infection.

Delivering medical care in a prison or jail requires coordinating the correctional requirements of custody, control, and punishment with the medical model of diagnosis, care, and treatment. It is natural in secure facilities for coordination to evolve subtly into subordination; in a conflict between security interests and concern for an inmate's well-being, the former is generally destined to predominate. Security concerns form the basis for prison administration. There is inevitable conflict between these imperatives - - one, to protect inmate populations and correctional staff from danger and, two, to provide care

according to the humanitarian principles of health care providers. Delivering decent and appropriate health care in prison requires knowledgeable medical professionals to set rules that define medical responsibility and to negotiate the realistic implementation of those rules in a correctional setting.

Because delivering health care in a correctional setting is complex and arduous, and because prisons are uninviting for medical professionals, it has always been difficult to recruit and retain quality medical staff. Reasons usually presented include the following: First, health care professionals, especially physicians, are accustomed to authority and control in the conduct of medical practice. Second, the setting of a correctional health facility is usually dismal and uninviting. Third, as the inmates are segregated from the general community, so too are the professionals who work there. Given the priority of security concerns, the institution constrains, if it does not actually confine, caregivers as well as inmates. For these and other reasons, prison health services until quite recently employed in general less well trained and less able professionals.

Since 1976 the problems of medical care in prisons have been somewhat ameliorated by a key decision of the U.S. Supreme Court which held that inmates possess a Constitutional right to health care protected by the Eighth Amendment. The Supreme Court reasoned that to place inmates in a prison or jail, where they could not

secure their own care, and not to provide that care, could result and had resulted in the kind of punitive pain and suffering the Eighth Amendment was designed to prohibit. The court stated: "Deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain...proscribed by the Eight Amendment." (Estelle v. Gamble, 429 U.S. 97, 104-105 (1976)). Since 1976, numerous constitutional proceedings in the Federal Courts have revealed serious deficiencies in the ability of correctional institutions in many states to deliver adequate health care.

In New York State reports of monitoring agencies and oversight organizations, and surveys commissioned by the state itself, demonstrate serious problems with the medical care of inmates, especially those with HIV infection and AIDS. There has been serious criticism of the DOCS health care system from, among others: 1) The New York State Commission of Correction: Special Needs Management of AIDS in the Department of Correctional Services (June 1988); 2) The Correctional Association of New York: AIDS in Prison Report (June 1988); 3) The Association of the Bar of the City of New York: "AIDS and the Criminal Justice System" (September 1989); and the 4) The Legal Aid Society.

In addition, the State Department of Health, with the help of surveyors expert in prison health care, reviewed the health services in ten prisons in 1988. The prisons reviewed presented

health service systems that ranged from "acceptable" to "deplorable." We note that this survey was courageously requested by Commissioner Coughlin.

In response to criticisms from the Legal Aid Society, which were presented to this committee, Dr. Griefinger has acknowledged the following broad areas in the health services in DOCS where improvement is needed:

-- Medical records and information systems
-- Quality assurance programs
-- Programs to educate, update and guide health professionals
-- Role definition among health professionals
-- Access to community facilities
-- Access to referral specialties in a timely manner
-- Staffing

In a study reported by the State Commission of Correction (Acquired Immune Deficiency Syndrome: A Demographic Profile of New York State Inmate Mortalities - September 1987 Update), inmates with AIDS survived an average of half as long as intravenous drug users with AIDS, a comparable population, in the community. In addition, Albany Medical Center found that inmates with a first case of pneumocystis carinii pneumonia (PCP), the most common AIDS opportunistic infection, had a 22% mortality rate compared with an 8% rate among community patients. Finally, the report of the

Correctional Association indicated that 25% of inmates with AIDS were not diagnosed until autopsy.

Recent reports in the scientific literature demonstrate that reforms in prison health care delivery are essential. It is now clear that primary prophylaxis for asymptomatic HIV infected persons can significantly postpone the onset of the opportunistic infections that mark advanced HIV infection. This evolution makes it more critical than ever that the prisons have health care delivery systems staffed by educated and skilled professionals who can provide appropriate care to HIV positive persons.

The following recommendations reflect the committee's review of evaluations and surveys of health care in DOCS, its discussions with persons involved in prison health care, both in New York State and other states, and its deliberations on these serious issues. Our recommendations will require action by DOCS, DOH, the Department of Mental Health and the Division of the Budget as well as enhanced oversight by the Commission of Correction. They will require the cooperation of community hospitals, academic medical centers and designated AIDS care centers. Without dramatic changes, the New York State prison system could become a charnel house in which inmates sentenced to reform and punishment are consigned to a tragic and hastened death, in pain and isolation.

I. Services

1) Authority

We recommend that health care services be structured, administered and supervised by a special medical authority within DOCS. As previously noted, the Department of Correctional Services has recently appointed a physician with medical administrative experience as the Chief Medical Officer and Deputy Commissioner for Health Services, reporting directly to the Commissioner. This action would have been the first of our recommendations. The Chief Medical Officer must have clear authority, an adequate budget, and the strong support of the Commissioner of DOCS to correct longstanding deficiencies.

This position is a pre-requisite for change and planning and administering an effective correctional health care service. We are heartened that DOCS has recognized the need and taken the first step toward remedying a clearly inadequate health care delivery system.

There are two agencies that could theoretically be responsible for prison health services, DOH or DOCS. DOH, like all state health departments, has certain duties and responsibilities that would naturally prepare it to function as the primary medical authority in the state prisons. It is responsible for state-wide performance standards for health facilities; state-wide personnel standards; supervisory and regulatory activities (including

surveillance and evaluation of personnel); review of health care plans for facilities; monitoring of laboratory services (inspections and enforcement); technical assistance; health education; and some direct patient care, especially for sexually transmitted diseases and tuberculosis. Most of its activity is in the area of regulation, technical assistance and public health oversight.

DOCS is charged by the state with the care and custody of inmates. Care for their medical needs falls naturally within this statutory mandate, especially since inmates have a constitutional right to health care. The provision of decent prison health services inevitably becomes a matter for negotiation. Correctional staff must accommodate response to an inmate's medical needs to the schedule, structure and programs of the correctional facility. Sick-call, ambulatory clinics, and consultant appointments require that inmates have access to the medical area that the security staff may decide to restrict for any number of reasons. Security considerations in general dominate competing interests. An effective medical authority must bridge these differences, resolve conflicts of authority and remain flexible to reschedule if required. These tasks are most easily accomplished when there is a good working relationship between the health and security staff, and this is best effected when both, at least at the highest level, are part of the same authority. Indeed, since security concerns are always paramount, the Commissioner of DOCS must provide strong

and consistent support for health care delivery strategies in the semi-autonomous individual prisons throughout the state.

The New York State prison system is continuing to expand. It will be least disruptive to the major improvements that must occur in prison health care services if these services remain in DOCS rather than shift to an entirely new authority.

Despite our recommendation that DOCS retain the authority over health care in the prisons, we further recommend that DOH monitor and evaluate the reforms and improvements that the present serious situation demands. If the new health service system in DOCS falls short of realizing substantial improvement in 18 months, authority for provision and oversight for health care services should be transferred to DOH.

We urge DOH, in concert with DOCS, to design and implement a strong quality assurance program in conjunction with the AIDS designated care hospital system. The same clinical criteria as the standards of practice in the AIDS centers should be the basis for evaluating the quality of care in DOCS facilities. DOH possesses the requisite skills and experience needed to assist DOCS in this mammoth program effort. The units of DOH that could be specifically helpful to DOCS are those concerned with technical assistance, epidemiology, health education for inmates and DOCS staff, staff training for medical personnel, monitoring of

laboratory services, HIV testing and counseling, primary care and pharmacy. This recommendation and the others in this report will require increased authorization of funds to DOH and DOCS.

2) Staffing

We recommend flexible arrangements for staffing prison health services that rely heavily, or even exclusively, on the negotiation of outside contracts.

DOCS must assess its staff needs as quickly and as accurately as possible, given the likely exponential rise in projected numbers of inmates with symptomatic HIV infection in the next few years. We recommend that DOCS adopt a flexible approach to staffing which depends in large measure, or exclusively, on contracting out services. In general, many states have found that contracts with existing health care systems, HMO's, PPO's, academic medical centers, and for profit prison health provider corporations have been useful in upgrading the quality and capability of staff.

Many state correctional systems have decided that attempting to provide services directly with professionals employed directly by DOCS increases the difficulty of hiring qualified personnel. Qualified health care professionals, especially physicians, are generally not eager to work full-time in a prison system for the salary level a correctional department can offer within the usual civil service guidelines. In addition, health care professionals

hired directly by DOCS are not provided with opportunities for continuing medical education, specialty consults, admitting privileges at community, secondary, and tertiary hospitals, and support from colleagues to the same extent as physicians based in the community.

Therefore, we recommend that DOCS contract out medical services and have non-correctional medical personnel based in the community assume responsibility for care whenever possible. When impossible, competitive salaries for full and part time professional staff will be essential to recruit and retain dedicated and competent individuals working in a setting that is commonly viewed as unattractive. In general, adquate salaries can only be created within sub-contracts to provider agencies.

Health care delivery directly by DOCS staff should always be the last option considered and should never be contemplated until there has been a clear demonstration that all other possibilities have failed. This strategy should attract more capable physicians to prison practice. In addition, physicians who are not DOCS employees will be more independent of prison norms and less constrained by prison practice.

At the same time, the option of providing services through contract must be carefully monitored. The contractor, usually on a fixed reimbursement schedule, may well be tempted to minimize

health care resources, depriving inmates of needed interventions in order to maximize profit. This danger calls for strict accountability provisions that include ongoing review of needs and expenditure. Such oversight systems currently exist in other state correctional provider contracts.

Some contract systems create other dangers if they rely heavily on the rotation of staff from community facilities. These rotations may result in excessively high physician turnover rates, disrupting continuity of care. These problems can be reduced by formal review processes conducted by DOCS staff and the community health care providers based on clear and comprehensive, problem oriented medical records systems.

Recognizing that each possible choice entails some problems, we conclude that DOCS will be able to provide adequate care most effectively by contracting out services to provider agencies that will assume primary responsibility for care although the ultimate responsibility for care must remain with DOCS. DOCS should also consider contracts with provider agencies that will supply full time staff. These contracts have advantages over direct hiring practices and permit flexibility in creating a competitive salary range and in monitoring performance.

Whenever a non-incarcerated person is suspicious of the loyalty, confidentiality and skill of a physician he is free to

seek an alternative caregiver. An inmate has no comparable choice -- he is compelled to use the physician provided by the facility. Hence, to the degree that the physician is under a general contract and not tied through salary and supervision directly to the prison administration, she may be better situated to protect inmate confidentiality and to advocate aggressively for the patient.

Physicians hired directly by departments of corrections often come in a short period of time to consider as a first concern the efficient functioning of the system. This is understandable, but regrettable. The more independent a physician is, the less likely he or she will be to succumb to administrative pressures to reduce expenditures, inconvenience and security risks, notwithstanding consequences to the well-being of the individual inmate. A more independent physician is better situated to argue for the complex medical needs of the inmate-patient.

Contracting out medical care services will compel DOCS, working with DOH, to scrutinize competing providers initially, to screen applicants, and to decide which provider offers the best mix of services at the best price. It will also require DOCS to develop a rigorous monitoring and evaluation system to assess performance at regular intervals. These initial and ongoing reviews provide the incentive and the framework for a quality of care audit process. Since DOCS will be investigating a contractor and not its own performance, it is more likely to uncover

deficiencies. DOCS will not be able to negotiate these contracts without technical and strategic support from DOH. DOH should identify possible licensed state providers and assist in negotiating contracts. It could help in expanding the mission of community hospitals and clinics to include some responsibilities for local prison health programs. DOH could also help evaluate bids if corporate agencies from outside the state compete for contracts.

Contracting agencies would be free to reverse the present state policy which restricts the reimbursement of consulting specialists in the prisons to the Medicaid fee schedule. Medicaid rates are clearly inadequate to attract qualified professionals to a prison setting. Any sub-contracts must ensure that all physicians, including those called on to provide emergency consultations, are adequately and fairly reimbursed.

3) Funding

We recommend that New York State spend an amount per inmate sufficient to insure that incarcerated persons receive decent and humane care for all stages of HIV infection.

New York State now spends $1,560 per inmate per year for health care, according to Dr. Greifinger, Deputy Commissioner for Health Services, DOCS. This does not include security, mental health or drug abuse treatment. The State of Illinois, according

to Ronald Shansky, M.D., Medical Director, Illinois Department of Correction, spends $2,000 per inmate per year and the State of California spends $2,560. California's system is similar to New York's in that currently there is no contracting out. While none of these figures are absolutely comparable, given the differing computational bases represented, they are relatively comparable. Each figure represents the cost of medical care divided by the number of inmates served. Given the fact that New York State has the highest national HIV seroprevalence for its prison populations, it is likely and foreseeable that medical care needs in this State will exceed those in other localities. Persons are sentenced to prison for punishment, rehabilitation and reform, not to die prematurely from inadequate medical care. It would be indefensibly callous to steadily increase our prison population without commensurately increasing necessary health care capacity.

Corrections is a growth industry. In 1980 in New York State there were 21,548 inmates in 33 facilities. There are now over 50,000 inmates in 60 facilities. The legislature has recently authorized construction or expansion of thirteen facilities. The State has arranged for bonds to finance the construction and will necessarily pay for operating costs out of tax levy funds. It is morally and legally mandatory that the State provide sufficient funds for decent and humane medical care for incarcerated persons. This is especially important now when escalating numbers of HIV positive asymptomatic and symptomatic inmates require greater

expenditures for medical care. As society incarcerates ever greater numbers of inmates, we will draw deeply from communities that are at the center of this second wave of the epidemic, i.e., African-American and Hispanic intravenous drug users.

When the State negotiates the placement of new prison facilities, planners must consider the availability of health care services. If the community cannot guarantee access to acute care treatment in its community hospitals, alternative avenues for provision of care should be assured before facility construction proceeds.

II. The Organization of Acute Care and Long-Term Care Services

1) Acute Care

As the number of prisoners with HIV infection and AIDS continues to grow substantially in the years ahead, DOCS will face a critical need to expand the number of acute care hospital beds available to it. In the near term, DOCS, with the assistance of DOH, must enlarge the network of acute care hospitals willing to care for inmates with AIDS. The role of the designated AIDS center hospitals should be emphasized, along with other hospitals that have substantial experience in the diagnosis and treatment of patients with HIV infection. DOH can encourage this effort through favorable reimbursement formulas and financial support for costs associated with the construction of secure units and beds in hospitals.

Because of the size of the HIV infected population within its facilities, DOCS, with the assistance of DOH, must develop secure units capable of providing full-service hospital care to inmate-patients with complicated illnesses, including AIDS. A model for such units exists in Texas, where the Department of Corrections utilizes a secure hospital ward at the University of Texas Medical Branch in Galveston, and in New York State, where DOCS has created 8 secure hospital wards, of which the 25-bed ward at St. Clare's Hospital is the largest.

We recommend that DOCS create two additional secure hospital wards, administered by existing medical centers, one in New York City and one in an upstate location. These units must be located within or in very close proximity to major medical centers, and must be staffed and administered by those centers in facilities approved by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), the major national body which sets and supervises standards for community health facilities. The professional staff and services for these secure hospital units should be provided under long-term contractual arrangements with one or more academic medical centers committed to high standards of care.

The ultimate number of acute hospital beds required for the proposed secure hospital wards can be determined only by a

methodologically sound study of incidence and prevalence. This study should also include projections regarding the needs for skilled nursing facility beds and hospice beds, both of which should be an integral part of the spectrum of secure health care facilities that must be developed. The study should be jointly conducted by DOH and DOCS. Even before the results of such a study, however, DOCS has sufficient information now about bed needs to begin to arrange for additional basic acute care services.

2) Long-Term Care

DOCS must develop long-term care facilities to provide a continuum of care for HIV infected individuals and to ensure that acute care and tertiary care facilities are utilized appropriately and not squandered on inmates who require a lower level of care but more skilled care than a prison infirmary can provide.

We recommend that DOCS create both Skilled Nursing Facilities (SNF) and Health Related Facilities (HRF), a less intensive but still necessary level of care. These facilities will serve prisoners who are too ill to remain in general population or be cared for by a facility infirmary, but who do not require acute care. Any facilities DOCS creates, whether within prisons or in secure wards at existing community long-term care facilities, must meet the standards required in general for these facilities in the community.

In the community, an HRF level of care for AIDS patients is largely required for homeless persons with AIDS. Most of the care provided in these facilities could be available in someone's home. But a prison is not a home. Access to frequent small meals and special liquids, adequate quiet and rest are usually precluded by the rigor and structure of prison life. In addition, inmates who are recovering from an opportunistic infection may no longer need acute care or even skilled nursing care, but may still be too weak to manage in the rigid, and sometimes dangerous, prison environment. There is therefore a particular need for HRF services for inmates with either functional or cognitive impairments.

SNF's are needed to assure the appropriate use of acute care beds. There are currently no SNF services for inmates. This results in longer than necessary hospitalizations or inappropriate discharges to a prison, followed closely by rehospitalization, both of which are harmful to inmates and expensive for society.

Most correctional facilities already have existing nursing units of some kind. Some are better than others, but all are below the standard of a licensed long-term care facility in the community. The atmosphere of these units and the service offered are set by the health care staff, mainly nurses, who supervise and administer the units. The AIDS Special Needs Units (SNU) within existing correctional medical units can only succeed in providing decent care if the staff is properly trained to give the kinds of

care and treatment inmates require. To fall short would allow for the creation of units where prisoners with AIDS and other debilitated inmates could be warehoused out of sight -- and out of mind -- of the medical staff. Given the number of long-term care beds the prison systems will require, the scarcity of these beds in the community, and the virtual impossibility of creating sufficient new beds in the community to meet the needs of prisoners, DOCS will need to find space within prisons to renovate and staff for long-term care. These facilities once renovated must be licensed by the state as adequate for the level of care provided.

It would be fruitless to attempt to carve out special secure prison beds from the already scarce long-term care bed capacity. Long-term care is a seller's market. The vast majority of facilities have not yet accepted patients with AIDS, let alone prisoners with AIDS. The requirement that long-term care beds be in community facilities would place impossible barriers to the development of adequate bed capacity. Moreover, with few exceptions, most community based long-term facilities across the state are inexperienced in dealing with persons with AIDS. It is only in areas where there are high rates of infection that community based medical staffs have the sophistication required to offer long-term AIDS care and treatment. Under these conditions community care would not necessarily be superior to well designed, staffed and supervised long-term care within a correctional

facility.

In general, neither acute care nor long-term care beds should be AIDS specific. Nonetheless, most bed capacity over the next years will be devoted to the spectrum of illness caused by HIV infection. Guidelines and standards, approved by DOH, should be established to ensure that medical needs (a medical model) rather than security concerns (the correctional model) govern admission to and discharge from facilities at all levels of care.

III. Interagency Collaboration for the Negotiation of Health Services

The process of negotiations and arrangements will require close collaboration between DOH, DOCS and the Department of Mental Health. With respect to the specific needs of inmates with AIDS, negotiations should be conducted by Dr. Robert Greifinger, working in close collaboration with the staff of the AIDS Institute within DOH and with the support of the Commissioner of DOH. This team should work closely with the Office of Health Systems Management (OHSM) of DOH. OHSM has the requisite expertise and authority to set hospital services reimbursement rates which will attract providers despite their reluctance to serve this population. OHSM must work with DOCS to structure and implement realistic reimbursement arrangements that will ensure timely and appropriate access to hospital services for inmates.

As part of its cooperative arrangement with DOCS, DOH should require all state approved designated AIDS centers to serve inmates either at regular ambulatory care facilities or at clinics in the prison staffed by members of the center. DOH should also help to negotiate the creation of a secure ward within the medical center whenever possible.

DOH must actively encourage community providers to participate in the state-wide effort to serve HIV positive persons during their time of incarceration. This is best done as part of the approval process for Certificate of Need Applications and by appropriate reimbursement formulae. We recognize that DOH will have difficulty imposing this plan on unwilling designated AIDS centers that may be hostile to the idea of serving inmates. The huge dimension of the problem, however, requires a state-wide effort which must be led by DOCS and supported by strong leadership in DOH.

IV. Integration of HIV Positive Inmates

We recommend that no segregated facilities or special dorms be created for HIV positive inmates within the prisons. If established, segregated units will act as dumping grounds for infected inmates. Some have suggested that inmates be offered a choice of living in segregated dormitories with access to enhanced medical care and program services or in general population. We oppose this suggestion.

Once segregated facilities exist, both other inmates and correctional officers will be tempted to intimidate those who are seropositive to "choose" the special facility. Inmates and officers alike fear HIV infection and will attempt to identify and isolate those who test positive. There is almost no free choice for inmates in prison, and this particularly sensitive area will most certainly be no exception.

Once segregated, despite prior assurances, HIV infected inmates will be deprived of programs, education and jobs. This is not only a matter of daily routine. Participation in programs is a relevant factor in parole board decisions. Staff with a choice will opt not to work with HIV positive inmates unless massive education can reverse fear.

Therefore we recommend that asymptomatic HIV positive prisoners and those with mild early stage symptoms should be maintained in the general population. While providing integrated housing, DOCS should: 1) encourage HIV counseling and testing for those at risk; 2) provide education for prisoners and staff about HIV transmission, the dangers of IV drug use and the protection of sexual partners; and 3) train and educate medical staff to identify early symptoms of disease (see Section XI).

V. Participation in Clinical Trials

We recommend that Clinical Trials be open for prisoners. We

support their participation in such trials on ethical, medical, and public health grounds. This participation is permitted by the Federal Regulations governing Research on Prisoners under certain circumstances.

In general, given the scarcity of good care for HIV infection, research subjects may receive a level of medical attention exceeding that available to other inmates. As the line between treatment and research changes in HIV infection, new interventions constantly move toward accepted treatment. Because of the speed of research, access to experimental products should be a choice for inmates as it is for others with HIV infection.

New drugs become approved and available through clinical trials, many of which have also excluded women and IV drug users. The burdens and benefits of testing should be equitably shared within the populations infected or at high risk of infection. It is extremely difficult to conduct long-term clinical trials involving IV drug users in the community. If the prison population can be permitted access to these trials, while remaining protected from coercion and abuse, not only individuals but society may benefit. An altruistic motive for behavior, which is permitted to non-incarcerated populations and may ennoble suffering, should not be denied to inmates. Of course, particular attention must be paid, in this instance as in all others, to the process of and protection for informed consent.

Inmates seek access to clinical trials. The "grapevine" of communication in correctional institutions provides rapid transmission of information, although the details transmitted may well be inaccurate. HIV positive inmates and those with full blown AIDS know of new and promising research developments and seek the opportunity to participate in trials of new treatments that could possibly be effective. They experience their exclusion from research as one more aspect of punishment.

The Code of Federal Regulations (C.F.R. Title 45.101-46.409) sets forth the rules that govern all research involving human subjects. Subpart C of the Regulations pertains to "Biomedical and Behavioral Research Involving Prisoners as Subjects" and can be interpreted to permit this research under certain conditions.

Despite the fact that a prison setting may preclude the truly voluntary and uncoerced choice envisioned by the regulations, prisoners should and can be permitted to choose to participate in clinical trials. This should be the case not only for prisoners with HIV infection but for prisoners with any illness, such as cancer, for which no standard, accepted, effective, generally available method of treatment exists. In order to grant prisoners equal access:

1. <u>DOH and DOCS should communicate with the various Federal agencies that fund research and request that they</u>

encourage prisoner participation in their Requests for Proposals.

2. DOH should request that all institutions engaged in research and located near correctional facilities attempt to include prison populations in research designs.

3. DOH and DOCS should work closely together to facilitate the participation of researchers from academic medical centers and from the Community Research Initiative (CRI) in research protocols in the prisons.

VI. Release of the Terminally Ill

We recommend the development of a plan for the discharge of all terminally ill inmates who do not pose a danger to society, whether their illness is AIDS or some other and whether they are eligible for parole or not. AIDS serves to dramatize the need for this humane form of release. Those released should be placed in settings where they receive continued medical care and supervision following discharge. This sort of program will permit inmates to die with dignity outside prison walls, attended by family and friends, and will also alleviate some of the heavy burden placed on the prison health care delivery system by the AIDS epidemic.

The New York City Department of Correction has implemented a release plan for terminally ill inmates which, with some

modification, could serve as a model for a similar program in the state system. Under the city plan, the attending physician initiates the application for release by notifying authorities of the prisoner's terminal condition. Qualification for release is measured against the following criteria: the life expectancy of the inmate; whether the inmate is expected to survive incarceration; whether the inmate's illness is sufficiently severe to preclude further criminal activity; and whether the inmate's health would deteriorate if he remains in prison.

To ensure prompt attention in the community to the inmate's acute medical problem, the prison health staff should furnish all necessary medical information in advance to outside facilities which have agreed to treat inmates released through furloughs, parole or clemency. Correctional authorities should expedite all applications for such releases but AIDS must not become the basis for "dumping" inmates out of the corrections system. Prior to an inmate's transfer from a correctional facility there must be a specific arrangement for care.

In order to facilitate discharges of the terminally ill, or the parole of any HIV infected person, the Department of Parole must develop a medical evaluation and referral capacity it does not now possess. The ability to evaluate medical and psychosocial needs must be part of the parole discharge planning process.

Before an inmate who has symptomatic HIV disease or AIDS is paroled, permitted medical furlough, or granted clemency, careful attention should be paid to:

1. the availability of housing and family support;
2. the availability of an appropriate level of medical care;
3. psychological support to deal with terminal illness; and
4. counseling about the routes of transmission of HIV infection to non-infected persons.

Whenever possible, a terminally ill inmate should be discharged from the prison system and permitted to die with family and friends nearby. Under no condition, however, should inmates be forced to leave the prison if they have no community connections or support. For some inmates prison is the closest thing they possess to a home and these inmates should be permitted to die at the facility, or one of its associated medical sites, if they so choose.

<u>A hospice should be created in a prison SNF so that appropriate palliative care, pain management and bereavement counseling are available to dying inmates who remain in the prison system</u>. Hospice skills manage pain, dementia, delirium and grief effectively and humanely. Hospice care would be required only for those few terminally ill who remain in the correctional system.

Hospice care must be carefully monitored and regulated by DOH so that it is never used as a pretense for denying possibly effective care, or as a "holding pen" for troublesome and demented patients who are difficult to manage and care for. Hospice care must be reserved for those who are truly terminal and in the process of dying.

VII. Substance Abuse Education and Treatment

We recommend that specific drug treatment centers be established in all of the state prisons and that they be under the aegis of the Prison Health Service. HIV education and prevention information must be incorporated into all prison drug treatment programs.

Between 50% and 80% of the inmates entering the state prison system admit to prior drug use. With the expansion of the prison system and the augmentation of law enforcement efforts against drug activities, the absolute numbers and the percentages are likely to grow. The period of incarceration is a time when addicts are truly a "captive audience." It is likely that a substantial proportion of these individuals will readily accept counseling and participate in educational programs. Failure to seize this public health opportunity is irresponsible given the reality that relapse to drug use upon release, in the absence of any effective intervention, is the rule rather than the exception.

Drug addiction treatment services must be expanded massively to deal with the host of problems associated with drug use, including AIDS. Two of the greatest obstacles to expansion are community opposition to the establishment of facilities, and, of course, cost. The former clearly is not an issue at all within a prison setting; costs would be considerably less, since most of the non-personnel expenditures are already provided for by DOCS. Accordingly, the corrections system is an ideal environment in which to increase treatment and educational services for those with drug problems, at relatively low expense and with no community opposition.

We urge that DOCS promptly discuss with one or more well-established, respected therapeutic community programs the development on a contract basis of large-scale services within the Department. We also urge that DOCS investigate other treatment options such as Twelve-Step Programs. Contracts with outside agencies would parallel the development of independent health care provider agreements suggested in the first sections of this report.

Although DOCS cannot influence directly decisions regarding services provided in the general community, it should do everything possible to encourage the establishment of treatment and counseling of inmates following their release from prison. Simply to discharge inmates who are known to have an exceedingly high

likelihood of recidivism to drug use, without referral or even a list of resources to which they might turn if they experience renewed problems with drugs, is short-sighted. Ideally, of course, there should be some degree of overlap between institutional and post-institutional services. For example, those programs that have the capacity to accept clients upon release might perform an initial screening interview before the custodial sentence is completed.

VIII. Mental Health Needs of HIV Positive Inmates

The mental health needs of prisoners with AIDS or HIV are the same as those of others with any life-threatening disease, except that they are intensified by conditions associated with incarceration. DOCS must work with the Department of Mental Health to ensure:

1) the availability of psychiatric consultation for signs of serious psychiatric problems, such as:

a) AIDS-Dementia Complex,

b) delirium (from hypoxia, sepsis),

c) depression with suicidal intent;

2) the availability of a psychiatrist for medication to control symptoms and to advise staff about management;

3) the availability of psychological counselling for inmates and staff;

4) education of staff about the psychological distress that accompanies AIDS;

5) the development of small mutual support groups to help inmates gain confidence in dealing with the feelings of isolation and despair, if they choose to do this despite problems with confidentiality;

6) the availability of individual and group counseling for family members and friends of prisoners with HIV infection and AIDS. These highly vulnerable individuals visit often, and lack knowledge about how to protect themselves from transmission and how to assimilate this catastrophe into their lives.

IX. Special Services for Incarcerated Women with HIV Infection

At present the absolute numbers of incarcerated women with AIDS lag behind the number of men. However, the estimated percentage of women who are HIV positive equals or exceeds that of men. The majority of these women have become infected either by intravenous drug use or through sexual contact with an infected drug user or bisexual man. Some of the needs of women are the same as those of men. Others are specific to their gender. When considering the special needs of women in prison, education remains the first priority.

The special needs of women in prison include:

1. Education regarding perinatal transmission and pediatric AIDS.

2. On-site substance abuse treatment which addresses the needs of the cocaine, crack and heroin user as well as the problems

of the alcohol abuser. These services must emphasize special dangers of substance abuse during pregnancy and provide drug free and self help programs.

3. Frequent pap smears because of the rapid progression of cervical dysplasia seen in women with AIDS, and special gynecological care for HIV infected women.

4. Aggressive surveillance and treatment for other sexually transmitted diseases such as syphilis, condylomata (venereal warts), gonorrhea and penicillin resistant gonorrhea.

5. Readily available on-site pregnancy testing for early pregnancy detection, accompanied by counseling and testing for HIV infection (with informed consent) and timely access to abortion services, should this be the woman's choice. Since 25 to 40% of infants born to HIV infected women will themselves be infected, pregnant women should be offered the opportunity to determine their HIV status and choose whether or not to continue a pregnancy. All pregnancies in women who have a history of substance abuse or who are HIV infected should be managed by or in consultation with a maternal-fetal medicine specialist with the appropriate fetal surveillance (non-stress test, sonograms, etc.).

6. Access to a pediatric infectious disease specialist who can monitor and care for children living in the nursery born to HIV infected mothers. There is no need to isolate children unless they are so severely immunologically suppressed that they require protection and hospitalization. Since these children are at high risk of losing one or both of their parents, it is essential to

identify members of the extended family and involve them in care plans if the mother agrees.

X. Condoms

<u>We recommend that the Commissioner of Health determine whether transmission of HIV could occur in prisons; if it does, we further recommend that condoms be made available</u>. Mississippi, Vermont, and the cities of New York and Philadelphia all distribute condoms, with no reported security problems. The practice is not inimical to correctional philosophy.

If prison authorities do not want to be seen as condoning sexual activity by distributing condoms, they can follow the example of some correctional systems in European countries. These systems do not distribute condoms directly to prisoners, but allow them to receive them in the mail.

We realize that there is no clear evidence that transmission is occuring in prisons, and that sexual interactions and needle sharing between inmates are clearly prohibited. Opponents of condom distribution in prison argue that providing condoms would contradict DOCS rules and provide some sanction, if not approval, for interdicted behaviors. DOCS contends that the distribution of condoms would both condone and encourage prohibited sexual activity and might subject far more inmates to the intimidation, terror, and degradation of unwanted violent attack. Yet those prison and jail

systems which do distribute condoms have not reported any increase in sexual assaults.

In addition to HIV, there are a number of sexually transmitted disease epidemics in New York State, e.g., syphillis, genital ulcer disease and hepatitis B. The most important barrier protection against this wide range of diseases is the condom.

It is clear that despite rules, when men are segregated and denied heterosexual sex, some sexual relationships are natural and inevitable. In prison, as in society as a whole, abstinence does not work for everyone. With a nearly 20% seropositivity rate among male prisoners, in all likelihood HIV is being transmitted. Denying prisoners access to condoms may be sentencing them to death.

XI. Autonomy in Medical Care Decision-Making

<u>Prisoners are entitled to maximum possible autonomy and self-determination in health care decision-making</u>. It is now generally accepted in medicine, and supported by statute and case law, that adults who are capable of making health care decisions are free to consent to or to refuse care even if the result of that refusal is death. The mechanism through which adults exercise choice is the process of informed consent. This process requires that physicians provide information on the diagnosis, the prognosis, the alternative treatments, the possible risks and benefits of those

treatments and the likely consequences if no treatment is provided. The patient must then measure the uncertainties of outcome against personal values and religious commitments, reach a decision, and communicate the results of this deliberation. The choice must be voluntary and uncoerced, informed and deliberated.

Many commentators argue that the prison setting is so barren, deprived, and dangerous that no choice is truly voluntary. While that may be so, it does not obviate, but rather underscores, the duty of responsible prison and medical officials to approach as nearly as possible the ideal of patient autonomy in medical decision-making.

Consent to and refusal of care in a prison is a complex matter. Many inmates do not appear for scheduled clinic or follow-up appointments. Sometimes this reflects the inmate's choice to refuse care. Sometimes, however, it is the result of a conflicting family visit, or a competing program, or a temporary lock-down, or a recently imposed punishment, or the decision of a correction officer to interfere with and deny access to care. All are possible, and a non-appearance in and of itself may never be accepted, without additional information, as a clear indication of refusing care. In a prison it is never possible to determine, without careful investigation and scrutiny, whether the refusal is a true, considered and informed rejection of care, or whether it is a denial of care by others. Refusals can also be an inmate's

way to try and manipulate the system and secure some self-perceived good otherwise denied him. Nothing can be taken for granted in a prison without further investigation.

Part of the freedom to choose care outside of prison is supported by the protection of confidentiality. Confidentiality does not exist in a prison. Prison officers and administrators have regular access to medical files, inmate movement and behavior is always monitored by officers and other inmates. The total lack of privacy affects health care decision-making and must be recognized as a potentially intimidating fact of prison life.

In addition to contemporaneous health care decisions, many persons with AIDS outside of prisons are concerned with future health care decisions should they become incapable of deciding about care. Some large proportion (20%-40%) of PWAs die with some degree of dementia, and all die with disabilities. Because of these possibilities, many persons with AIDS outside of prison have chosen to execute advance directives (living wills and durable powers of attorney) to guide caregivers in the event of their later incapacity. Prisoners should be afforded these same opportunities. <u>All advance directives designed to refuse care should be scrutinized by outside non-prison providers, such as chaplains and advocates, to ensure that a prospective refusal is not a present denial of care</u>.

XII. Education and Prevention

DOCS has the responsibility to ensure that all staff and inmates receive HIV education that is culturally appropriate, linguistically acceptable, scientifically accurate, and presented at an appropriate educational level. All educational presentations and materials for inmates should be available in Spanish.

Educational content must include modes of HIV transmission, risk reducing behaviors, signs and symptoms of AIDS, meaning of the HIV antibody test, infection control procedures, and confidentiality requirements. Education must be ongoing and continuous for staff and inmates. It must be provided for new inmates, continued throughout incarceration, and reinforced before release. For inmates especially, face-to-face education is more effective than written materials. Indeed, we question whether print materials are at all effective, given the relatively low literacy rate of the prison population.

HIV prevention activities are critical in the prison setting because the prison population has a high seroprevalence, the population is very much at risk for HIV, there are opportunities for HIV transmission among prisoners, and most prisoners will be released into the community where they may spread HIV infection to sexual and needle-sharing partners. The prison setting presents an ideal opportunity to provide education regarding risk reduction to a large population at risk.

While DOCS is responsible for overseeing education programs DOH should remain directly involved. Curricula should be developed and approved by DOH. Educational messages will be more effective coming from DOH rather than DOCS personnel, where there is no underlying custodial relationship. Sessions presented by DOCS should be evaluated periodically by DOH. Pre- and post-test counseling for HIV testing should be done by DOH personnel; inmates will be reluctant to admit risk behaviors to DOCS personnel, especially risk behaviors occurring in the prison.

Education should be provided to all inmates concerning all means of transmission of HIV. Risk reduction information may save prisoners' lives and should not be withheld from them. This information should also be reinforced in anticipation of the inmate's release.

XIII. Prisoner Involvement in Education

Prisoners should be involved in developing inmate HIV curricula, in teaching other inmates about HIV, and in peer counseling programs. The burden of inmate education should not be placed upon inmates -- it is still the responsibility of DOCS and DOH to see that inmates are educated -- but any education program will be more effective with strong inmate involvement beginning with the planning stages.

Health educators have consistently demonstrated the positive value of counseling and education by those most nearly like the targeted populatioh. It has been successful in the gay community and in self-help programs such as Alcoholics Anonymous. There are examples of successful educational programs of former intravenous drug users teaching current users about risk reduction.

Inmate peer educators/counselors may be most effective because prisoners are more likely to listen to and trust other prisoners. Counselors can provide extra support for behavior change from their own experience and may be able to change attitudes towards prisoners with AIDS through setting an example. The AIDS Counseling and Education (ACE) program at Bedford Hills Correctional Facility provides an example of a successful, prisoner-initiated program of peer counseling and education.

In assisting prisoners in establishing a peer program, strict rules for confidentiality must be stressed, and prisoner peer counselors must be given appropriate education, training and support.

The committee recognizes the need to transfer prisoners among institutions when prison security is threatened. However, inmates must not be led to feel that if they participate in a peer education or counseling program, they will automatically be transferred. A level of trust must be established as the basis for

a successful peer program: this cannot happen with frequent transfers that are perceived as retaliative and punitive. One reason the program for women at Bedford Hills is successful is that the women cannot be transferred, as no comparable institution exists.

XIV. Educational Needs of Correction Officers

We recommend that DOCS and DOH institute education and offer counseling and testing for correctional officers and their families regarding HIV infection. As recently stated by a committee of the Association of the Bar of the City of New York: "Education of all criminal justice system personnel about AIDS is an absolute prerequisite to the development and implementation of fair, consistent and just policies for dealing with persons with AIDS who come into contact with the criminal justice system."

That broad recommendation - covering, among others, police, judges, private defense counsel, prosecutors and court officers - applies explicitly and clearly to correction officers. As stated in that report and by other groups that have studied the problem, the need is for mandatory, comprehensive and continuing education for all correction officers. There is need to ensure that the coverage is complete and that there are regular updates so that educational messages reach everyone and supply the most current information available.

The educational effort should be structured and led by competent professionals in conjunction with the correction officers and the union. To the extent feasible, the efforts of the professionals should be supplemented and enhanced by imaginative forms of peer counseling. The purpose of this thought, which requires creative plans for its implementation, is to promote a maximum of comprehension and sympathetic understanding among those for whom the education is designed.

The objectives and subject matter of the education for corrections officers may be summarized as follows:

1. To teach the nature of the infection, the courses it may take, and the huge dimensions of the problem.

2. To teach the limited modes of transmission and dispel mistaken notions about how the infection may be transmitted. (Note the report of the American Federation of State, County and Municipal Employees, certainly not inclined to under-protect its members, that no case of AIDS had been discovered by transfer from a prisoner to a correction officer.)

3. At the same time, to take seriously and to teach about the dangers of infection and the proper measures of infection control - in dealing with needlesticks, blood spills, open wounds, etc.

4. In general, on the subject of transmission and otherwise, to allay undue and irrational fears and avoid to the extent possible concomitant mistreatment of prisoners known or suspected

to be infected.

5. To explain rights of confidentiality and the means of their enforcement.

6. More generally, to make clear how the experience of the HIV crisis points up the need for prompt, effective, and adequate medical care for all prisoners.

7. To supply reminders of governmental and individual liability for deliberately inadequate and incompetent medical care.

XV. HIV Antibody Counseling and Testing

As new and promising interventions are developed for the spectrum of HIV infection, it is increasingly important for inmates to know their serology status. Given the ongoing discrimination against HIV positive persons both inside and outside of prisons, this information must be surrounded with whatever protection for confidentiality can be provided. In addition, it only makes sense to institute testing if there are adequate medical services to monitor the progress of undiscovered infection and to provide prophylaxis and care when appropriate. Counseling and testing can be particularly important for inmates in pre-release programs as the basis for their adoption of risk reduction behaviors. A counseling and testing program, therefore, has implications for the individual prisoner's health and for the health of others, both inside and outside the prisons.

It is in our interest as a society, as a matter of public

policy, to encourage voluntary HIV counseling and testing within prisons. As with HIV testing programs in non-incarcerated populations, the greater the number of options presented, the more likely that people will choose to be tested. Therefore, both confidential and anonymous counseling and testing should be offered. In anonymous testing only the person tested receives the result, and no name-linked record is created; in confidential testing the result is placed in the general medical chart. We recognize that neither route in a prison is fully protective of individual privacy rights; even anonymous testing is possibly discoverable, since movement in a prison is never unobserved. Both correction officers and other inmates may quickly know if an inmate has been tested, even if anonymous testing is chosen.

Confidential testing can promise even less protection, since a prison medical record is a readily accessible and widely available document. Because of the possible dangers knowledge of HIV infection presents to individual inmates, and because it is in society's interest to encourage testing, DOCS, as the agent of society in this matter, should: first, establish a separate file for HIV information which is easily accessible and quickly recoverable, but is more protected than the general medical record; second, promulgate no rules or regulations that would discriminate against or punish HIV positive persons; third, guard against administrative and staff behaviors that informally stigmatize or punish those identified as HIV positive.

XVI. Conjugal and Family Visits

HIV positive persons should be permitted to participate in conjugal and family visits.

In so far as conjugal visits are permitted for other prisoners, they should not be denied to persons who have HIV infection or AIDS. The fear of infection is real, of course, in prison or out. It should not be sufficient, however, to deny conjugal or family visits.

Conjugal and family visits are especially important now for AIDS patients, since medical discharge programs do not exist. Data have demonstrated that there is no transmission between an HIV infected person and close family who shared beds, towels and even toothbrushes. Therefore, as there is no danger to family members who are not sexually intimate, they should be permitted to visit privately with a prisoner with AIDS.

Prohibiting conjugal and family visits is a counter-productive policy as it will discourage prisoners from being tested for HIV infection. It is also bad law as this sort of discrimination is prohibited by the Federal Restoration of Civil Rights Act of 1988. Discriminating against those who behave responsibly and acquire knowledge about their HIV status is a chilling punishment for decent and responsible behavior.

We recommend that all participants in the family reunion or conjugal visit programs be provided with education and counseling about HIV infection and AIDS. This education could easily be integrated into the orientation program in which all visitors participate and need in no way burden the valuable Family Reunion Program. In addition, special education and counseling should be provided to prisoners before such visits. Prisons represent one of the few settings in which many persons at risk are available for education. It is the moral obligation of society to provide the resources and the obligation of DOH and DOCS together to offer appropriate education.

NEW YORK STATE AIDS ADVISORY COUNCIL

AD HOC COMMITTEE ON AIDS IN CORRECTIONAL FACILITIES

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Institute for Mediation and Conflict Resolution

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Preventive Medicine
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Memorial Sloan Kettering Cancer Center

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Morrison & Foerster

David Rothman, PhD.
Director and Bernard Schoenberg Professor of Social Medicine
Columbia Presbyterian Hospital

Jerome Washington

Consultant

Nancy Neveloff Dubler, LLB
Director, Division of Law and Ethics
Department of Epidemiology & Social Medicine
Montefiore Medical Center

Staff

Catherine Bergmann, MPH
AIDS Institute
New York State Department of Health

NEW YORK STATE AIDS ADVISORY COUNCIL

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EXPERT DISCUSSANTS

David Axelrod, MD, New York State Commissioner of Health

Robert Cohen, MD, Medical Director, AIDS Center, St. Vincent's Hospital, former Director of Rikers Island Prison Health Services

Robert Greifinger, MD, Deputy Commissioner for Health Services and Chief Medical Officer, New York State Department of Correctional Services

James Lawrence, Director of Health Systems Evaluation, New York State Commission of Corrections

William J. Rold, Esq. and John A. Beck, Esq., Prisoners' Rights Project, Legal Aid Society

Ronald Shansky, MD, Medical Director, Illinois Department of Correction

Victoria Sharpe, MD, Director, Spellman Center, St. Clare's Hospital

Staff and inmates of Sing Sing Correctional Facility Special Needs Unit

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AND LEGISLATIVE REPRESENTATIVES

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Raymond Broaddus, PhD, Assistant Commissioner for Health Services, Department of Correctional Services

Scott Christianson, PhD, Executive Assistant, New York State Division of Criminal Justice Services

Roberta Glaros and Lisa McMurty, Staff, Senate Majority Task Force on AIDS

David Hopkins, Legal Counsel for the Speaker of the New York State Assembly

Martin Horn, Director of Operations, and Terry Wurmser, Client Service Specialist, New York State Division for Parole

James Lawrence, Director of Health Systems Evaluation, and William Gaunay, Health Evaluator, New York State Commission of Corrections

Lloyd F. Novick, MD, and Noel Bonacci, Center for Community Health, New York State Department of Health

Rich Olson, Staff to Senator Mega, Chair of the Senate Corrections Committee

Janet Rothacker, Chief of Planning and Policy Development, Division of Probation and Correctional Alternatives

Frank Rundle, MD, Federal Master, Bedford Hills Correctional Facility

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THE LEGAL AID SOCIETY PRESENTATION EXHIBITS

Contents

1. New York State Commission of Correction, Final Reports on the deaths of E (Arthur Kill C. F.), M Washington C.F.), R (Auburn C. F.), S 'Attica C.F.), R (Attica C. F.), T (Green Haven C. F.), T (Otisville C. F.), B (Green Haven C. F.), J (Wyoming C. F.), M (Elmira C. F.), C "response"), and H (Green Haven C. F.) (with (Attica C. F.).

2. New York State Commission of Correction, Final Reports on the deaths of J (Great Meadow C. F.), L (Great Meadow C. F.), D (Sing Sing C. F.), J (Auburn C. F.), D (Collins C. F.), M (Sing Sing C. F.), and Y (Bedford Hills C. F.).

3. New York State Commission of Correction, Final Reports on the deaths of J , R , D , and V , at Eastern Correctional Facility.

4. Department of Correctional Services responses regarding the deaths of L , D , M , R , and J

5. Correspondence with Green Haven Correctional Facility Health Services Administrator regarding the deaths of F and T .

6. Letter from DOCS General Counsel, dated January 7, 1988, concerning Commission of Correction Demographic Profile of New York State Inmate Mortalities (1981-1986).

7. Letter from Prisoners' Rights Project, dated February 27, 1989, concerning mortality review at Green Haven Correctional Facility.

8. Evaluation of Medical Services at Bedford Hills Correctional Facility by Frank Rundle, M.D.

9. Correspondence protesting the opening of an "AIDS dormitory" for ambulatory HIV+ patients at Greene Correctional Facility.

10. Doe v. Coughlin, Opinion, United States District Court, Northern District of New York.

11. Matter of Lopez v. Coughlin, Opinion, Supreme Court of the State of New York, Albany County.

12. State of New York, Department of Health, Citation of Glens Falls Hospital for violation of New York Human Rights Law and federal Rehabilitation Act of 1973.

13. Testimony of Archibald R. Murray, Executive Director of The Legal Aid Society before the Joint Subcommittee on AIDS in the Criminal Justice System, Association of the Bar of the City of New York.

14. <u>Todaro v. Coughlin</u>, Memorandum of Law in Support of Plaintiffs' Motion for Contempt and Modification of Injunction.