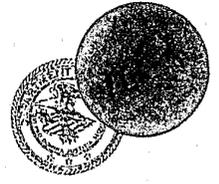


U.S. Department of Justice  
National Institute of Justice  
*Office of Communication and Research Utilization*



National Institute  
of Justice

*Issues and Practices*

# AIDS in Correctional Facilities:

## Issues and Options

Second Edition with 1986 Update

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**James K. Stewart**

*Director*

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U.S. Department of Justice  
National Institute of Justice  
*Office of Communication and Research Utilization*

# AIDS in Correctional Facilities: Issues and Options

Second Edition with 1986 Update

by

Theodore M. Hammett

with assistance from  
Monique Sullivan  
and  
Taylor McNeil

U.S. Department of Justice  
National Institute of Justice

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# Foreword

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Since its first appearance in 1981, AIDS — Acquired Immunodeficiency Syndrome — has become a major issue for public officials in all areas of the country and in all sectors of government. Today there is an enormous amount of uncertainty, fear, and misinformation about the origins and transmission of the disease. As a result, public health officials, school, hospital, police, and correctional administrators face a dilemma: how to develop effective and equitable policies that not only reflect the most current medical information available but also address the unique responsibilities of their professions.

For corrections agencies, the problem of AIDS is a formidable challenge. A substantial percentage of inmates fall within identified high-risk groups for AIDS. The presence — or potential presence — of AIDS within the prison is more than a simple health problem: correctional administrators are faced with tough decisions about prevention, institutional management, the best and most equitable means of identifying and treating inmates with AIDS, potential legal issues, and the costs of medical care.

Though much remains to be learned about AIDS, the National Institute of Justice recognizes that policymakers and corrections officials cannot afford

to wait until medical science produces the ultimate answer. The problem must be addressed today, and to do so effectively, correctional administrators need the best and most current information available. This issues and practices report updates *AIDS in Correctional Facilities: Issues and Options* published in 1986. These studies could not have been completed without the cooperation and assistance of numerous professionals in the fields of corrections and medicine.

While it is not appropriate at this time to prescribe any single course of action, this report describes the current range of correctional system practices related to AIDS, and discusses some of the advantages and drawbacks of each approach. In addition, it presents the basic facts on AIDS itself — how it is transmitted, how it can be prevented, and how widespread it is in both the general and correctional populations. With this knowledge, corrections officials will be in a stronger position to deal with the problem of AIDS through public education efforts, treatment, and reasonable and effective management policies.

James K. Stewart  
Director  
National Institute of Justice

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Taylor McNeil served as Research Assistant on the second edition. His diligent followup efforts helped ensure the high survey response results. Joan Mullen reviewed several drafts of the 1986 update section and offered useful suggestions. Charles Weise was word processor, and Sarah Colson and Ann Winkler coordinated production.

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Theodore M. Hammett  
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# 1986 Update

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## Introduction

The first systematic research on AIDS in prisons and jails was done late in 1985, when the National Institute of Justice and the American Correctional Association jointly sponsored a report entitled *AIDS in Correctional Facilities: Issues and Options*. This is the second edition of that report. During the year since the original research was done, even more attention has been focused on AIDS and there have been numerous significant research developments. This first section updates the survey findings presented in the original study. It is based on responses received between October 1, 1986 and January 1, 1987 from all 50 state correctional systems, the Federal Bureau of Prisons, and 31 of the 33 large city and county correctional systems previously surveyed. This section also updates medical research, policy issues, and legal implications associated with AIDS in the correctional setting. Current plans call for the report to be updated annually for the next several years. The full original report follows this 1986 update section.

Since the publication of the original report in April 1986, evidence against transmission of the AIDS virus through casual contact has become even more conclusive, but so has evidence of heterosexual transmission. The number of inmate AIDS cases in correctional institutions has increased, although at a slower rate than in the United States at large. The number of AIDS-related inmate lawsuits against correctional systems has significantly increased. Inmate and staff training on AIDS continue to be widespread, but there is still much room for improvement in format and content. Even fewer correctional systems than last year are screening all inmates for antibodies to the AIDS virus, but more are screening members of risk groups. Finally, fewer correctional systems are segregating inmates with AIDS-Related Complex (ARC) and those who are asymptotically seropositive.

## Medical Research Developments

### Transmission of Human Immunodeficiency Virus (HIV) Infection

#### *Heterosexual Transmission of HIV Infection*

Recent research has yielded increasing evidence that the AIDS virus (now generally called human immunodeficiency virus, or HIV, instead of HTLV-III/LAV, the term used in 1985) can be transmitted through

heterosexual contact, both male-to-female and female-to-male. However, disagreement continues on the current and projected scale of heterosexual transmission. Studies of stable, long-term monogamous heterosexual couples reveal that 5 to 37 percent of the steady sexual partners of HIV-infected individuals themselves become infected within a few years.<sup>1</sup>

Other evidence of heterosexual transmission comes from Africa. The sex distribution of African AIDS cases is nearly equal, in contrast to the male-dominated epidemiology seen in the United States. It should be noted, however, that African cultural factors might strongly inhibit the reporting of homosexual experiences, thus possibly exaggerating the apparent extent of heterosexual transmission. In any case, sexual activity seems the most likely means of transmission in Africa since almost all African cases are in the sexually active age range. Non-sexual modes of transmission, such as the use of unsterile needles in medical practice, would presumably produce many more cases than have been identified among persons in non-sexually active age groups. African studies also suggest that prostitutes are often carriers of HIV.<sup>2</sup>

A study of American military recruits discovered a male-to-female ratio among HIV seropositives of 3 to 1, although these data must be interpreted cautiously due to possible self-selection effects. The national average male-to-female ratio of AIDS cases is 13 to 1. The study also found a large number of married couples in which both partners were seropositive.<sup>3</sup> Finally, evidence of heterosexual transmission comes from the report that Australian women have seroconverted following artificial insemination with semen from an infected male.<sup>4</sup>

Despite evidence of heterosexual transmission of HIV infection, only a small and relatively stable percentage of AIDS cases in the United States have been attributed to heterosexual contact. This figure has increased only slightly to about 4 percent since the Centers for Disease Control (CDC) began compiling surveillance data on the disease. However, the past and current epidemiological profile of AIDS cases may not accurately predict the disease's future course. This is primarily because of the large number of asymptomatic carriers now in the population. Although there are probably far more infected men than infected women in the American population at present, heterosexual transmission has been demonstrated and must be considered a very serious potential problem in the United States.

### ***Evidence Against Transmission by "Casual Contact"***

Evidence continues to accumulate that HIV infection cannot be transmitted by casual contact. Altogether, studies of 437 family members of AIDS patients have identified no HIV seroconversions, despite long-term close contact with the patients. A recent study of hemophiliac and non-hemophiliac children in a French private school found that half of the former but none of the latter had seroconverted. All these children had had "close casual contact, some of them for several years." The only known case of seroconversion in a family setting was recently reported from Germany, where a 6-year-old sibling of an AIDS patient became infected.<sup>5</sup> The cause of this seroconversion is presently unknown. Except for a very small number of seroconversions in health-care workers attributed to accidental needlesticks cited in the 1985 report (3 of 666, or 0.5 percent), there continue to be no reports of HIV infection as a result of any occupational contact.

### ***Evidence Against Transmission Through Body Fluids Other Than Blood and Semen and Through Biting Incidents***

Despite the fact that contact with blood or semen continues to be the only known means of transmitting the AIDS virus, correctional staff have expressed concern that they might become infected by contact with body fluids other than blood or semen, or through biting incidents. All evidence continues to point to the extreme unlikelihood of viral transmission through such means.

One study which found the HIV virus in saliva has been criticized on the ground that the saliva samples were not drawn directly from the salivary glands, but from fluid already in the mouth, which may have contained blood. AIDS patients often have intraoral bleeding from gums and ulcers.<sup>6</sup>

Correctional officers and others who administer cardio-pulmonary resuscitation (CPR) may wonder why CDC recommends using masks or airways when performing CPR if saliva is not an efficient medium for HIV transmission and no cases of such transmission have been reported. The reason is that masks represent a reasonable precaution that also helps to prevent transmission of other infections.

Biting and spitting incidents may particularly concern correctional officers. Research findings on saliva should allay fears regarding the risk from spitting incidents. Biting may involve blood contact, but it should be emphasized that it is the individual doing the biting

who comes into contact with the blood of the victim. The victim cannot be infected by the blood of the person committing the bite unless that person somehow has blood in his or her mouth that then comes into contact with the victim's blood. There have been no reports of HIV transmission through biting.

### **Other Research Findings**

#### ***Relationship Between HIV Seropositivity and Development of Illness***

With the passage of more time to track infected individuals, the estimates of the percentage who will become ill has increased. Recent studies of six groups of HIV seropositive persons in the United States and Denmark found that 8-34 percent developed AIDS within 3-5 years of infection. With the long and uncertain incubation period of AIDS, it is likely that the percentages of individuals in these cohorts who develop the disease will continue to rise.<sup>7</sup> A recent National Academy of Sciences report estimates that 25-50 percent of seropositives will develop AIDS within 5-10 years of infection. The report also notes that more than 90 percent of seropositive individuals show some immune system deficiency within 5 years of seroconversion.<sup>8</sup>

#### ***Complexity of HIV Infection***

Recent research has stressed that HIV infection is extremely complex. While the typical elapsed time between infection and seroconversion is six to eight weeks, this period is extremely variable. There have been reported instances in which seroconversion has not occurred until eight months after infection.<sup>9</sup> This variability in timing may suggest longer followup periods for antibody testing following incidents in which HIV infection may have been transmitted.

The National Academy of Sciences report points out that persistent swollen lymphnodes, ARC and AIDS "cannot be considered simply as stages of an orderly progression in the spectrum of HIV infection."<sup>10</sup> For those individuals who do pass through these conditions sequentially, there is no standard rate or pace of progression. Some patients remain asymptomatic for long periods—perhaps indefinitely—while others quickly develop end-stage AIDS and die. What causes these wide variations in clinical history is not known.

#### ***Prospects for Vaccines and Cures***

In the past year, scientists have made some significant progress in understanding the complex structure and

behavior of the HIV virus. Such knowledge is a prerequisite for developing an AIDS vaccine. However, the goal is extremely elusive and new knowledge about the virus as often frustrates as contributes to progress on vaccine development. The most recent scientific development, for example, is that there may be a second virus in addition to HIV that is a causative agent of AIDS.

Development of therapeutic drugs for AIDS has progressed in the past year. Several drugs, including azidothymidine (AZT) and ribovirin, are now undergoing clinical trials. At the same time, there have been some setbacks and some prematurely dramatic announcements of therapeutic success, which later had to be retracted or qualified.

In general, prospects for a vaccine or cure for AIDS remain less than promising for the immediate future. The National Academy of Sciences concludes that the probability of a vaccine becoming available in the next 5-10 years is "low". The report also concludes that "development of therapy for HIV infection will most likely be a difficult and long-term process with no presently available guarantees of success."<sup>11</sup> The poor prospects for vaccines or cures in the foreseeable future only serve to underline the importance of educational efforts. As many have already stated, education is our only available weapon against AIDS.

### *Safety of the Blood Supply*

The HIV antibody test was originally developed to protect the blood supply, and it has been successfully used for that purpose. Several recent reports indicate that a small number of infected units of blood may have slipped through undetected, because the donor was only recently infected and antibodies had not had time to appear by the time the blood was donated. However, the Centers for Disease Control (CDC) estimate that only about 100 transfusion-associated infections will occur annually out of a total of 16 million units transfused. The recent National Academy of Sciences report on AIDS estimates the risk of transfusion-associated infection at fewer than 1 in 34,000 recipients of packed red blood cells.<sup>12</sup>

### **Incidence of AIDS in the United States**

The dimensions of the AIDS problem continue to grow alarmingly. CDC figures through calendar year 1986 report over 28,700 adult AIDS cases in the United States. In addition, there have been over 400 pediatric cases. Thus far, almost 16,500 persons have died of AIDS in this country.<sup>13</sup>

New York State and California together account for 54 percent of the AIDS cases in the United States, while New Jersey, Florida and Texas collectively account for another 19 percent. Within these states, as elsewhere, cases are heavily concentrated in cities and major metropolitan areas. In addition to confirmed AIDS cases, the National Academy of Sciences estimates that there may be as many as 50,000 to 125,000 cases of AIDS-Related Complex and the Public Health Service estimates that there are 1-1.5 million asymptomatic HIV infected individuals. CDC believes 270,000 AIDS cases will have been diagnosed in the United States by the end of 1991.<sup>14</sup>

Ninety-three percent of all American AIDS cases have been in males and 89 percent of the adult cases have been in persons aged 20-49 years. The overall racial/ethnic distribution of adult cases has remained essentially the same since 1985: White—60 percent; Black—25 percent; Hispanic—14 percent; Other/unknown—1 percent. Blacks and Hispanics (11 percent and 6 percent, respectively, of the population 15 years of age and older) are disproportionately represented.<sup>15</sup>

Figure U.1  
**BREAKDOWN OF CONFIRMED AIDS CASES BY RISK GROUPS**

Risk Group	% of all cases
Homosexual/bisexual males <sup>a</sup>	65%
Intravenous drug abusers	17
Homosexual male and IV drug abuser <sup>a</sup>	8
Transfusion recipients	2
Hemophiliacs	1
Heterosexuals with a partner in one of the above risk groups	4
Other/unclassified	3
<b>TOTAL</b>	<b>100%</b>

<sup>a</sup>At the time of the original report, CDC was combining the "homosexual/bisexual males" and "homosexual male and IV drug abuser" categories under "homosexual/bisexual males."

Source: CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987.

The most recent CDC breakdown of confirmed AIDS cases by risk group is shown in Figure U.1. There is an overlap of approximately 8 percent between the homosexual/bisexual and intravenous drug abuser categories. Thus, about 25 percent of reported AIDS cases are in persons with some history of intravenous drug abuse and about 74 percent of cases have been in homosexual/bisexual males.<sup>16</sup> The only change in the risk group distribution since 1985 was a 3 percent decrease in the "other/unclassified" category and a corresponding increase in the heterosexual partner category. Many epidemiologists believe the percentage

of cases attributed to intravenous drug abuse is likely to grow dramatically in the next few years. Moreover, they believe the greatest threat for significant spread of infection to the heterosexual population is through infection of the sexual partners of intravenous drug users.

The latest medical research and epidemiological data together show that AIDS is a very serious and growing problem, but also that the HIV virus that causes AIDS is transmissible only by unprotected sexual relations and blood-to-blood contact. In all settings, including correctional agencies, the response to AIDS should stress both these facts. Education and prevention programs which rationally address the real nature and extent of the risk should be implemented. It is equally dangerous to take a complacent or an alarmist approach to this problem.

### Incidence of AIDS Among Correctional Inmates

As of October 1, 1986, there had been 1,232 confirmed AIDS cases among inmates in 58 responding federal, state, and local correctional systems. There had been 784 cases in 31 state and federal correctional systems—up 72 percent from the 455 cases reported as of November 1, 1985, the time of the original survey. Twenty-seven responding city and county jail systems reported 448 cases—up 44 percent from the 311 cases reported in the original survey eleven months earlier. Total AIDS cases in all responding correctional systems increased from 766 to 1,232—or 61 percent—in the eleven-month interval. This is a large increase in cases, but it is, in fact, smaller than the 79 percent national increase from 14,519 cases as of November 4, 1985 to 26,002 as of October 6, 1986.<sup>17</sup>

The figures above are *cumulative* totals—that is, all cases reported since the correctional systems began keeping records. Twenty-three state and federal systems reported 174 *current* cases of AIDS among inmates, while six responding city and county systems reported 29 current cases. State and federal systems report that a cumulative total of 463 inmates have died from AIDS while in custody; responding city and county systems report 66 inmate deaths. Of these total inmate AIDS deaths, 254—or 48 percent—have occurred since the 1985 survey was taken.<sup>18</sup>

More correctional systems now appear to be maintaining statistics on ARC than were doing so at the time of the 1985 survey. However, several of the jurisdictions with the largest numbers of AIDS cases still do not maintain figures on ARC. Thus, these statistics are still

probably artificially low: 321 current ARC cases in 26 state and federal systems, and 28 current cases in 25 city and county systems.

The distribution of cumulative total AIDS cases across correctional systems is still highly skewed (Figure U.2). While 10 more systems than last year reported at least one case, the majority (35 of 51 state and federal systems—or 68 percent—and 18 of 33 city and county systems—or 54 percent) still have had fewer than four cases. At the other extreme, only three state and federal systems and one responding city or county system have had more than 50 cases. Three state systems (6 percent) account for 74 percent of the cumulative total AIDS cases, while two of the responding city and county systems (6 percent) contribute 73 percent of the cases.

Figure U.2  
DISTRIBUTION OF CONFIRMED AIDS CASES AMONG INMATES, BY TYPE OF SYSTEM

Range of Total AIDS Cases	State/Federal Prison Systems							
	Original Survey: November 1985				Update Survey: October 1986			
	n systems	%	n cases	%	n systems	%	n cases	%
0	26	51%	0	0%	20	39%	0	0%
1-3	15	29	24	5	15	29	22	3
4-10	5	10	30	7	9	18	56	7
11-25	2	4	42	9	1	2	23	3
26-50	1	2	33	7	3	6	101	13
51-100	1	2	95	21	1	2	57	7
> 100	1	2	231	51	2	4	525	67
Total	51	100%	455	100%	51	100%	784	100%

Range of Total AIDS Cases	City/County Jail Systems							
	Original Survey: November 1985				Update Survey: October 1986			
	n systems	%	n cases	%	n systems	%	n cases	%
0	13	39%	0	0%	6	18%	0	0%
1-3	10	30	16	5	12	36	24	5
4-10	7	21	43	14	10 <sup>a</sup>	30	60	13
11-25	1	3	12	4	3	9	39	9
26-50	1	3	40	13	1	3	40	9
51-100	0	0	0	0	0	0	0	0
> 100	1	3	200	64	1	3	285	64
Total	33	99% <sup>b</sup>	311	100%	33	99% <sup>b</sup>	448	100%

Source: NIJ/ACA Questionnaire Responses.

<sup>a</sup>Two systems in this category at the time of the original study failed to respond to the 1986 survey. Therefore, the numbers reported are from the 1985 survey.

<sup>b</sup>Due to rounding.

Figure U.3  
**REGIONAL DISTRIBUTION OF TOTAL AIDS CASES  
 BY TYPE OF SYSTEM**  
 (Federal Bureau of Prisons Excluded)

Region	State Prison Systems			
	Original Survey: November 1985		Update Survey: October 1986	
	n Cases	% of Total	n Cases	% of Total
New England <sup>a</sup>	16	3.7%	34	4.6%
Mid-Atlantic <sup>b</sup>	327	75.5	531	71.3
E.N. Central <sup>c</sup>	6	1.4	19	2.6
W.N. Central <sup>d</sup>	0	0.0	1	0.1
S. Atlantic <sup>e</sup>	49	11.3	88	11.8
E.S. Central <sup>f</sup>	1	0.2	5	0.7
W.S. Central <sup>g</sup>	12	2.8	28	3.8
Mountain <sup>h</sup>	2	0.5	2	0.3
Pacific <sup>i</sup>	20	4.6	37	5.0
Total	433	100.0%	745	100.2% <sup>k</sup>

Region	City/County Jail Systems			
	Original Survey: November 1985		Update Survey: October 1986	
	n Cases	% of Total	n Cases	% of Total
New England <sup>a</sup>	0	0.0%	0	0.0%
Mid-Atlantic <sup>b</sup>	222	71.4	307 <sup>j</sup>	68.5
E.N. Central <sup>c</sup>	8	2.6	17	3.8
W.N. Central <sup>d</sup>	1	0.3	2	0.4
S. Atlantic <sup>e</sup>	24	7.7	27 <sup>j</sup>	6.0
E.S. Central <sup>f</sup>	0	0.0	0	0.0
W.S. Central <sup>g</sup>	3	1.0	6	1.3
Mountain <sup>h</sup>	1	0.3	6	1.3
Pacific <sup>i</sup>	52	16.7	83	18.5
Total	311	100.0%	448	99.8% <sup>k</sup>

<sup>a</sup>Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut

<sup>b</sup>New York, New Jersey, Pennsylvania

<sup>c</sup>Ohio, Indiana, Illinois, Michigan, Wisconsin

<sup>d</sup>Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas

<sup>e</sup>Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida

<sup>f</sup>Kentucky, Tennessee, Alabama, Mississippi

<sup>g</sup>Arkansas, Louisiana, Oklahoma, Texas

<sup>h</sup>Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada

<sup>i</sup>Washington, Oregon, California, Alaska, Hawaii

<sup>j</sup>One system in this region failed to submit a follow-up questionnaire. We used the numbers reported on the original questionnaire.

<sup>k</sup>Due to rounding

The Middle Atlantic states still account for the vast majority of AIDS cases among correctional inmates (Figure U.3). Seventy-one percent of state systems' cases and 68 percent of cases in responding city and county

systems have been in the Middle Atlantic region. However, it should be noted that correctional AIDS cases have increased in all regions since the original survey was taken. More and more correctional systems are likely to experience AIDS cases each year, although the overall distribution of cases will probably remain highly skewed across correctional systems and geographic regions.

The incidence rate of AIDS in the United States was 5.3 cases per 100,000 population in 1986,<sup>19</sup> up from 3.4 in 1985. Incidence rates for individual states range from 0 to 21, with most under 3. In state and federal correctional systems incidence rates ranged from 5 to 215 per 100,000, although two-thirds of the states have rates less than 25 and only three have rates over 100.<sup>20</sup> Rates in city and county jail systems vary from 15 to 148 cases per 100,000, although rapid jail population turnover makes these statistics extremely suspect.

Incidence rates are predictably higher in correctional systems than in the population at large because of the concentration in inmate populations of persons with demographic, racial/ethnic and behavioral characteristics closely associated with AIDS—young adult males; Hispanics and blacks; and intravenous drug abusers. Moreover, the method of calculating incidence rates per 100,000 population guarantees that a correctional system with a very small number of AIDS cases—the typical case—will have a somewhat higher rate than a much larger outside population with substantially more AIDS cases.

The wide range in incidence rates obviously reflects the uneven distribution of AIDS cases across correctional systems. The jurisdictions with the highest incidence rates continue to be in the Middle Atlantic region, where HIV infection is pervasive among intravenous drug users who are drastically over-represented in corrections institutions.

## Characteristics of Inmate AIDS Cases

Though data on the characteristics of correctional AIDS cases are limited, a study of 177 inmate deaths from AIDS in the New York State correctional system reveals some striking demographic information. Ninety-seven percent were males, and 76 percent were between 25 and 39 years old. Fully 92 percent of these inmates *admitted* to intravenous drug abuse, 40 percent were Hispanic, 39 percent were black, and 86 percent came from New York City.<sup>21</sup>

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## Transmission of HIV Infection in Correctional Institutions

The extent to which HIV infection is transmitted within correctional institutions remains a controversial subject. The few systematic studies done suggest that transmission in prisons and jails has occurred infrequently. The Maryland study discussed in the 1985 report discovered a seropositivity rate of 1.5 percent among long-term inmates who volunteered to be tested. Seropositivity in an inmate continuously incarcerated for 7 years or more (i.e. since before the AIDS virus appeared in the United States) was assumed to mean that seroconversion occurred during incarceration.

New York State recently analyzed the periods of continuous incarceration of all of its correctional inmates with AIDS. The analysis revealed that none of the inmates had been continuously incarcerated for more than 7 years prior to their diagnosis, and only 5 inmates (2.3 percent) had been continuously incarcerated for 5-7 years prior to their diagnosis.

These figures also suggest low rates of transmission. However, as the New York report notes, "the long incubation period, the existence of the asymptomatic HIV carrier state, small number of long-term inmates and absence of data on antibody status make this finding inconclusive."<sup>22</sup> Firmer conclusions on HIV transmission in correctional facilities await systematic followup studies. At this writing, CDC is planning to sponsor such studies in several correctional systems.

### AIDS Cases Among Correctional Staff

As with the original survey, the 1986 survey identified no cases of AIDS among correctional staff attributable to contact with inmates.

### Education and Training for Inmates and Staff

Because prospects for an AIDS vaccine or cure are less than promising for the immediate future, education and training must continue to be the cornerstone of the response to AIDS in correctional facilities, as in the society at large. Training and education programs in correctional systems are widespread, but this survey shows that programs in most jurisdictions have not changed dramatically in format, frequency or content since last year.

The 1985 survey found that the vast majority of correctional systems were providing some type of AIDS

education or training to both inmates and staff. (Education and training includes live training sessions, audio-visual programs, and distribution of written materials.) The 1986 numbers reveal slight increases in the ensuing year: two additional systems now provide education to inmates (raising the percentage from 83 percent to 86 percent), while one system added programs for staff (raising the percentage from 93 percent to 96 percent). Only ten responding correctional systems have no AIDS educational programs for inmates, while only three have no programs for staff.

A larger percentage of state/federal than city/county systems provide education for inmates (94 percent to 77 percent), a fact probably explained by the high inmate turnover in jails. However, education and training are possible—and necessary—no matter how rapid the inmate turnover. Indeed, they may be more important where turnover is high, because each inmate may come into contact with many other individuals in a relatively short period of time. Inmate training on AIDS serves important public health objectives, particularly where turnover is high and individuals quickly return to the greater society. Regardless of turnover rates, training of inmates also serves important correctional management purposes such as promoting institutional security, reducing medical care costs, and limiting potential liability exposure.

The 1985 report strongly recommended *live* training—lectures, discussion groups and seminars—on AIDS for both inmates and staff. These continue to be the most effective training formats if they are presented by persons knowledgeable about both the medical and correctional aspects of AIDS and if they allow inmates and staff to ask questions. The correctional systems most experienced in dealing with AIDS cases all present live training to both inmates and staff. Figures U.4 and U.5 show that the percentages of systems that provide live training to inmates or staff have increased slightly in the last year. Still, less than half the correctional systems surveyed currently provide this important type of training. Audio-visual programs have also found increasing use, but distribution of written materials remains the most popular form of AIDS education in all categories of correctional systems.

One new audio-visual program deserves special mention. "AIDS—A Bad Way to Die" is a videotape produced by and for New York State correctional inmates. It is an extremely effective presentation, based on extensive interviews with AIDS patients in the New York State correctional system. It shows the effects of AIDS in graphic detail and offers dramatic words of warning from inmates suffering from the disease.<sup>23</sup>

Figure U.4  
**MODES OF AIDS TRAINING PRESENTATION FOR INMATES**

Modes of Presentation	State/Federal Prison Systems				City/County Jail Systems			
	Original Survey: November 1985 (n=51)		Update Survey: October 1986 (n=51)		Original Survey: November 1985 (n=33)		Update Survey: October 1986 (n=31)	
	n	%	n	%	n	%	n	%
• Live Training	16	31%	19	37%	8	24%	9	29%
• Audio-visual Programs	14	28	24	47	10	30	10	32
• Written Materials	28	55	33	65	15	45	16	52

Figure U.5  
**MODES OF AIDS TRAINING PRESENTATION FOR STAFF**

Modes of Presentation	State/Federal Prison Systems				City/County Jail Systems			
	Original Survey: November 1985 (n=51)		Update Survey: October 1986 (n=51)		Original Survey: November 1985 (n=33)		Update Survey: October 1986 (n=31)	
	n	%	n	%	n	%	n	%
• Live Training	19	37%	23	45%	10	30%	14	45%
• Audio-visual Programs	17	33	24	47	12	36	16	52
• Written Materials	26	51	31	61	18	55	23	74

Figure U.6  
**HIV SCREENING/TESTING POLICIES FOR INMATES<sup>a</sup>**

Policy Category	State/Federal Prison Systems				City/County Jail Systems			
	Original Survey: November 1985		Update Survey: October 1986		Original Survey: November 1985		Update Survey: October 1986	
	n	%	n	%	n	%	n	%
• Mass Screening (all or all new inmates)	4	8%	3	6%	0	0%	0	0%
• Screening of Risk Groups (including pregnant women)	2	4	11	22	7	21	6	18
• Testing <i>only</i> for Diagnosis, Incident Response or Epidemiological Studies	39	77	30	59	20	61	14	42
• Testing <i>only</i> on Inmate request	1	2	1	2	1	3	4	12
• No Testing	5	10	6	12	5	15	7	21
• No Update	—	—	0	—	—	—	2	6
<b>TOTAL</b>	<b>51</b>	<b>101%<sup>b</sup></b>	<b>51</b>	<b>101%<sup>b</sup></b>	<b>33</b>	<b>100%</b>	<b>33</b>	<b>99%<sup>b</sup></b>

<sup>a</sup>Includes actual and planned policies. This is a hierarchical categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that do screening of all members of at least some risk groups, but no mass screening, are placed in the "screening risk groups" category regardless of whether they also do testing for diagnosis, incident response, or epidemiological studies.

<sup>b</sup>Due to rounding.

The 1985 survey found that most systems provided only infrequent training on AIDS. Yet, the 1986 follow-up survey revealed that only 14 percent of state/federal systems and 16 percent of responding city/county systems had increased the frequency of training or distribution of written materials to inmates. Thirty percent of state/federal systems and 26 percent of responding city/county systems had increased the frequency of training or materials distribution to staff. It should be re-emphasized that without regular doses of the truth about AIDS and how it is transmitted, misinformation may reassert its hold.

Less than half the correctional systems surveyed (42 percent of state/federal systems and 32 percent of responding city/county systems) had expanded or updated their training programs or written materials for inmates since the 1985 survey. Similarly, 46 percent of state/federal systems and 35 percent of responding city/county systems had expanded or updated staff programs or materials. Given rapid research developments, updating AIDS training and educational materials on a regular basis is extremely important.

Despite education and training efforts, inmate and staff concerns about AIDS have not dramatically increased or decreased between 1985 and 1986. Twenty-two percent of responding correctional systems believe inmate concern has increased in the last year, 26 percent believe it has decreased, and 52 percent believe it has remained the same. The analogous figures for staff concern are 24 percent, 37 percent, and 39 percent, respectively.

The 1986 survey suggests that there is still substantial room for improvement in correctional training on AIDS. More live training, more frequent training, and more regularly updated training are still necessary. As for content, the conclusion of the 1985 report holds true: AIDS training should carefully avoid the extremes of alarmism and complacency.

## **HIV Antibody Screening and Testing**

Significant controversy continues to surround the use of the antibody test to screen people, as opposed to screening blood. Primary issues in the debate have been the test's utility in predicting the future course of infection, the difficulty of maintaining the confidentiality of test results, and the discrimination and other detrimental effects on individuals' lives if results are divulged.<sup>24</sup> Correctional management issues—in particular, what to do with seropositives once they are identified—must also be carefully weighed in any application of mass screening programs in prisons or jails.

Probably as a result of some combination of all these factors, very few correctional systems have implemented mass screening programs. Several correctional departments have also rejected mass screening on the basis of CDC's recommendation against routine screening of the population at large. This seems to reflect the belief that mass screening is no more "productive or desirable" in correctional settings than in the larger society.<sup>25</sup> If and when therapeutic drugs such as AZT and Ribovirin are approved and become available, there may be better reason to screen inmates. This will be particularly true if such drugs prove effective in inhibiting the development of illness in asymptomatic seropositive individuals.

Figure U.6 reveals few significant changes in the screening and testing policies followed by correctional systems since the 1985 survey. None of the four jurisdictions that now collectively account for 70 percent of all inmate AIDS cases—New York State, New York City, New Jersey, and Florida—have implemented mass screening of inmates. New York State and New York City continue to follow a policy of no testing whatsoever, and Florida has maintained its policy of testing only when clinically indicated. New Jersey now tests all pregnant females believed to be at risk (e.g., intravenous drug abusers), and inmates with clinical indications of HIV infection.

The number of jurisdictions with mass screening programs has decreased from four to three. Two states dropped mass screening policies: Missouri has decided that mass screening is unnecessary and plans to screen risk group members only; Iowa discontinued screening after a prevalence study of about 800 inmates identified no seropositives. On the other hand, South Dakota instituted a mass screening policy during the last year. None of the responding city and county systems has instituted mass screening.<sup>26</sup> Most systems continue to test only when clinically indicated, in response to incidents, or for blind epidemiological studies. Michigan conducted anonymous screening of all inmates admitted to the state system during November 1986.

The most significant change reflected in Figure U.6 is the increase in the number of state and federal systems that screen all members of at least one risk group. All of the states with mass screening programs, and 76 percent of the jurisdictions with risk-group screening policies have had fewer than four cases of AIDS. Two of the systems with larger numbers of cases whose policies are classified as risk-group screening apply the policy only to pregnant women—a very small number of inmates. It appears that screening is more common

Figure U.7  
RESULTS OF MASS SCREENING AND RISK-GROUP SCREENING PROGRAMS

*A. Mass Screening*

<u>Jurisdiction</u>	<u>Number Tested</u>	<u>Inmate category(ies)</u>	<u>Number HIV Seropositive</u>	<u>% Seropositive</u>
Colorado	2847	all new inmates	15	0.5%
Iowa	800	all new inmates (Jan.-Apr. 1986)	0	0.0
Nevada	2638	all new inmates	8	0.3
Nevada	3820	all current inmates (Aug. 1985)	96	2.5
South Dakota	427	all new inmates	1	0.2
South Dakota	1124	all current inmates (Jan.-Feb. 1986)	2	0.2

*B. Epidemiological Studies*

Michigan	457	All new inmates (Nov. 1986)	4	0.8
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*C. Risk-Group Screening*

Alabama	301	unspecified risk groups	7	2.3%
New Hampshire	128	homosexuals and IV drug users	5	3.9
Orange County, CA	978	female prostitutes	28	2.9
Hennepin County (Minneapolis), MN	260	homosexuals and IV drug users	2	0.8

in low-incidence systems and in restricted applications where it is likely to identify relatively few seropositives, and thus pose fewer correctional management problems.

Thirty-three respondents provided aggregate results from their screening and testing programs. Most programs are small-scale, involving some combination of inmates with clinical indications, those in risk groups, and those who request testing. Data from such testing programs cannot be used to suggest seroprevalence because of the biases introduced in the selection process. However, four states reported the results of mass screening programs, and Michigan reported the results

of its one-month epidemiology study. These are shown in Figure U.7.

Seroprevalence rates among new and current inmates in these jurisdictions were all very low—from 0 to 2.5 percent with all but one group under 1 percent. These are comparable to estimated seroprevalence rates in the population at large. Four other jurisdictions reported the results of large-scale screening of risk-group members—generally homosexuals and intravenous drug abusers—which are also shown in Figure U.7. In one county jail system, all female prostitutes were tested at intake. Seroprevalence rates in these risk groups were slightly higher than among all inmates—from 0.8 percent to 3.9 percent—but still quite low.

Figure U.8  
HOUSING POLICY COMBINATIONS<sup>a</sup>

Policy Combination	State/Federal Prison Systems				City/County Jail Systems			
	Original Survey: November 1985		Update Survey: October 1986		Original Survey: November 1985		Update Survey: October 1986	
	n	%	n	%	n	%	n	%
• Segregate AIDS Cases; ARC Cases and Seropositives Maintained in General Population	3	6%	8	16%	3	9%	3	9%
• Segregate AIDS and ARC Cases; Seropositives Maintained in General Population	10	20	8	16	3	9	4	12
• Segregate All Categories	8	16	8	16	13	41	9	27
• No Segregation of any Categories	2	4	6	12	0	0	1	3
• No Policy	8	16	5	10	1	3	0	0
• Combinations involving case-by-case determination	16	31	14	27	10	30	12	36
• Other Policy Combinations	4	8	2	4	3	9	2	6
• No Update	—	—	0	—	—	—	2	6
Total	51	101% <sup>b</sup>	51	101% <sup>b</sup>	33	101% <sup>b</sup>	33	99% <sup>b</sup>

<sup>a</sup>For the purposes of this categorization, segregation means that the *basic* policy is to hospitalize (either within or outside the correctional system) or to segregate administratively the particular category of inmate, regardless of whether these inmates are returned to the general population when their symptoms subside. Single-celling is also included in segregation.

<sup>b</sup>Due to rounding.

### Housing Policies for Inmates with AIDS, ARC and Asymptomatic HIV Seropositivity

Figure U.8 shows that there have been no dramatic changes in housing policies, but that these policies continue to be extremely diverse. The only changes of any significance are the decreasing percentage of city and county jail systems that segregate all three inmate categories (from 41 percent to 27 percent) and the increasing percentage of state and federal systems that segregate none of these categories (from 4 percent to 12 percent).

These figures seem to reflect a slight shift away from policies stressing segregation, particularly for inmates with ARC and HIV seropositivity. The majority of all systems (59 percent of state and federal systems and 76 percent of city and county systems) still hospitalize AIDS patients, but slightly smaller percentages than in the 1985 survey now hospitalize inmates with ARC and those who are asymptotically seropositive.

Seven (or 20 percent) of 34 systems whose policy at the time of the 1985 survey was to segregate all inmates with ARC had decided against segregation one year later; six of 21 systems (or 29 percent) had made a similar policy change for HIV seropositive inmates. In addition, 4 of 11 systems (or 36 percent) which originally reported no housing policy for inmates with ARC had decided on a no-segregation policy one year later; six of 13 systems (or 40 percent) had made a similar policy decision for seropositive inmates. Segregation policies for all AIDS-related inmate categories are still generally more common in city and county systems than in state and federal systems.

The trend away from segregating inmates with ARC and HIV seropositivity may reflect concern that segregation capacity will be insufficient to accommodate increasing numbers of such inmates. However, these policy changes undoubtedly also reflect a growing awareness that segregating inmates with ARC and HIV seropositivity may be unnecessary and inappropriate, and may lead to inmate lawsuits raising difficult legal issues.

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Initial segregation policies may have been based primarily on a perceived need to protect HIV-infected inmates from physical harm at the hands of other inmates. However, at least in some correctional systems, this concern has turned out to be unfounded.

Moreover, CDC has issued strong regulations against such segregation in health care facilities. As with testing, correctional systems may be concluding that they should not deviate from policies considered appropriate for the society at large. For example, Michigan has determined that housing decisions should not be based on blanket AIDS-related categories but rather on each individual's security classification and medical needs. The state correctional department's protocol provides that "HIV-infected prisoners who do not require inpatient care will be eligible for general population housing at any institution which can meet their health care and security needs, and will also be eligible for any programming and work assignment which their health and behavior allows." As an alternative to inflexible segregation policies, Michigan has implemented an extensive program for identifying and monitoring high-risk behaviors and making timely housing and programming decisions for inmates exhibiting such behaviors.<sup>27</sup>

### **Medical and Psycho-Social Care for Inmates with AIDS, ARC and Asymptomatic HIV Seropositivity**

The 1985 report emphasized the importance of quality medical care but also stressed the need for counseling and other psycho-social support services. A promising AIDS support group has been initiated at a state prison in Georgia. This support group has helped to address and ease the personal difficulties of inmates with AIDS and ARC, and raised the general level of information and awareness regarding AIDS among both inmates and staff. It thus serves not only to enhance care for AIDS and ARC patients but also to supplement educational programs.<sup>28</sup> Other correctional systems may wish to replicate this model.

### **Legal and Legislative Developments**

In late 1985, most legal issues regarding AIDS in correctional facilities remained potential or theoretical; few actual cases had been filed at that time. In the past year, however, numerous inmate cases have been filed, and a few have reached disposition. Most cases have been filed in United States District Courts, although some have been filed in state and county courts as well.

To date, very few AIDS-related cases have been instituted by correctional staff. This reflects the fact that there have been no cases of seroconversion, AIDS or ARC among correctional staff attributable to contact with inmates. This section summarizes legal developments in 1986 and discusses the status of state legislative initiatives on AIDS in correctional facilities.<sup>29</sup>

### **Inmate Legal Issues**

Before summarizing the inmate cases, it should be emphasized that most are still pending. Obviously, anyone can file a suit for any reason. Many cases will undoubtedly be decided in favor of the correctional systems. The following discussion reflects the types of allegations that may be raised in inmates' AIDS-related lawsuits.

### ***Equal Protection and Related Issues***

This type of case generally involves inmates with AIDS, ARC or HIV seropositivity alleging that the conditions of their confinement violate equal protection standards and/or constitute cruel and unusual punishment. The leading case is *Cordero v. Coughlin*,<sup>30</sup> discussed in the original report, in which the court upheld the New York State Department of Correctional Services' policy of medical segregation for inmates with AIDS. In an Oklahoma case, *Powell v. Department of Corrections*, the court took a very similar position regarding segregation of a seropositive inmate. Although it did not cite *Cordero*, the court declared that the segregation policy furthered legitimate correctional objectives, namely prevention of the spread of disease and protection of the seropositive inmate from other inmates. Further, the court stated that inmates have no constitutional right to be in general population and that the inmate had not been denied equal protection since he had not been treated differently from other seropositive inmates—in fact, no other seropositive inmates had been identified in the Oklahoma prison system.<sup>31</sup>

In Colorado, by contrast, the Department of Corrections has eased its segregation policy for seropositive inmates. In motions filed under *Marionaux v. Colorado State Penitentiary*, a broad correctional conditions case pending since the 1970s, seropositive inmates complained of being placed in a maximum security segregation unit next to death row, in violation of an objective classification system agreed to by the correctional department under *Marionaux*. The state pleaded "special circumstances", but plaintiffs countered that the classification scheme contained no provision for special circumstances. Ultimately, the correctional department decided to move those seropositive inmates

who ordinarily would have been classified as medium security or lower to a medium security unit. The department also plans to hold a national conference of experts to discuss a comprehensive correctional AIDS policy.<sup>32</sup>

Two other cases involving segregation of seropositive inmates are still pending. In *Farmer v. Levine*,<sup>33</sup> a seropositive inmate in the Baltimore County Detention Center was isolated in a disciplinary unit and denied access to rehabilitation programs, the law library, and religious services. (The last two restrictions were removed after the suit was instituted.) The plaintiff also complained that guards routinely wore masks when entering his cell, left his meals at the opposite end of the cell rather than handing them to him directly, and subjected him to other forms of abuse. Farmer alleged that all of this constituted punishment without due process (i.e. that he was placed in the disciplinary unit without a hearing on any specific conduct), as well as denial of equal protection, right to privacy, and freedom of expression and association. The state, citing *Cordero*, responded that the isolation was not punitive but rather was in furtherance of a legitimate institutional objective—prevention of the spread of disease.

In a new Alabama case, an inmate alleges that his segregation and disqualification from work release programs due to his seropositivity are unconstitutional. As in the other cases, the state will respond that these restrictions are justifiable on the basis of institutional security and health.<sup>34</sup> The major difference between *Cordero*, on the one hand, and *Powell, Farmer*, and the Alabama case, on the other, is that the former involved inmates with confirmed AIDS while the latter involved asymptomatic seropositive inmates.

Finally, several recent cases in New York and Florida involve complaints from inmates with confirmed AIDS regarding the conditions of their confinement. The Florida case alleges cruel and unusual punishment associated with plaintiffs' illness. The inmates were isolated and prohibited access to the canteen and to recreational facilities; they also contend they were subjected to persecution and poor treatment by correctional officers. This case was recently dismissed on a technicality, but may be refiled. A recent New York case in which an inmate complained of denial of conjugal visits was decided in favor of the Department of Correctional Services. Following initiation of another New York suit, a correctional system policy was changed to permit HIV-infected inmates to receive visits from their children.<sup>35</sup>

### *Quality of Care and Related Issues*

Typically, these are cases brought by inmates with AIDS alleging inadequate medical care or "deliberate indifference" to serious medical need. *Storms v. Coughlin*, another New York case discussed in the 1985 report, has been withdrawn. The plaintiffs' attorney reports that it became impossible to proceed in the absence of a measurable standard of adequate care for AIDS patients and without complete charting of their care while hospitalized.<sup>36</sup>

In Arizona, a case brought by the state prison system's only inmate with AIDS has been transformed by that inmate's death into a broader class action. The plaintiffs are seeking an injunction requiring development of a comprehensive correctional policy on care of inmates with AIDS, ARC, and HIV seropositivity.<sup>37</sup>

A class action in Nevada challenging a broad range of correctional conditions includes a complaint of inadequate attention to the medical needs of the state's seropositive inmates.<sup>38</sup> Finally, a wrongful death suit may soon be filed on behalf of a former Los Angeles County inmate who succumbed to AIDS and the parents of a Florida inmate who died of AIDS in 1983 have filed an intent to sue alleging that the correctional department provided inadequate care to their son.<sup>39</sup>

### *Failure to Protect Others from AIDS or HIV Infection*

Numerous cases have now been filed by inmates alleging that correctional systems have not provided them adequate protection from HIV infection while in prison. The first case of this type was *La Rocca v. Dalsheim*,<sup>40</sup> discussed in the original report, in which New York State's policies were held to provide adequate protection. However, this case arose before the HIV antibody test became available and now a number of suits have been filed seeking antibody screening and other policies for the systematic identification and segregation of infected inmates. Many of these cases demonstrate that misinformation about AIDS still influences attitudes and actions in correctional institutions.

A North Carolina case seeking mass screening of inmates for antibodies to HIV, as well as an end to sharing of kitchen utensils, toilet facilities, clothing and bed linen with infected inmates, and steps to halt homosexual activity in prison was decided in favor of the correctional department. Another case on the same issues remains pending in North Carolina.<sup>41</sup>

In three pending Oregon cases<sup>42</sup> and a pending Florida case<sup>43</sup>, inmates are seeking mass HIV screening in correctional institutions. Finally, an Arkansas case seeks not only mass screening, but also hospitalization of all inmates with AIDS, discharge of any staff who develop AIDS, removal of any seropositive correctional staff from contact with other staff and inmates, and systematic reporting of all AIDS cases to the correctional department and the state health department.<sup>44</sup> This case is still pending.

Two pending New Jersey cases allege failure to follow established administrative and medical screening policies and demand systematic identification and segregation of high-risk inmates and those with symptoms of HIV infection, as well as more and better inmate training on AIDS. These suits do not call specifically for mandatory HIV antibody screening, rather, they seek to have testing made available on a voluntary basis.<sup>45</sup>

In Arizona, a case seeking removal of an inmate with AIDS from the institution was dismissed, while another suit seeking damages for "severe emotional distress" as a result of being housed in the same unit with ARC inmates remains pending.<sup>46</sup> A group of pending Florida cases demands an end to homosexuals working in prison food service, and protection against homosexuals spreading HIV infection through assaultive and consensual sexual acts. One case alleges that inmates adulterated coffee with the blood of an AIDS patient.<sup>47</sup> Finally, in a Pennsylvania case an inmate seeks release from prison or elevation of the institution's conditions to a constitutional level. He alleges wanton neglect by being placed in population with inmates who have ARC or AIDS, thus endangering his life.<sup>48</sup>

No cases have been filed as yet by inmates seeking damages for allegedly contracting HIV infection or AIDS while in a correctional facility. Correctional systems have been required by courts to adhere to a standard of reasonable care in protecting inmates. Breaches of this standard may constitute cruel and unusual punishment.<sup>49</sup> In several cases, correctional systems and their officials have been held liable for damages resulting from homosexual rapes and other inmate-on-inmate assaults on the ground that inadequate supervision had been provided to prevent such incidents.<sup>50</sup>

However, correctional systems have not been held responsible for insuring the *absolute* safety of persons in their custody. In several cases, for example, courts have held that a correctional system could be liable for

damages resulting from inmate-on-inmate assault only if its officials knew—or should have known—in advance of the risk to the particular inmate.<sup>51</sup>

In sum, law enforcement agencies perceive AIDS to pose serious potential legal problems. However, there have been no actual cases filed on these issues as yet and, with the exception of the police lockup scenario, there do not appear to be very strong grounds for suits alleging departments' liability for damages associated with HIV infection or AIDS either by officers or by members of the public.

### *Confidentiality and Other Issues*

Several cases have been filed alleging improper disclosure, or seeking to halt disclosure, of AIDS-related information. In a pending New Jersey case, inmates allege that under current policies AIDS-related medical records might be seen by guards. They also ask to be tested for HIV antibodies but to be freed from any disciplinary action for engaging in needlesharing activities that might have led to their infection.<sup>52</sup> A Florida case alleges improper disclosure of antibody test results by the correctional department.<sup>53</sup> New Mexico has promulgated a comprehensive policy for maintaining the confidentiality of AIDS-related medical information on inmates that other systems may wish to consider. The policy provides for strict security of all HIV antibody test results, restrictions on use of the term "AIDS" on medical charts in the absence of a firm diagnosis, and disciplinary measures for persons divulging confidential information on patients with HIV infections.<sup>54</sup>

Several cases regarding AIDS-related information have been brought by inmates against the Federal Bureau of Prisons. In a recently dismissed case, a private attorney sued under the Freedom of Information Act for information on the number of AIDS cases, correctional management policies for inmates with AIDS, and training programs on AIDS.<sup>55</sup> In two other pending cases, inmates who had incidentally appeared in an AIDS training film allege that they have suffered damages because other inmates now believe they have AIDS.<sup>56</sup>

The sharp increase in the number of AIDS-related inmate lawsuits in the last year underscores the continuing importance of education, training, carefully considered housing policies, and maintenance of the confidentiality of medical information.

### *Staff Legal Issues*

As noted above, thus far there have been very few AIDS-related suits filed by correctional staff. A

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major reason for this is that there have been no cases of AIDS among correctional staff attributable to contact with inmates.

One staff-initiated case involved AIDS training. An informational memorandum circulated in a state prison contained the statement that "no one really knows the way AIDS is transmitted, so be careful. . . ." The actual training program stressed that the virus is not transmitted by casual contact. Nevertheless, a correctional officer refused to search inmates and was fired for disobeying an order. However, an arbitration board reinstated the officer on the ground that his fears had resulted in part from the misleading memorandum.<sup>57</sup> The lesson for correctional departments is unmistakable: be sure that all informational materials and training are clear and consistent regarding the means of transmission of the AIDS virus.

Another case involved a non-work-related case of AIDS in a correctional officer. After he informed his supervisor of the AIDS diagnosis, the officer was transferred to another position outside the institution. The officer filed an equal employment opportunity complaint seeking a return to his original position. However, a settlement was reached under which the individual's employment with the Federal Bureau of Prisons was terminated, but the FBOP agreed to continue paying for his health insurance.<sup>58</sup>

Although no cases of this type have arisen involving correctional officers, administrators should probably be aware of the controversy regarding whether AIDS is a protected handicap under Section 504 of the federal Rehabilitation Act of 1973.<sup>59</sup> If so, an employee could not be fired or otherwise discriminated against simply because he or she had AIDS. Several states and municipalities have passed laws and ordinances prohibiting discrimination against AIDS patients. By contrast, the U.S. Department of Justice issued an opinion last summer holding that measures taken to reduce the spread of AIDS could not be restricted under the Rehabilitation Act.

The U.S. Supreme Court has recently heard a case involving dismissal of a teacher for being susceptible to tuberculosis which addresses the same legal issues being raised under Section 504 in AIDS cases.<sup>60</sup> This case may begin to settle these key labor relations issues.

## Legislative Developments<sup>61</sup>

During 1986 legislative sessions, bills on AIDS in correctional facilities were introduced in at least eight states. Three states considered and rejected bills that would have mandated HIV antibody testing in correctional facilities. Legislation filed in Arizona and Michigan would have required testing of all inmates, with an additional provision in Michigan for testing all individuals arrested and charged with prostitution. California's proposal would have required individual inmates to submit to testing in the presence of clinical indications. This would have overridden existing state law, which prohibits testing without written consent of the subject. An Alabama proposal to quarantine all inmates with AIDS was also rejected.<sup>62</sup>

Three states passed laws mandating studies of AIDS in correctional facilities. In Connecticut the study was to focus on education, training, and protection of correctional officers; in Pennsylvania, it was to assess the adequacy of the correctional department's policies and procedures on AIDS; and, in Virginia, it was to examine the feasibility of screening inmates for HIV, as well as the legal and ethical issues raised by such a program. Finally, pending New Jersey legislation would require a study of the extent of AIDS among inmates, the current correctional policies regarding the disease, and possible measures to control the transmission of HIV infection in correctional facilities.<sup>63</sup>

## Conclusion

AIDS continues to present difficult and complex policy issues for correctional administrators. The incidence of AIDS is increasing in correctional institutions, although perhaps not as rapidly as in the society at large. Correctional systems' policies on AIDS are being challenged in increasing numbers of lawsuits. The 1986 survey reported here suggests a continuing need for expanding and improving education and training programs for inmates and staff and for careful attention to developing, evaluating, and refining policies regarding antibody testing, housing, medical care, and psycho-social services.

## Footnotes

1. Thomas Peterman, M.D. (CDC), Presentation at 10th National Conference on Correctional Health Care, Washington, D.C., October 31, 1986. Institute of Medicine, National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care and Research* (Washington, D.C., 1986), p. 51.
2. R.J. Biggar, "The AIDS Problem in Africa," *Lancet* (January 11, 1986), 79-83; Deborah M. Barnes, "AIDS Research in New Phase," *Science* (July 18, 1986), 282.
3. "HTLV-III/LAV Antibody Prevalence in U.S. Military Recruit Applicants," CDC, *Mortality and Morbidity Weekly Report* (hereafter *MMWR*) 1986 July 4; 35:421-424; Barnes, "AIDS Research in New Phase," 283.
4. G.T. Stewart et al., "Transmission of HTLV-III by Artificial Insemination by Donor," *Lancet* 1985; 2:581-584.
5. G.H. Friedland et al., "Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis," *New England Journal of Medicine* 1986; 314:344-349; Peterman, Presentation at 10th NCCHC; *Lancet* (September 20, 1986), p.694. A. Berthier et al., "Transmissibility of HIV in Hemophilic and Non-Hemophilic Children Living in a Private School in France," *Lancet* (September 13, 1986), 598-601.
6. Nicholas Dello Russo, "Inaccuracies about AIDS Lead to Hysteria," Letter to the Editor, *Boston Globe*, November 12, 1986, p. 14.
7. Peterman, Presentation at 10th NCCHC; J.J. Goedert et al., "Three-year Incidence of AIDS in Five Cohorts of HTLV-III-Infected Risk Group Members," *Science* (February 28, 1986), 992-995.
8. *Confronting AIDS*, pp. 44, 91.
9. *Ibid.*, p. 45.
10. *Ibid.*, p. 46.
11. *Ibid.*, pp. 219, 229.
12. "Transfusion-Associated HTLV-III/LAV Infection from a Seronegative Donor—Colorado," *MMWR* 1986 June 20; 35:389-391; Peterman, Presentation at 10th NCCHC; *Confronting AIDS*, p.54.
13. CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987.
14. CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987; W.M. Morgan et al., "AIDS: Current and Future Trends," *Public Health Reports* 1986; 101:459-465; *Confronting AIDS*, pp. 69-70.
15. CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987. *MMWR* 1986 October 24; 35:664.
16. CDC, AIDS Weekly Surveillance Report—U.S., January 5, 1987.
17. CDC, AIDS Weekly Surveillance Report—U.S., November 4, 1985 and October 6, 1986. Responses to the original survey were received between November 1985 and January 1986. For the purpose of calculating change in the cumulative total cases, we considered the data current as of November 1, 1985.
18. For a demographic study of inmate deaths from AIDS in New York State, see New York State Commission of Correction, *Acquired Immune Deficiency Syndrome: A Demographic Profile of New York State Inmate Mortalities 1981-1985* (Albany, March 1986).
19. The incidence rate per 100,000 population is a standard measure used to facilitate comparisons. The incidence rates for the population at large were calculated as follows:  

$$\text{incidence rate} = \frac{\text{Total number of cases reported to CDC in 1986} \times 100,000}{\text{Total population}}$$
20. The incidence rates for correctional systems were calculated as follows:  

$$\text{incidence rate} = \frac{\text{Current AIDS cases in system} \times 100,000}{\text{Current population of system}}$$

The reported number of *current* AIDS cases may slightly underestimate the total number of cases reported during 1986, but most correctional systems do not keep statistics on cases by year reported. Using the current number may slightly underestimate the real annual incidence rate in a correctional system.
21. *Demographic Profile of New York State Inmate Mortalities*, pp.12-18.
22. Bureau of Communicable Disease Control, New York State Department of Health, *AIDS Surveillance Monthly Update*, August 1986, pp. 3-5.
23. Copies of the videotape are available without charge by sending a blank VHS cassette with a self-addressed mailer to Charles Hernandez, Superintendent, Taconic Correctional Facility, 250 Harris Road, Bedford Hills, NY 10507, Telephone: (914) 241-3010.
24. See Ronald Bayer et al., "HIV Antibody Screening: An Ethical Framework for Evaluating Proposed Programs," *Journal of the American Medical Association* Oct. 3, 1986; 256:1768-1774.
25. Nebraska Department of Correctional Services, Administrative Regulations Number 115.28, "Medical Services: Acquired Immune Deficiency Syndrome," (March 16, 1986), p.2.
26. Lake County, Indiana, which is not in the survey sample, has implemented a mass screening policy (with informed consent) in its jail. Alfonso D. Holiday II and Debora Robinson-Watson, "Clinical and Cost-Effectiveness of HTLV-III Screening," Presentation at 10th National Conference on Correctional Health Care, Washington, D.C., October 30, 1986.
27. "Protocol for the Prevention and Management of HIV Infection in the Michigan Department of Corrections," (Revised October 1986) pp.9-11.
28. Don Wardrope (Psychiatric Nurse Consultant, Augusta Correctional and Medical Institution, Grovetown, Georgia), "An AIDS/ARC Support Group in a Correctional Institutional Setting: General and Specific Considerations," Paper presented at the 10th NCCHC, Washington, D.C., October 31, 1986.
29. For an introduction to some of the legal issues surrounding AIDS in correctional facilities, see William C. Collins, *Correctional Law* 1986, pp. 15-22.
30. 607 F Supp 9 U.S.D.C., (S.D.N.Y., 1984).
31. U.S.D.C., N.D. Oklahoma, Nos. 85-C-820-C and 85-C-816-B, dismissed February 20, 1986. A similar Oklahoma case, *Morse v. Meachum* (U.S.D.C., W.D. Oklahoma, No. CIV-86-1309-T), was decided in favor of the correctional department in late December 1986.
32. *Marionaux v. Colorado State Penitentiary*, 465 F Supp 1245 (1979); interview with David Miller, Colorado ACLU.
33. U.S.D.C. Maryland, No. HM-85-4284.
34. Interview with T.L. Allen, Associate Commissioner, Alabama Department of Corrections.
35. *Saunders v. Wainwright*, U.S.D.C. Middle District, Florida, No. 85-677-CIV-J-16. Questionnaire response, New York State Department of Correctional Services.
36. Interview with Attorney Carol Kahn, White Plains, New York.
37. *Brown v. Arizona Department of Corrections*, (U.S.D.C., Arizona, No. CIV-85-2709-PHX-PGR [MM]); Interview with Attorney Cynthia Cheney, Phoenix, Arizona.
38. *Burns v. State of Nevada*, (U.S.D.C., Nevada, No. CV-S-86-366-HDM); Interview with Attorney Bruce Schup.
39. Questionnaire responses.
40. 120 Misc 2d 697 (NY, 1983).
41. *Wiedmon v. Rogers* (U.S.D.C., E.D., North Carolina, No. C-85-116-G); *Maberry v. Martin* (U.S.D.C., E.D., North Carolina, No. 86-341-CRT), pending.
42. *Herring v. Keeney* (U.S.D.C. Oregon, filed September 17, 1985); *Sheppard v. Keeney* (U.S.D.C. Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C. Oregon, filed October 11, 1985).
43. *Potter v. Wainwright* (U.S.D.C., Middle Dist. Florida, No. 85-1616-CIV-T15).
44. *Knight v. Henderson* (U.S.D.C. Arkansas, No. PB-C-86-16).
45. *Telepo v. Fauver* (U.S.D.C. New Jersey, Civil Action No. 85-1742 (HAA)); *Hook v. Fauver* (U.S.D.C. New Jersey, Civil Action No. 85-5962 (HAA)).
46. *Piatt v. Ricketts* (U.S.D.C. Arizona No. CIV-85-538-PHX); *Yates v. Lewis* (U.S.D.C. Arizona No. CIV-86-1538-PHX).

47. *Stalling v. Cave* (2d Circuit, De Leon County); *McCallum v. Stagers* (5th Circuit, Lake County, No. 85-1338-CA01); *Bailey v. Wainwright* (8th Circuit, Baker County); *Lloyd v. Wainwright* (2d Circuit, De Leon County, No. 86-3144); notice of intent to sue, *Elliot v. Department of Corrections and Prison Health Services*.
48. *Fergley v. Faulconer* (Huntington County, PA Court).
49. See, e.g., *Doe v. Lally* 457 F. Supp. 1339 (U.S.D.C., Maryland, 1979); *Campbell v. Bergeron* 486 F. Supp. 1246 (U.S.D.C., Middle Dist. Louisiana, 1980), aff'd 654 F. 2d 719 (5th Cir. 1981); *Streeter v. Hopper* 618 F. 2d 1178 (5th Cir. 1980); *Rhodes v. Chapman* 101 S. Ct. 2392 (1981).
50. See, e.g., *Redmond v. Baxley* 475 F. Supp. 1111 (U.S.D.C. E. Dist. Mich. 1979); *Garrett v. United States* 501 F. Supp. 337 (U.S.D.C., N. Dist. Georgia 1980); *Saunders v. Chatham County* 728 F. 2d 1367 (11th Cir. 1982); *Kemp v. Waldron* 479 N.Y.S. 2d 440 (Sup. Ct. 1984); *Thomas v. Booker* 762 F. 2d 654 (8th Cir 1985).
51. See, e.g., *Mosby v. Mabry* 699 F. 2d 213 (8th Cir. 1982); *O'Quinn v. Manuel* 767 F. 2d 174 (5th Cir. 1985).
52. *Sheridan v. Fauver* (U.S.D.C. New Jersey, pending).
53. Notice of intent to sue, *Niosy v. Bowles*.
54. New Mexico Corrections Department, "Guidelines, Policies, and Procedures Relating to AIDS," (January 6, 1986), pp.21-22.
55. *Lewisburg Prison Project v. Federal Bureau of Prisons* (U.S.D.C. Middle Dist. Pennsylvania No. 86-1339).
56. *Torres v. James* (U.S.D.C., S.D.N.Y. No. 86-3112); *Wills v. Carlson* (U.S.D.C., S.D.N.Y. No. 86-6414).
57. *AFSCME and State of Minnesota Department of Corrections*, 85 LA 1185 (Gallagher, 1985); 24 Government Employee Regulations Reporter 187 (December 1985).
58. *Swinney v. Meese* (U.S.D.C., N.D. California).
59. 29 U.S.C. 794.
60. *School Board of Nassau County v. Arline*, No. 85-1277.
61. The information in this section was provided by Constance Thomas of the Intergovernmental Health Policy Project at George Washington University. We are grateful for her assistance.
62. Arizona—HB 2136; Michigan—HB 5247 and HB 5279; California—AB 3318, AB 3393, and SB 1513; Alabama—HB 25.
63. Connecticut—Public Act No. 86-421; Pennsylvania—House Resolution No. 168, Adopted January 22, 1986; Virginia—House Joint Resolution No. 125, Adopted March 6, 1986; New Jersey—AR 10 and AJR 37.

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# Introduction and Summary

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Acquired Immunodeficiency Syndrome (AIDS) has become a major policy and management issue for correctional administrators in the United States. Correctional institutions have become a focus of concern about this disease—due to perceptions that prisons and jails hold high concentrations of individuals at risk of developing AIDS as a result of prior intravenous drug abuse and that correctional inmates frequently engage in behaviors likely to spread the disease—particularly homosexual activity.

Because of the continuing concern regarding the correctional response to AIDS, many administrators have expressed interest in receiving information to guide them in developing sound policies for dealing with the problem. The National Institute of Justice and the American Correctional Association have jointly sponsored the development of this report to address the urgent information needs of correctional administrators in this area.

## Purposes of this Document

This document is intended to be informational rather than prescriptive. The issues affecting the correctional response to AIDS are too complex for simple policy formulas. While certain principles, such as the importance of inmate and staff education on AIDS, are indisputable, there are many other issues and policy questions on which lively debate continues both within and between the correctional and medical communities. It appears that correctional administrators' primary need is for information to assist them in making the difficult decisions required to address AIDS in the institutional setting. The following categories of information appear to be in particular demand:

- concise statements of the major facts and issues affecting the correctional response to AIDS;
- a broad base of information on AIDS-related policies and procedures currently in force or in development in correctional systems nationwide; and
- delineation of the range of specific policy options available to administrators for dealing with this complex and difficult problem.

This document seeks to provide these types of information and to present as fairly and objectively as possi-

ble the rationales advanced for various policy options. Because of the rapidly changing situation, it is imperative that correctional administrators have the most up-to-date information. The document serves this purpose by summarizing the most current information on medical knowledge and correctional practice. It is also hoped that the report will facilitate information exchange across jurisdictions and, ultimately, the development of more informed policies and procedures.

Recent meetings of correctional administrators have featured numerous calls for nationally consistent policies on AIDS. At the same time, there is a need to make correctional policies as consistent as possible with the most current medical knowledge and advice. There are several ways to achieve the best balance between medical and correctional considerations and thereby to promote policy consistency both within and across jurisdictions. Among the appropriate responses are development and distribution of standard educational materials and the establishment of task forces or designation of "key" agencies to develop consistent policy and to mediate among the conflicting views and proposals that may be presented by various actors and advocacy groups. We hope that this report will foster the development of such mechanisms and thus facilitate the development of consistent policies and procedures.

## Intended Audiences for this Document

This document is directed to all officials who may be involved in making and implementing decisions regarding the correctional response to AIDS. This includes the following groups: correctional commissioners; other correctional administrators at both the departmental and institutional levels; correctional medical directors and other medical staff at both the departmental and institutional levels; public health authorities; legal staff of correctional departments; and legislators and other decisionmakers considering laws or policy initiatives related to AIDS in correctional facilities—e.g. budgets for prison construction and staffing and laws or policies requiring confidentiality of AIDS-related medical information.

## Study Methodology

The data and information presented in this report were gathered from the following major sources:

- responses to a national mail questionnaire;
- discussions at meetings of correctional administrators and public health officials;
- aggregate data provided by the Centers for Disease Control (CDC);
- interviews with medical authorities and correctional officials; and
- an extensive literature review.

A mail questionnaire was sent to the correctional departments of all 50 states, the federal prison system, and 37 large city and county jail systems. (A list of the city and county jail systems who responded to the questionnaire is included in Appendix C.) The questionnaire included basic questions on population and incidence of AIDS and related conditions, as well as series of questions on major policies regarding AIDS and associated legal and cost issues. We obtained an overall response rate of 95 percent to the questionnaire: 100 percent for states and the federal system; and 89 percent for city/county systems. Following extensive telephone callbacks to respondents to clarify answers, the questionnaires were coded and analyzed using the microcomputer version of the Statistical Package for the Social Sciences (SPSS/PC). One questionnaire was received too late to be included in the analysis conducted for the pre-publication version of this report which was distributed at the American Correctional Association's mid-winter meeting in San Diego, California in January 1986. However, this questionnaire has been included in the final analysis and all results have been updated as necessary for this final report. All data in this report are current as of November 1985—January 1986, the period during which all questionnaire responses were prepared.

Questionnaire respondents were assured that data on the incidence of AIDS and related conditions would not be reported by state or jurisdiction. Thus, we do not identify particular incidence figures with particular jurisdictions. Moreover, respondent jurisdictions were given the option of remaining fully anonymous—that is, of not being identified in the report in connection with any policy, procedure or piece of information. Several respondents chose full anonymity. This explains why some policies, procedures and items of information mentioned in the report are not associated with named jurisdictions.

Abt Associates and NIJ staff were invited to a series of meetings held to discuss the problem of AIDS in correctional facilities: two meetings of state correctional administrators organized and sponsored by the National Institute of Corrections for the Association

of State Correctional Administrators, one of which also included legal and medical representatives of the correctional departments; and a meeting of a CDC *ad hoc* work group constituted to consider ways of addressing the problem of AIDS in correctional institutions. The discussions at all three of these meetings were extremely useful to project staff in identifying the key issues and options.

The project made extensive use of CDC aggregate data on AIDS case reports. These data form the basis of the summary epidemiological profile of AIDS and the AIDS incidence rates for the population at large which are presented in the report.

Project staff interviewed numerous physicians, medical researchers, correctional administrators, public health officials, attorneys and others to gather information on key issues and options. These discussions were especially helpful in fleshing out the conflicting arguments on particularly controversial issues.

Finally, project staff reviewed a great deal of scientific literature, educational material, correctional and public health procedures, and newspaper and magazine articles. We made use of several automated database searches to ensure that we had identified all relevant literature and articles.

## **AIDS in Correctional Facilities: Key Issues and Organization of the Report**

This section summarizes key facts and issues regarding the incidence and management of AIDS in the correctional setting—with reference to the subsequent chapters that will provide detailed discussions.

### **Cause, Transmission and Incidence of AIDS**

Chapter One of this report summarizes the latest medical information and research on the cause, transmission and incidence of AIDS. AIDS is a serious communicable disease that undermines the human body's ability to combat infections. In 1983 and 1984, the probable cause of AIDS—variously called Human T-Cell lymphotropic virus Type III (HTLV-III) and lymphadenopathy-associated virus (LAV)—was discovered by scientists. Thus far, most cases in the United States have been among homosexuals and intravenous drug abusers. End-stage AIDS is almost always fatal. However, there is a range of milder forms of illness, sometimes called AIDS-related complex (ARC), that may also appear among those infected with the AIDS virus.

Infection with HTLV-III is transmitted through contaminated blood and semen, primarily during sexual activity and needle-sharing related to intravenous drug abuse. The virus is difficult to transmit and there is absolutely no evidence of its transmission through casual contact.

Within the last year, a test has been developed and made widely available to detect the presence of antibodies (evidence of the body's attempts to fight off an infection) to HTLV-III. However, the test does not detect the presence of the virus itself and there is substantial debate surrounding the uses of the antibody test and the meaning of its results.

As of January 1, 1986, over 16,000 cases of AIDS had been reported in the United States. Cases are heavily concentrated in large metropolitan areas on the east and west coasts. Responses to the NIJ/ACA study questionnaire reveal that, as of the period November 1985—January 1986, there have been 455 confirmed AIDS cases in 25 state and federal correctional systems. In addition, twenty large city and county jail systems reported 311 cases of AIDS among inmates. Thus, questionnaire responses reveal a total of 766 correctional AIDS cases. These figures represent *cumulative* total cases since the responding jurisdictions began keeping records. According to questionnaire responses, as of the period November 1985—January 1986, there were 144 *current* cases of AIDS among state and federal inmates in nineteen systems and 35 *current* cases among city and county inmates in eleven systems. The vast majority of correctional AIDS cases are believed to be associated with intravenous drug abuse.

The distribution of AIDS cases across correctional systems is heavily skewed. Fifty-two percent of state prison systems have had *no* cases and 82 percent have had fewer than four cases. Among responding city and county systems, 39 percent have had no cases and 69 percent have had fewer than four cases. At the other extreme, four percent of the state and federal systems have had 72 percent of the cases in those systems and six percent of the responding city and county systems have had 77 percent of the cases in those systems.

The higher incidence rates in the correctional setting are almost certainly due to the higher concentrations of high-risk group members (particular intravenous drug abusers) in inmate populations than in the population at large. There is substantial debate, but little hard data, on the extent to which the AIDS virus is being transmitted within correctional institutions. However, logic and common sense suggest that, even in the best-managed correctional facilities, there may

be at least some transmission of the infection occurring among inmates.

## Key Issues in Developing Correctional Policies and Procedures

Part Two of the report covers the following major policy areas: Education and Training (Chapter Two); HTLV-III Screening and Testing (Chapter Three); and Medical, Legal and Correctional Management Issues (Chapter Four). The following issues affect decision-making in all of these major policy areas:

- *The importance of education and training.* Effective educational programs, which address identified concerns and present rational and practical measures to reduce risk, can dramatically reduce the fears of inmates and staff and thereby influence a whole range of policy options regarding housing, work assignments and the daily routine of the correctional institution.
- *The relative importance of medical and correctional considerations in reaching policy decisions.* Administrators must decide among sometimes conflicting advice based on medical guidelines designed for the outside community, on the one hand, and the special circumstances of the correctional institution, on the other. Such conflicts may affect decisions regarding testing, housing, medical management, and precautionary measures.
- *The extent and nature of the correctional system's responsibilities for preventing the transmission of HTLV-III infection and AIDS.* This issue requires administrators to decide whether their institutions should bear responsibilities for disclosure of information and other precautionary measures that are not practiced in the community at large. This, in turn, depends on deciding whether there is more intrinsic risk that the disease will be transmitted in the correctional setting than in other settings in the outside world.
- *The uniqueness of AIDS among other communicable diseases.* Administrators must decide whether new and unique policies and procedures are required for AIDS or whether they would do better to deal with the problem by following existing policies covering all communicable diseases.

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## Key Policy Options

### *Education and Training*

Chapter Two discusses education and training on AIDS for correctional staff and inmates. Because of the concern expressed by inmates and staff about contracting AIDS and because of the amount of misinformation on the subject, education and training must be the cornerstone of the correctional response to AIDS. Responses to the NIJ/ACA questionnaire reveal that education and training are already in place in most correctional systems. Well-conceived educational programs have already been effective in many jurisdictions in reducing the fears of inmates and staff.

Chapter Two covers the following major areas in the development and implementation of educational programs:

- 1) Types of education and training programs;
- 2) Timing and frequency of training;
- 3) Development of educational materials;
- 4) Modes of presentation;
- 5) Use of training teams; and
- 6) Subjects addressed in staff and inmate training (this section of Chapter Two and Appendix D present examples from well-conceived education and training materials).

### *Screening and Testing*

Chapter Three discusses the major applications of HTLV-III antibody testing in the correctional setting and the perceived advantages and disadvantages of the range of testing options open to correctional administrators. The most controversial testing application is mass screening—that is, the testing of individuals in the absence of clinical indications. In the correctional setting, we define mass screening as the testing of all inmates or all new inmates. A more limited form involves the screening of high-risk groups.

Four state correctional systems have implemented or are planning to implement mass screening programs; no city or county systems have instituted or planned such programs. However, almost 90 percent of the jurisdictions responding to the NIJ/ACA questionnaire do use HTLV-III antibody testing for more limited purposes, such as supporting diagnostic work and responding to incidents in which transmission of the infection may have occurred.

The issue of mass screening for antibody to HTLV-

III in correctional institutions has sparked a lively debate. In general, proponents of mass screening argue that such programs are necessary to identify potentially infectious individuals, to understand the scope of the AIDS problem in the institution, and to target educational and prevention programs. Opponents argue that the test serves no useful purposes for correctional programming that cannot be advanced more effectively through other means—such as education and training, alternative methods of identifying and tracking high-risk individuals, and anonymous epidemiological studies. Moreover, opponents argue, testing will only add to the concerns of inmates and staff and will subject seropositive individuals to rumor, ostracism and perhaps violence while in prison, and to serious discrimination in housing, employment and insurability when they are discharged. Chapter Three discusses the key questions involved in this debate. These are the following:

- 1) Why should correctional systems take steps not being taken in the community at large?
- 2) What are the policy implications of identifying seropositive individuals (those with positive tests)?
- 3) How would mass screening affect education and prevention programs?
- 4) Is it possible to develop a reliable and confidential screening program?
- 5) What are the legal implications of screening?
- 6) What are the costs of mass screening?
- 7) Will mass screening allay or inflame fears?
- 8) Are there feasible alternatives to screening?

Finally, Chapter Three discusses the range of implementation issues faced by correctional administrators who decide to institute any type of testing program. These include when and where to administer the test, where to conduct the laboratory analysis, and whether testing should be voluntary, mandatory or on request. This section of Chapter Three discusses the serious legal issues regarding both whether inmates can be compelled to submit to testing and whether they have a right to testing on request.

### *Medical, Legal and Correctional Management Issues*

Chapter Four discusses the range of issues and policy options faced by correctional administrators in dealing with identified cases of AIDS, ARC and HTLV-III seropositivity. Because AIDS is relatively difficult

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to detect, develops only after a long—indeed, potentially indefinite—incubation period, and appears almost always to be fatal, it presents an unprecedented challenge to correctional administrators.

Numerous factors must be considered in developing a correctional response to AIDS. Inmate populations may include a higher than usual proportion of individuals at risk of developing AIDS. In addition, during the time that the correctional system has custody of an inmate, the system—and not the inmate—has the responsibility for providing and financing medical care. Further, the correctional system has other responsibilities concerning inmate safety and maintenance of security and order in the institution. When responding to the challenging problem of AIDS in prisons, administrators must not only deal with the difficult medical issues, but they must also balance medical considerations and medical advice against complex correctional management factors. Medical guidelines and correctional considerations may often be at odds. Finally, decisionmaking is further complicated by legal and cost concerns.

Chapter Four seeks to assist correctional administrators with these decisions by discussing the following issues and options:

#### Medical Issues

- Detection, diagnosis and medical surveillance
- Counseling and support services

#### Correctional Management Issues

- Housing policies for inmates with AIDS,

ARC and HTLV-III seropositivity (e.g. maintaining inmates in the general population, returning inmates to the general population when their illnesses are in remission, administratively segregating inmates in a separate unit, employing single-cell housing, hospitalizing inmates, and case-by-case determination of all housing and treatment decisions)

- Precautionary measures to prevent spread of the disease
- Disclosure versus confidentiality of medical information on inmates with AIDS, ARC or HTLV-III seropositivity
- Duration of incarceration (executive clemency versus extended custody)
- Costs of medical care and ancillary services
- Responsibility for aftercare

#### Legal Issues

- Standards for correctional medical care
- Equal protection issues
- Quality of care in AIDS cases
- Failure to protect other inmates and staff from AIDS

The appendices to this report present an extensive resource list, as well as examples of well-conceived educational, training and counseling materials and other documents useful to the formulation of correctional policies on AIDS.

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## **Part One**

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### **The Problem of AIDS**

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# Chapter 1: The Cause, Transmission and Incidence of AIDS

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Acquired Immunodeficiency Syndrome (AIDS) is a serious communicable disease that undermines the human body's immune system. It makes the individual susceptible to a range of "opportunistic" infections, malignancies and other diseases which would not generally be life-threatening to persons with normally functioning immune systems. AIDS is also now suspected of causing dementia and other disorders of the central nervous system. While the overall incidence of AIDS in the American population is still relatively small (3.4 cases per 100,000 population in 1985<sup>1</sup>), the disease nonetheless represents a very serious public health problem. This is primarily because of the high mortality rate, the lack of a vaccine or cure for the disease, the potentially very large number of infected (and infectious) individuals, the uncertain but often prolonged incubation period, and the high degree of uncertainty as to whether an infected person will ever develop AIDS-related symptoms or the end-stage disease itself.

AIDS was first recognized in the United States in 1981, although it may actually have appeared somewhat earlier. The disease was identified through studies of several groups of previously healthy gay men who developed an unusual form of pneumonia (*Pneumocystis Carinii* pneumonia) and a rare form of cancer (Kaposi's sarcoma). In the absence of other causes, the appearance of these diseases gave evidence of an underlying immunodeficiency in the patients.

AIDS is almost always fatal. Although research is proceeding on many fronts and there are beginning to be some promising results, there is presently no known vaccine or cure for AIDS. Indeed, it has been estimated that it will be five to fifteen years before the disease is brought under control in the United States through some combination of educational efforts and medical advances. According to researchers at the Centers for Disease Control (CDC), "right now, our only tools are education and behavioral change."<sup>2</sup> This statement is as true for the correctional setting as for society at large. Indeed, this report will stress that education and training must be the cornerstone of the correctional response to AIDS.

## The Probable Cause of AIDS: HTLV-III/LAV Virus

In 1983 and 1984, scientists at the Institut Pasteur in Paris and the National Institutes of Health identified

and isolated the probable cause of AIDS: a virus variously called Human T-Cell lymphotropic virus Type III (HTLV-III) or lymphadenopathy-associated virus (LAV). While it is generally believed that HTLV-III/LAV is an indispensable requirement for the development of AIDS, it is not fully established that this virus is the sole cause of AIDS; there may well be important "co-factors" that enter into the causal formula.

HTLV-III infects and destroys certain white blood cells (T4 cells), thereby undermining that part of the body's immune system which normally combats infections and malignancies. During the period of infection, these cells are unable to grow normally. One can be infected with HTLV-III for years, even indefinitely, without ever developing symptoms. However, asymptomatic (as well as symptomatic) persons may transmit the infection. In fact, it is sometimes suggested that asymptomatic individuals may be more infectious than those with symptoms. This is because individuals in the initial stages of infection have more white blood cells (leukocytes) which are the hosts of the HTLV-III virus. Thus, they may have more of the virus in their bodies to transmit. As the infection progresses, more of the white cells are destroyed, leaving fewer to host the virus. Thus, the individuals will have progressively less of the virus to transmit.

## HTLV-III Antibody Test

In early 1985, a commercial test for antibody to HTLV-III became available. The test is an Enzyme-Linked Immunosorbent Assay (ELISA or EIA), a method which is used for other purposes besides detection of antibody to HTLV-III. (However, for convenience, we refer hereafter to the HTLV-III antibody test as the ELISA test.) It does not detect the presence of the virus itself—only the presence of antibodies to the virus. (Antibodies are evidence present in the blood of the immune system's attempt to fight off an infection.) A positive result on the ELISA test means that the individual was infected at some time in the past. However, the test cannot pinpoint the date of infection or even determine whether the individual remains infected.

Actual culturing of the virus (i.e., growing the virus from a specimen of body fluid or tissue) is very difficult and is currently performed in only a few research laboratories. Other blood tests for the virus (e.g. T-

cell tests) are also difficult and expensive. However, CDC notes that new, more viable techniques for detecting the HTLV-III virus (as opposed to antibodies to the virus) may be available within one or two years.

The ELISA test was developed to screen the blood supply, and it has been very effective for that purpose. The nation's blood supply is now considered safe. However, the ELISA test is now being used to screen people rather than blood, as well as to complement diagnostic procedures. Screening of donated blood and blood products is usually limited to a single ELISA test. However, when the test is used to screen people, specimens which test positively are usually subjected to a second ELISA and/or to a more accurate but expensive method of detecting antibodies—the "Western Blot" test—to confirm or disconfirm the original result.

Perhaps the most widely publicized application of the test to screen people is the Defense Department's screening of all potential recruits for the armed forces and its plans to institute screening of all active-duty and reserve personnel as well. As will be discussed in Chapter Two, there is substantial controversy surrounding use of the test to screen and diagnose individuals.

## Definitions

AIDS is not a single disease: indeed, there is a spectrum of possible reactions to the virus thought to be the cause of AIDS, from no symptoms to "end-stage" AIDS. Terms have been given to the degrees of reaction along this spectrum. However, there are variations in the definitions of these terms and, in fact, some researchers and physicians have defined alternative points along the spectrum of illness. A basic understanding of the complexities and variations of the definitions is a prerequisite for understanding statistics on incidence and epidemiology of AIDS. The following categories are the most important and widely used. [Appendix B presents some additional terms and categories that have also been used.]

### AIDS ("end-stage")

AIDS has no independent symptoms. Rather, diagnosis is based on the presence of "opportunistic infections" or unusual cancers. An opportunistic infection is one occurring in individuals whose immune systems are compromised, but not generally seen in individuals with normal immune systems. The CDC "surveillance definition" of AIDS (i.e., the definition

used for enumeration and epidemiological analysis of AIDS cases in the United States) is the most widely used.<sup>3</sup> According to this definition, AIDS is

an illness characterized by: I) one or more opportunistic diseases that are at least moderately indicative of underlying cellular immunodeficiency, and II) absence of all known underlying causes of cellular immunodeficiency (other than HTLV-III/LAV infection) and absence of all other causes of reduced resistance. . . .

[The latest revision of CDC's complete surveillance definition is included in Appendix B.] The CDC definition includes a long list of opportunistic infections, malignancies and other conditions, the two most common of which are probably *Pneumocystis Carinii* pneumonia and Kaposi's sarcoma.

### AIDS-Related Complex (ARC)

A diagnosis of ARC is based on presence of a combination of conditions, often quite mild, that together give evidence of infection with the AIDS virus. Individuals with ARC may get better but remain infected. The most commonly used definition of ARC is from the National Institutes of Health: any two from a long list of symptoms including swollen lymph nodes, weight loss, and night sweats and *any* two from a list of laboratory abnormalities, including blood test results showing depressed helper T-cells and depressed helper/suppressor ratio.<sup>4</sup> [The complete NIH definition is also included in Appendix B.]

### HTLV-III Seropositivity

Confirmed seropositivity (i.e., confirmed presence of antibodies to HTLV-III) means that the individual has been infected with the AIDS virus at some time, although the body may have subsequently fought off the infection. The likelihood that HTLV-III seropositivity means current infection with the virus is considered much greater for individuals in identified AIDS risk groups. Nevertheless, seropositive individuals may never develop any symptoms, let alone develop end-stage AIDS. On the other hand, seropositive individuals may be able to transmit the infection to others, even if they never develop symptoms themselves. CDC's recommended criteria for a determination of seropositivity are two positive ELISA tests for antibody to the AIDS virus confirmed by a Western Blot test.

Figure 1.1

**RELATIONSHIPS AMONG EXPOSURE, INFECTION, HTLV-III SEROPOSITIVITY AND DEVELOPMENT OF ARC OR AIDS**

<u>Stage</u>	<u>Meaning</u>	<u>Relationship to Previous Stage(s)</u>
Exposure	Individual has contact with HTLV-III in a way that makes transmission possible (e.g., sexual contact or needle-sharing activity)	—
Infection	Individual is infected with HTLV-III. Infection may be permanent or body may successfully combat the virus.	Unknown, although multiple exposures probably increase the risk of infection.
Seropositivity	Individual has antibodies to HTLV-III, meaning that infection has occurred at some time in the past. ELISA test cannot pinpoint date of infection or determine whether individual remains infected. It takes 1-3 months from the time of infection for the antibodies to appear.	CDC considers ELISA test a reliable indicator that infection has occurred at some time. Reliability increases with repeat ELISA and Western Blot Tests. (See Chapter Three.)
ARC	Presence of a combination of conditions together giving evidence of infection with AIDS virus.	CDC estimates that about 25 percent of seropositive individuals will probably develop ARC. However, this estimate is uncertain due to the lengthy incubation period.
AIDS	Illness characterized by one or more opportunistic infections at least moderately indicative of underlying cellular immunodeficiency.	CDC estimates that about 5-6 percent of seropositive individuals will probably develop AIDS. However, recent studies place the fraction as high as one-third and all estimates are uncertain due to the lengthy incubation period.

**The Relationships Among Exposure, Infection, HTLV-III Seropositivity, and Development of ARC or AIDS**

Figure 1.1 summarizes the meanings of exposure, infection, seropositivity, ARC, and AIDS and the relationships among these stages. "Exposure" to HTLV-III means that the individual has had contact with the virus in a way that would make it possible for him or her to become infected (e.g., sexual contact or needle-sharing activity). No one knows exactly what fraction of exposed persons will become infected and remain infected. However, research on a cohort of 6,875 sexually active homosexual males in San Francisco reveals very high rates of seroconversion (i.e., becoming HTLV-III seropositive over time), indicating that multiple exposure increases the risk of infection. A representative sample of the cohort was 4 percent

seropositive when their blood samples (collected in 1978) were first tested. By 1985, the seropositive rate in the sample had increased to an astounding 73 percent.<sup>5</sup>

HTLV-III seropositivity means that the individual was, in fact, infected at some time in the past, although the ELISA test cannot pinpoint the date of infection or determine with certainty that the individual is still infected. Thus, the view commonly presented in articles regarding AIDS (as well as in some correctional departments' educational materials and policy statements) that HTLV-III seropositivity merely indicates possible "exposure" to the virus is considered by many physicians and epidemiologists to be a serious misunderstanding. Indeed, CDC's current position is that, for the purposes of counseling and making public health recommendations, any seropositive person should be considered infected and potentially infec-

tious. The long—possibly indefinite—incubation period of AIDS makes seropositivity a very serious problem because it is never possible for a seropositive individual to know for certain that he or she is free from risk of becoming ill or infecting others.

However, probably only a minority of seropositive persons will develop ARC or AIDS. Based on data from the San Francisco cohort study, CDC estimates that 25 percent of seropositive individuals will develop AIDS-Related Complex. Such figures may be open to debate because of variations in definitions of ARC and because of the uncertain length of the incubation period. Finally, the San Francisco cohort data suggest that about 5-6 percent of HTLV-III seropositive persons will develop AIDS. The San Francisco figures are based on a five-year follow-up period; with the long and uncertain incubation period of AIDS, it is possible that the percentages of individuals in the San Francisco cohort who develop AIDS or ARC will rise. Indeed, a recent study of 800 seropositive persons in the United States and Denmark found that 10-15 percent developed AIDS within 3½ years and another recent study of a group of New York City homosexual males found that one-third of those infected with HTLV-III as of 1982 have developed AIDS.<sup>6</sup>

These research findings are beginning to suggest the quantitative relationships among seropositivity, infection, and the development of illness. However, among the most puzzling questions about AIDS remain the determinants of actual infection among those persons exposed to the virus and the determinants of developing symptoms or becoming ill among those persons who are infected.

There are numerous theories, but no clear answers, regarding the determinants of infection among those persons exposed to the virus. Dr. Charles Rabkin, a New York City Health Department epidemiologist, describes three of the theories as follows:<sup>7</sup>

- “The Russian-roulette theory”: development of infection is almost purely a matter of chance. A person who engages in sexual activity during which the infection may be transmitted or shares a potentially contaminated needle has a small chance, each time, of becoming infected; however, the more potential exposures, the greater the cumulative risk of infection.
- “The safe-period theory”: development of infection depends on certain specific, but as yet unknown, circumstances which may be present at some times but not at others.

- “The last-straw theory”: development of infection becomes more likely with each in a series of exposures, because each exposure progressively weakens the immune system, making it more susceptible to the virus. In addition, drug abuse (whether or not it involves sharing of contaminated needles) or other independent medical conditions may progressively weaken the immune system so that the body is more susceptible to HTLV-III infection.

While these theories refer specifically to the relationship between exposure and infection, similar hypotheses have been advanced regarding the relationship between infection and development of ARC or AIDS. In particular, it has been suggested that continued exposures subsequent to initial infection may increase the chances that symptoms will develop.

### Incubation Period of AIDS

As more information is gathered and analyzed by CDC on the natural history of AIDS, the more it appears that the progression from asymptomatic infection to ARC to end-stage AIDS occurs very slowly. The incubation period for AIDS may be two and one-half to five years or more. Indeed, some researchers believe that there may be no real maximum incubation period—that is, an infected person may develop symptoms at any time during his or her life. Because of the painful uncertainties and anxieties involved, this is one of the most troubling aspects of the disease.

The often lengthy incubation period of the disease also poses problems for epidemiological analysis. The patterns of actual disease appearing now reflect the patterns of infection that were occurring several years ago; they do not necessarily reflect what the patterns of the disease will be several years from now.

### Transmission of AIDS

One of the most serious problems surrounding the public response to AIDS has been the large amount of misinformation and rumor about how the infection is transmitted. For example, a recent national survey commissioned by the American Association of Blood Banks discovered that 34 percent of the respondents incorrectly believed that one could contract AIDS from donating blood.<sup>8</sup> Misinformed fear has been particularly prevalent among inmates and staff of correctional institutions. This section summarizes the most current medical knowledge on how AIDS is and is not transmitted.

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## **Known Means of Transmission: Blood and Semen**

According to CDC, there is extremely reliable information on the means of transmission of HTLV-III infection and AIDS. The virus appears to be transmitted exclusively through exposure to contaminated blood and semen. This occurs primarily through sexual relations and needle-sharing activities.

As with any sexually transmitted disease, the risk increases as the number of potential exposures increases. Thus, those who are extremely active sexually, with numerous partners and especially with partners not previously well-known to them, may be at higher risk. This applies to heterosexuals as well as to homosexuals and bisexuals. While there is some evidence that anal intercourse (especially for the receptive, as opposed to the insertive, partner) and other practices that may involve trauma or bleeding are especially risky, the risk of transmission involved in vaginal intercourse and other forms of sexual activity should not be minimized. CDC emphasizes that any form of sexual activity involving exchange of body fluids should be avoided when either partner is known or suspected to be infected.

Currently, exposure to contaminated blood occurs almost exclusively through needle-sharing by intravenous drug abusers. There have been cases associated with blood transfusions and hemophiliacs' receipt of blood products. However, the nation's supply of blood and blood products is now considered safe, as a result of universal ELISA screening of donated blood and heat treatment of Factor VIII preparations of blood products regularly given to hemophiliacs.

Finally, there have been cases of perinatal transmission to infants by infected mothers. It is not yet clear whether the infection is transmitted before or during delivery.

## **Difficulty of Transmission**

CDC emphasizes that HTLV-III infection is difficult to transmit. A relatively large dose of the virus is required and infection is highly unlikely based on a single exposure of any kind. Moreover, the virus is not very hardy when outside the human body. It is susceptible to heat, to many common household disinfectants and detergents, and to washing with simple soap and water.

HTLV-III infection is often compared to Hepatitis-B infection in that both are transmitted by exposure to contaminated blood and other body fluids, primarily during sexual activities and intravenous drug use.

However, Hepatitis-B is transmitted more efficiently than HTLV-III infection.<sup>9</sup> Therefore, infection control measures (such as precautions regarding contact with blood and other body fluids) designed to prevent transmission of Hepatitis-B should be more than sufficient. Indeed, CDC recommends that these precautions be used in AIDS cases. More extreme measures than those recommended for Hepatitis-B are unnecessary and inappropriate for controlling transmission of HTLV-III infection and AIDS.

The most critical point to convey in education and training programs regarding AIDS is that there is absolutely *no* evidence of the infection being transmitted by casual contact. CDC emphasizes that AIDS is not spread by sneezing, coughing, breathing, hugging, handshaking, sharing eating and drinking utensils, using the same toilet facilities or any other form of non-sexual contact or activity. The lists of non-dangerous contacts published by the CDC and by state and local public health agencies are not intended to be exhaustive. Indeed, it would be impossible to develop an exhaustive list. Therefore, if any particular type of contact is omitted from a list, this does not mean that it is dangerous. The critical point is that the disease has not been transmitted by any type of casual contact.

## **Evidence Against Transmission by "Casual Contact"**

Strong evidence for the conclusion that AIDS is not spread by casual or even intimate non-sexual contact comes from studies of family members of AIDS patients and of health-care workers who cared for AIDS patients, as well as from experience in other settings where close but non-sexual contact or ostensibly risky exposures have occurred. A study of 101 family members and others (other than sexual partners and infants who might have been perinatally infected) living in the same household with AIDS patients revealed no cases of AIDS or ARC and only one case of HTLV-III seropositivity. The seropositive individual was a very young child who was probably infected at or before birth.

These family members shared dishes, cooking and eating utensils, toothbrushes, razors, toilets, beds, baths, kitchens and many other places and objects with AIDS patients. They also engaged in extensive non-sexual physical contact with AIDS patients. However, despite the closeness and frequency of the contact, no transmission of HTLV-III infection or AIDS took place in these households.

There have been cases of AIDS among health-care workers, but almost all of these individuals were

themselves in known high-risk groups. There have been a few AIDS cases among health-care workers not known to be in AIDS risk groups. However, none of these individuals had had an occupational exposure to the virus.

Even actual exposure to contaminated blood in a health-care setting has proven to be very low-risk for those not already in known risk groups. CDC has identified 1,498 health-care workers with all kinds of direct exposures to the blood and other body fluids of AIDS patients; 666 had actual blood-to-blood contact through needlesticks or other sharp instrument injuries. Of these 666 individuals, 26 (or 4 percent) tested seropositive. However, 23 of these 26 seropositives were already in AIDS risk groups. Thus, only three U.S. health-care workers who have been exposed to the AIDS virus through needlesticks or other sharp instrument injuries, and who were not in known risk groups, have tested positive for antibody to HTLV-III (0.5 percent of the 666 persons with needlesticks).

In two of the U.S. cases, it was not even clear that seroconversion occurred as a result of the needlestick because no prior test results were available to show whether the individuals were positive or negative at the time of the incident. Both of these health-care workers developed lymphadenopathy (prolonged and unexplained enlargement of the lymph nodes), but neither has developed end-stage AIDS. In the third U.S. case, no additional information was available.

One case has also been reported from Great Britain. In this case, a health-care worker seroconverted as a result of a needlestick (a prior negative test was available in this case), but this individual has thus far remained entirely asymptomatic.<sup>10</sup>

There is no evidence of AIDS transmission in schools, offices, churches or other social settings, nor are there any documented cases of police officers, paramedics, or firefighters contracting the disease as a result of rendering first aid or mouth-to-mouth resuscitation to an infected person. Finally, as the present NIJ/ACA study shows, there have been no cases of correctional staff contracting AIDS (or even seroconverting) as a result of contact with an infected inmate.

While the AIDS virus has been isolated in saliva, tears and urine, although at lower concentrations than in blood and semen, CDC notes that there is no evidence of spread of the disease through any bodily fluids other than blood or semen. A recently reported study strengthens the conclusion that HTLV-III infection is not likely to be transmitted through saliva. Researchers at Massachusetts General Hospital attempted to grow the HTLV-III virus from 83 saliva samples taken from

71 homosexual men, all of whom are HTLV-III seropositive (20 are presently healthy, 32 have ARC and 19 have AIDS). The actual virus could be grown from only one (1 percent) of these 83 saliva specimens. In contemporaneous studies, other researchers are reaching similar conclusions.<sup>11</sup>

Moreover, physicians and medical researchers emphasize that the studies of family members and health-care workers strongly suggest that the risk of contracting HTLV-III infection through body fluids other than blood or semen is very low. Although CDC notes that biting and kissing which involve exchange of saliva may present some limited risk,<sup>12</sup> there have been no reported cases of AIDS associated with biting or kissing.

These research findings are particularly important to the correctional setting because of concerns among inmates and correctional staff that AIDS may be transmitted by urine-throwing incidents, biting incidents and other such incidents that may occur in institutions. The research on family members and health-care workers with analogous exposures (and even ostensibly more serious exposures, such as needlesticks) indicates that these risks are extremely low.

The possibility of transmission of the infection by food-service workers has caused concern in correctional facilities as well as in the community at large. However, it would be very difficult for such transmission to occur and there are no documented cases of this kind. To be successfully transmitted through food, a sizable dose of the virus would first have to get into the food and thence into someone else's mouth. This in itself is unlikely, but even if it happened the virus would probably be killed by acidic juices in the stomach. This would be the likely outcome in the common hypothetical correctional scenario in which an infected inmate working in a food service assignment deliberately or accidentally spits or bleeds in the food. Because there is no evidence that the infection is transmitted through food, CDC specifically recommends against screening food service workers for antibody to HTLV-III.

## **Incidence of AIDS in the Population at Large**

According to CDC figures through the end of 1985, there have been over 16,000 adult cases of AIDS in the United States. In addition, there have been over 200 pediatric cases. New York State and California together account for 60 percent of the cases in the United States, while New Jersey, Florida and Texas

collectively account for another 18 percent of the total. Within these states, cases are heavily concentrated in major metropolitan areas. CDC estimates that for each confirmed AIDS case, there are five to ten cases of ARC—thus perhaps as many as 160,000 nationwide. Also, there may be as many as 1.6 million HTLV-III seropositive individuals.

### AIDS High-Risk Groups

Ninety-four percent of all AIDS cases have been in males and 90 percent of the adult cases have been in people 20-49 years of age. The overall racial/ethnic distribution of all cases is as follows: White—60 percent; Black—25 percent; Hispanic - 14 percent; and Other/Unknown—1 percent.<sup>13</sup> Thus the racial/ethnic distribution of total cases is not dissimilar from the racial/ethnic breakdown of the total population of the United States.

About 30-40 new case reports are received by CDC each day. CDC believes that the number of cases will double between November 1985 and November 1986, although the cumulative total cases may not continue to double in subsequent twelve-month periods.

Thus far, more than 8,000 people have died of AIDS in the United States. The end-stage disease is almost always fatal; in no known case has the patient's immune system been restored. Statistically, the overall death rate for known cases is about 50 percent, but this substantially underestimates the real death rate, because the vast majority of cases in the CDC database have only been reported in the last two years; many of these patients are still alive, but will ultimately die. Because of the passage of time, death rates for cases reported in earlier years are now about 80 percent.

The reason for the high AIDS death rate is that the immune abnormality created by the HTLV-III infection persists even if treatment of discrete opportunistic infections is initially successful. The average life expectancy for the AIDS patient is 224 days after first hospitalization for an opportunistic infection.<sup>14</sup> However, there are patients still living more than three years after diagnosis of end-stage AIDS.

Most cases of sexually transmitted AIDS have occurred in homosexual and bisexual males. While the AIDS virus is generally hard to transmit, it appears to spread very efficiently among some groups, particularly those in which repeated exposures are likely to occur. This is established by the very high seroconversion rates in the cohort of San Francisco homosexual males discussed earlier.

There is also evidence of transmission through

heterosexual relations. Heterosexual transmission has been largely male-to-female in the United States, although African evidence strongly suggests female-to-male transmission. There is some disagreement among epidemiologists over the extent to which AIDS is likely to appear among heterosexuals in the United States. Some believe that large numbers of heterosexuals will inevitably be infected. Others argue that HTLV-III infection will probably continue to be transmitted predominantly through homosexual contact because anal intercourse, which is more likely than vaginal intercourse to result in direct insertion of the virus into the blood stream, is more prevalent among homosexuals than among heterosexuals.<sup>15</sup>

The most recent CDC breakdown of confirmed AIDS cases is shown in Figure 1.2. There is an overlap of approximately 7 percent between the homosexual/bisexual and intravenous drug abuser categories. CDC uses a hierarchical classification under which cases who are both homosexual/bisexual and intravenous drug abusers are assigned only to the former category, although it is not necessarily true that they contracted the infection through sexual activity rather than through drug abuse. Taking into account the overlap, about 24 percent of reported AIDS cases are in persons with some history of intravenous drug abuse.

Figure 1.2

#### BREAKDOWN OF CONFIRMED AIDS CASES BY RISK GROUPS

Risk Group	% of all cases
Homosexual/bisexual males	73%
Intravenous drug abusers	17
Transfusion recipients	2
Hemophiliacs	1
Heterosexuals with a partner in one of the above risk groups	1
Other/unclassified	6
<b>TOTAL</b>	<b>100%</b>

Source: Dr. Harold Jaffe (CDC), presentation at National Institute of Corrections meeting of Correctional Administrators on AIDS, Atlanta, Georgia, November 6, 1985.

A minority of the "Other/Unclassified" cases (about 2 percent of total cases) are Haitian-born individuals living primarily in South Florida and the New York

Figure 1.3

**DISTRIBUTION OF CUMULATIVE TOTAL AIDS CASES AMONG INMATES,  
BY TYPE OF SYSTEM**

Range of Total AIDS Cases	State/Federal Prison Systems				City/County Jail Systems			
	n systems	%	n cases	%	n systems	%	n cases	%
0	26	51%	0	0%	13	39%	0	0%
1-3	15	29	24	5	10	30	16	5
4-10	5	10	30	7	7	21	43	14
11-25	2	4	42	9	1	3	12	4
26-50	1	2	33	7	1	3	40	13
51-100	1	2	95	21	0	0	0	0
> 100	1	2	231	51	1	3	200	64
Total	51	100%	455	100%	33	99 <sup>a</sup>	311	100%

Source: NIJ/ACA Questionnaire Responses.

<sup>a</sup>Due to rounding.

City area and the remainder are unclassified. The "unclassified" fraction are thought to have had known risk factors, but information on these factors was unavailable for various reasons—e.g. they could not be interviewed before they died, they refused to be interviewed, or they had forgotten or failed to admit activities involving possible exposure. The breakdown of AIDS cases by risk groups has remained remarkably stable since CDC began tracking the disease. This fact has been used as an argument in the ongoing debate regarding the relative risks of transmission by homosexual and heterosexual contact.

### Incidence of AIDS Among Correctional Inmates

Until the current NIJ/ACA study, there were no national data on the incidence of AIDS in correctional institutions. The CDC surveillance database is not able to identify all correctional cases. All that was available until now were scattered figures for state and county/municipal systems.

All fifty states, the Federal Bureau of Prisons, and 33 large city and county jail systems responded to the NIJ/ACA questionnaire. (Appendix C presents a list of these city and county systems.) Responses to the questionnaire reveal that there have been 455 confirmed AIDS cases among inmates in 25 state and federal

correctional systems and 311 cases in 20 responding city and county jail systems.<sup>16</sup> Thus, questionnaire responses reveal a total of 766 correctional AIDS cases. These figures represent *cumulative* total cases since the respondent jurisdictions began keeping records. Nineteen state and federal systems responding to the questionnaire reported 144 current cases of AIDS among inmates; eleven city and county systems reported 35 current cases. Thus, our study identified a total of 179 current cases of AIDS among correctional inmates. According to questionnaire responses, 275 inmates have died of AIDS while in the custody of state and federal correctional systems, and 47 city and county inmates have died of AIDS.

Federal and state correctional systems reported 140 ARC cases, while city and county systems reported 112 ARC cases. The figures for ARC are artificially low because many jurisdictions, including the states with the largest numbers of AIDS cases, do not maintain statistics on ARC cases. Moreover, there are problems of double-counting, since most confirmed AIDS cases were probably ARC cases at one time. We are unable to present figures on the incidence of HTLV-III seropositivity since, as discussed further in Chapter Three, very few jurisdictions have initiated the mass HTLV-III screening that would be necessary to develop such statistics.

Figure 1.3 presents the distribution of total confirmed AIDS cases by type of correctional system. The

Figure 1.4

**DISTRIBUTION OF CUMULATIVE TOTAL AIDS CASES  
Across State/Federal Prison Systems**

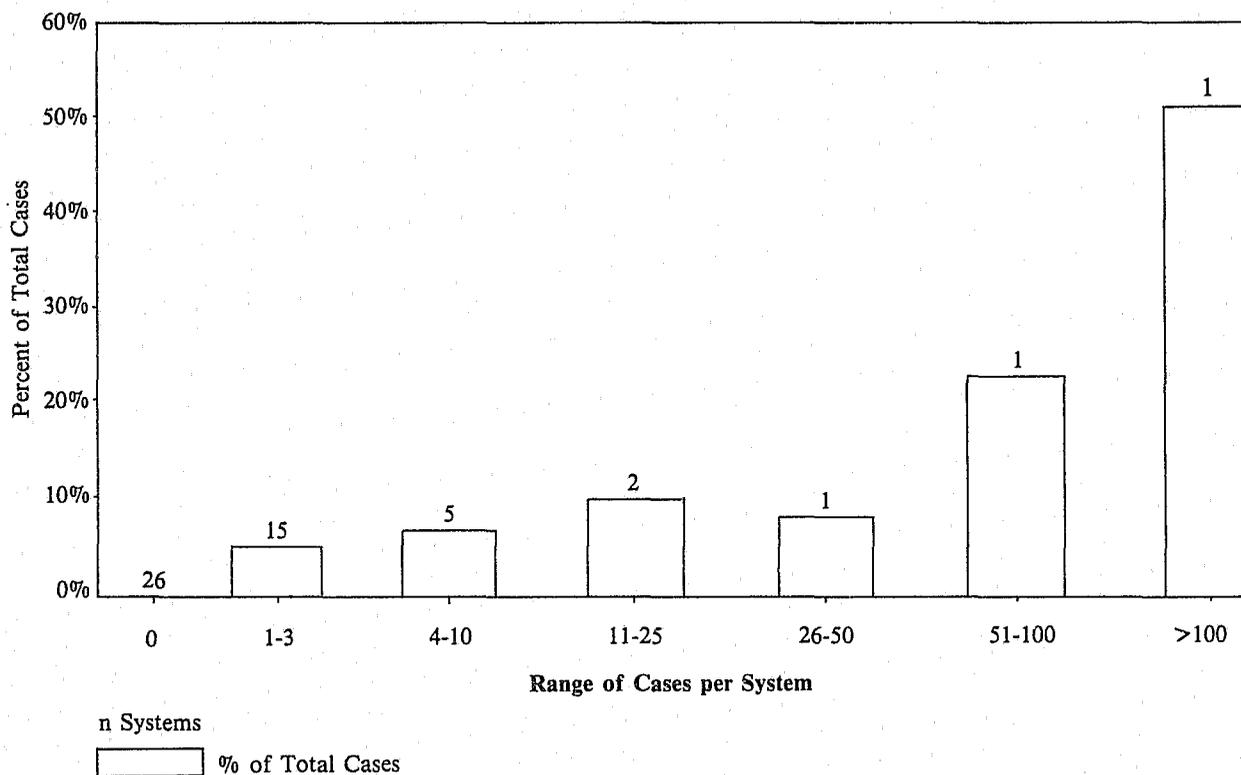


Figure 1.5

**DISTRIBUTION OF CUMULATIVE TOTAL AIDS CASES  
Across City/County Jail Systems**

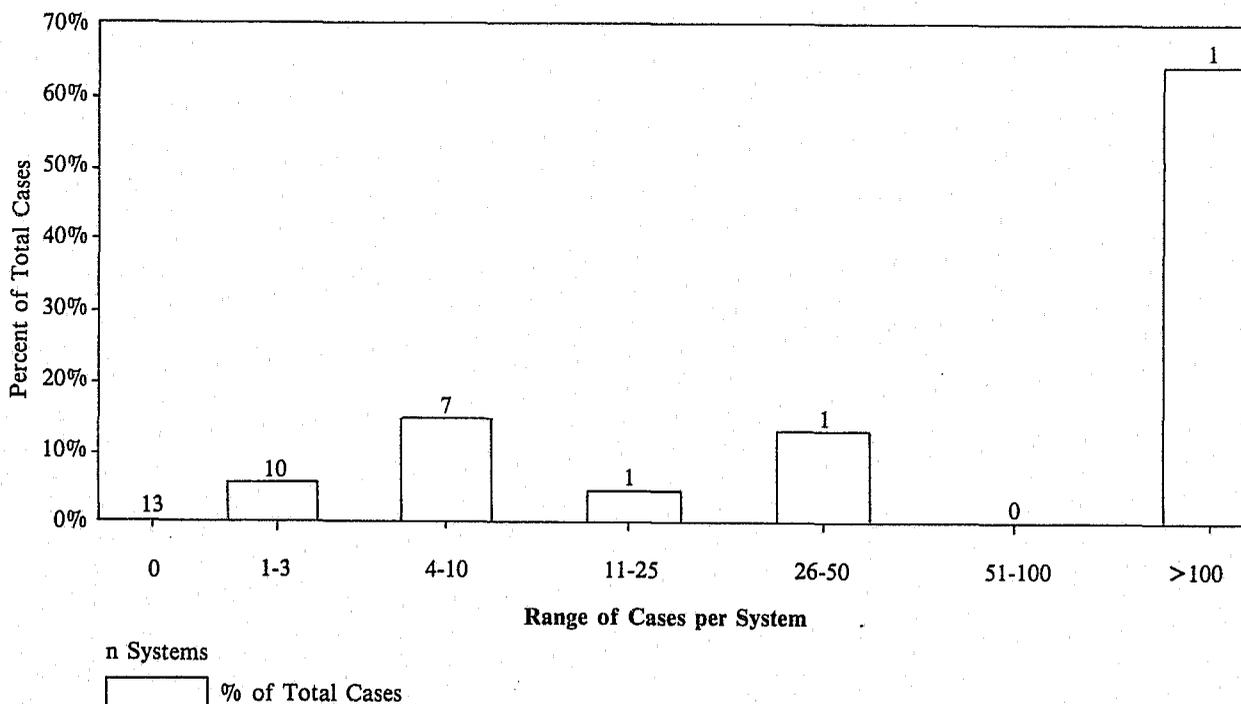


Figure 1.6

**REGIONAL DISTRIBUTION OF CUMULATIVE TOTAL AIDS CASES  
BY TYPE OF SYSTEM  
(Federal Bureau of Prisons Excluded)**

Region	State Prison Systems		City/County Jail Systems	
	n cases	% of total	n cases	% of total
New England <sup>a</sup>	16	3.7%	0	0.0%
Mid-Atlantic <sup>b</sup>	327	75.5	222	71.4
E.N. Central <sup>c</sup>	6	1.4	8	2.6
W.N. Central <sup>d</sup>	0	0.0	1	0.3
S. Atlantic <sup>e</sup>	49	11.3	24	7.7
E.S. Central <sup>f</sup>	1	0.2	0	0.0
W.S. Central <sup>g</sup>	12	2.8	3	1.0
Mountain <sup>h</sup>	2	0.5	1	0.3
Pacific <sup>i</sup>	20	4.6	52	16.7
Total	433	100.0%	311	100.0%

<sup>a</sup>Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut

<sup>b</sup>New York, New Jersey, Pennsylvania

<sup>c</sup>Ohio, Indiana, Illinois, Michigan, Wisconsin

<sup>d</sup>Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas

<sup>e</sup>Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida

<sup>f</sup>Kentucky, Tennessee, Alabama, Mississippi

<sup>g</sup>Arkansas, Louisiana, Oklahoma, Texas

<sup>h</sup>Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada

<sup>i</sup>Washington, Oregon, California, Alaska, Hawaii

figure shows that the distribution of cases across systems is highly skewed. Fifty-one percent of state and federal systems have had *no* cases and 80 percent have had fewer than four cases. Among responding city and county systems, 39 percent have had no cases and 69 percent have had fewer than four cases. At the other extreme, only two state and federal systems and only one city or county system have had more than 50 AIDS cases. Another way of considering the distribution is that four percent of the state and federal systems have had 72 percent of the cases in those systems and 6 percent of the responding city and county systems have had 77 percent of the cases in those systems.

Figures 1.4 and 1.5 graphically depict the uneven distributions of cumulative total AIDS cases across the prison and jail systems responding to the NIJ/ACA

questionnaire. Figure 1.4 shows that three state prison systems contributed 79 percent of the total cases while another 41 systems contributed only 5 percent of the total cases. Figure 1.5 depicts a similar distribution for city and county jail systems: two systems accounted for 77 percent of the cumulative total cases while another 23 systems accounted for only 5 percent of the cases.

As might be expected, the high-incidence jurisdictions tend to be coastal and/or urban and industrial areas. Figure 1.6 presents the regional distribution of cases by type of system. This figure shows the extremely high concentrations of cases in the Middle Atlantic region: 75 percent of the cases in state systems and 71 percent of the cases in responding city or county systems.

There is an extremely wide range of incidence rates of

confirmed AIDS among prison inmates, even in those state correctional systems with current cases. This reflects the uneven distribution of cases across systems. In over one-half of the state and federal correctional systems, the incidence rate is zero, since there are no cases. In the systems reporting current cases of AIDS, the incidence rates range from 5 to 725 cases per 100,000 population.<sup>17</sup> However, incidence rates in 65 percent of the state prison systems with current cases fall between 5 and 40 per 100,000 inmates; only three systems have rates in excess of 100; and the next highest incidence rate after 725 is 126. In short, the system with the rate of 725 per 100,000 inmates is an extreme outlier. The highest incidence rates are in jurisdictions on the East Coast where needle-sharing in intravenous drug abuse is prevalent and where there are extremely high rates of seropositivity and AIDS among non-incarcerated intravenous drug abusers.

Any claims for the day-to-day accuracy of incidence rates for jails must be heavily qualified because of rapid population turnover. As with the state and federal systems, the incidence rates in about one-half of the city and county systems was zero, because they had no cases. Questionnaire responses reveal a range of 16 to 429 cases per 100,000 inmates in city or county jail systems which reported current cases of confirmed AIDS. The highest incidence rates were in jurisdictions in the Northeast.

Comparable incidence rates for the population at large were calculated using CDC figures for cases reported during 1985. As already noted, the incidence rate for the U. S. is 3.4 cases per 100,000 population in 1985. State-level incidence rates for 1985 range from 0 to 14 cases per 100,000 population, but the vast majority fall between 0 and 3. The higher incidence rates in correctional systems reflect the higher concentrations of risk-group members in inmate populations than in the population at large.

It should also be noted that there are wide variations in the incidence of AIDS in the general population both within and across states. For example, there are particularly high incidence rates in the New York City/Northern New Jersey metropolitan area. These are almost certainly associated with the unique drug culture in that area in which users make heavy use of "shooting galleries" where "works" are rented and shared.

### **Incidence of AIDS Among Correctional Staff**

Correctional staff in almost every jurisdiction have expressed concern about the possibility of contracting

HTLV-III infection or AIDS from inmates in the institutions. This NIJ/ACA study provides the first national test for the validity of those concerns. Responses to our questionnaire indicate that there are no known cases of AIDS, ARC or HTLV-III seropositivity among correctional staff as a result of contact with inmates. Respondents reported nine cases of AIDS among current or former staff members, but none of these individuals had been involved in incidents with inmates in which transmission of the infection could have occurred. Moreover, almost all of these staff members were themselves either known or strongly suspected to be in identified AIDS risk groups.

### **Characteristics of Correctional AIDS Cases**

Responses to the NIJ/ACA questionnaire show that all prison AIDS cases are thought to be related to intravenous drug abuse or sexual activity. In the jurisdictions with relatively large numbers of AIDS cases, respondents believe that the vast majority of inmate cases are associated with intravenous drug abuse. Fully 95 percent of cases in the New York state correctional system are intravenous drug abusers,<sup>18</sup> as opposed to 17 percent of cases in the New York State population at large. This is not surprising, given the high incidence of intravenous drug abuse and relatively low incidence of a homosexual lifestyle among criminal offenders. In addition, it appears that there is already a particularly high incidence of AIDS among intravenous drug abusers in the New York/Northern New Jersey area. The racial breakdown of cases in the New York state correctional system differs dramatically from the racial breakdown for all cases in the American population. In the New York state correctional system, 48 percent of cases are Hispanics, 32 percent are blacks, and 20 percent are whites. Because Hispanics and Blacks are over-represented among intravenous drug abusers, state correctional officials believe that this breakdown reflects the strong correlation between intravenous drug abuse and AIDS both in the state population at large and in the state correctional population.

### **Transmission of HTLV-III Infection in Correctional Institutions**

The issue of transmission of HTLV-III infection in prisons and jails is a complex one, whose handling is very important in the overall management of the AIDS problem in correctional systems. The complexity is largely due to the length and variability of the incubation period of AIDS, which make it difficult to know exactly when transmission of the virus occurred. There

is sharp debate on the subject, but little hard data as yet. CDC is not aware of any cases of AIDS among inmates continuously incarcerated since before the disease first appeared in this country. This may suggest that AIDS is not being transmitted within correctional institutions. However, the extreme variability of incubation periods renders this finding inconclusive. In some states, there may be too few inmates continuously incarcerated (without any parole, furlough or any other break in their incarceration) to support any such inference. Moreover, seroconversion rather than development of ARC or AIDS is the best indicator of transmission of the infection. The only way to study this systematically is through screening and followup studies.

Maryland is currently conducting a two-pronged study. First, the system anonymously tested 748 males and 39 females on intake. This represents all inmates entering two institutions during the period April-July 1985. Followup tests will be carried out on a sample from the original cohort to determine rates of seroconversion. Second, the system conducted voluntary testing of 137 inmates in one facility who had been continuously incarcerated for seven years or more.

The intake study revealed that 52 male inmates (7 percent) and six female inmates (15 percent) were confirmed seropositive (using a double ELISA and a Western Blot test). The higher rate among women was believed to be a result of higher prevalence of individuals with a history of intravenous drug abuse among incarcerated women than among incarcerated men in the Maryland system.

The testing of long-term inmates revealed two confirmed seropositives (1.5 percent). Because of their continuous incarceration since before the virus appeared in the United States, these two inmates are strongly believed to have seroconverted while in prison. However, Maryland officials point out that these data suggest very low transmission rates in their system. Moreover, these seroconversions occurred before the implementation of intensive educational programs on AIDS which are believed to have influenced inmate behavior.<sup>19</sup> Maryland correctional officials caution against assuming that the results of their study are applicable to other prison and jail systems. Such an assumption would be perilous because of the extreme geographic variability in the epidemiology of AIDS and in the incidence of behaviors known to transmit the infection.

Several attendees at a recent meeting of correctional administrators, medical directors and legal counsel on AIDS sponsored by the National Institute of Correc-

tions recommended that epidemiological studies similar to those being done in Maryland be conducted in the correctional populations of 3-5 additional states. These would be blind (i.e., anonymous) studies in which incoming inmates would be tested for antibody to HTLV-III. Re-testing would be performed at certain intervals to determine the rates of seroconversion. The followup testing could be performed on the same inmates as originally tested or, to provide additional assurance of anonymity, on a sample of inmates from the same cohort as those originally tested. The proposed studies would also include viral culturing of specimens testing positive for antibody to HTLV-III.

Although the Maryland study begins to provide some answers, the debate over the extent to which HTLV-III infection is being transmitted in correctional institutions is likely to continue for some time. The basic elements of the debate are as follows: correctional administrators point to the paucity of AIDS cases among long-term inmates and some argue further that AIDS is not being transmitted in prisons because the behaviors primarily associated with transmission (sexual activity and intravenous drug abuse) are effectively controlled in the institutions. Questionnaire respondents are virtually unanimous in the belief that all of their inmates with AIDS brought it with them into the institution rather than contracting the infection after they were incarcerated. These conclusions are based on the fact that the intervals between these inmates entering the system and their developing AIDS were much shorter than most estimates of the disease's incubation period.

On the other hand, some physicians and medical researchers argue from the following syllogism:

- 1) HTLV-III infection is transmitted through sexual activity and intravenous drug abuse;
- 2) some sexual activity and intravenous drug abuse occurs in even the best-managed correctional institutions; therefore
- 3) it is highly likely that HTLV-III infection is being transmitted in correctional institutions.

We emphasize that, with the exception of the results from the Maryland study, information on the extent of transmission of HTLV-III infection within correctional facilities simply does not exist. However, there are a number of factors regarding prison life that should be considered in attempting to assess the potential extent and primary means of transmission:

- Known outbreaks of syphilis and other sexually transmitted diseases in prison popula-

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tions suggest that AIDS can also be transmitted in the correctional setting.

- In two studies, the annual seroconversion rates for Hepatitis-B in correctional facilities were found to be about one percent.<sup>20</sup> Bearing in mind that Hepatitis-B is easier to transmit than HTLV-III infection, these figures may help to suggest how much transmission of HTLV-III infection is occurring in correctional institutions. On the other hand, seroconversion rates for Hepatitis-B may underestimate the incidence of transmissible behaviors (e.g., sexual activity and intravenous drug abuse), since there appear to be high rates of immunity to Hepatitis-B among prisoners. Thus, they may be engaging in such behaviors without seroconverting.
- Many (in some jurisdictions, most) inmates have histories of intravenous drug abuse. While it is unclear how much drug abuse involving needle-sharing occurs in prison (and some observers believe that drug use not involving needles is much more common), it is probably inevitable that at least some takes place.
- Reportedly, tattooing and the use of tattoo machines are prevalent in many correctional facilities, and this activity may expose inmates to blood contaminated with the AIDS virus.
- While the incidence of all types of sexual activity may vary widely across correctional systems, a report by the Federal Bureau of Prisons (based on data from the federal system and from some state systems) estimates that 30 percent of inmates engage in homosexual activity while in prison.<sup>21</sup> It should be noted that the data on which this estimate is based were collected before

AIDS became a serious problem in the United States. Since then, AIDS-related educational efforts may have reduced the incidence of homosexual activity in correctional facilities.

- Of particular concern with regard to the question of AIDS transmission in prison is the extent to which inmate sexual activity is non-consensual. According to the Federal Bureau of Prisons report, perhaps nine to twenty percent of prison inmates (particularly new inmates and openly homosexual inmates) are targets of aggressive sex acts during their incarceration. However, in the federal system, less than one percent were found to have been actually victimized.<sup>22</sup> Prison sexuality is complex; it includes consensual, quasi-consensual (i.e., consensual, but based on intimidation), and non-consensual activity. These components require very different responses, insofar as the prevention of AIDS is concerned. Consensual activity may be addressed through educational programs (and there are indications that behavioral change is occurring in prisons, perhaps as a result of educational efforts). It may only be possible to reduce quasi-consensual and non-consensual activity by more intensive supervision or surveillance and by more effective prosecution of inmate rapists.

As noted above, there are currently no conclusive data on the extent of transmission of HTLV-III infection within correctional facilities. Thus, correctional administrators must necessarily form their judgments and shape their policies on the basis of logic and common sense. Logic and common sense both suggest that even in the best-managed correctional institutions there may be at least some transmission of the AIDS virus occurring among inmates.

## Footnotes

1. The incidence rate per 100,000 population is a standard measure used to facilitate comparisons. The incidence rates for the population at large were calculated as follows:
 
$$\text{incidence rate} = \frac{\text{total number of cases reported to CDC in 1985} \times 100,000}{\text{total population of U.S.}}$$
2. Dr. Harold Jaffe (CDC), presentation at National Institute of Corrections meeting of Correctional Administrators on AIDS, Atlanta, GA, November 6, 1985.
3. It has been revised several times since first being issued in 1981, in order to add new opportunistic infections. There is some sentiment for further broadening of the definition due to the appearance of a broad range of syndromes not previously seen in AIDS cases.
4. There is some question as to whether this definition is still officially recognized. It was developed before the advent of the HTLV-III antibody test. There is a new definition under development by NIH.
5. CDC, *Mortality and Morbidity Weekly Report* (hereafter *MMWR*) 1985; 34:573-575. H.W. Jaffe et al., "AIDS in a Cohort of Homosexual Men: A Six-Year Follow-Up Study," *Annals of Internal Medicine* 1985; 103: 210-214.
6. *MMWR* 1985; 34: 573-575. AIDS cases as of August 1985 = 262 (5.2 percent of total cohort). Two of 31 (6.4 percent) initially seropositive men from the representative sample who were enrolled in the follow-up study developed AIDS and eight (25.8 percent) developed ARC over a median follow-up period of 61 months. Jaffe, et al., "AIDS in a Cohort of Homosexual Men," p. 212. Judy Foreman, "Study Said to Raise Risk Estimates for Exposure to AIDS," *Boston Globe*, January 9, 1986, p. 9. Boyce Rensberger, "Studies Indicate AIDS Escalation," *Washington Post*, January 10, 1986, p. 1.
7. Adapted from Janice Hopkins Tanne, "The Last Word on Avoiding AIDS," *New York Magazine*, October 7, 1985.
8. Press Release, American Association of Blood Banks, Arlington, Virginia, January 9, 1986.
9. This conclusion is based on a comparison of studies of health-care workers exposed to the Hepatitis-B virus and HTLV-III virus through needlesticks and other sharp instrument injuries.
10. *MMWR* 1985; 34: 575-578; *MMWR* 1985; 34: 101-103; S.H. Weiss et al., "HTLV-III Infection Among Health-Care Workers: Association with Needlestick Injuries," *Journal of the American Medical Association* 1985; 254:2089-2093.
11. D.D. Ho et al., "Letter: Infrequency of Isolation of HTLV-III Virus from Saliva in AIDS," *New England Journal of Medicine*, December 19, 1985, p. 1606; Daniel Q. Haney, "Researchers Say AIDS Virus Is Rarely Transmitted in Saliva," *Boston Globe*, December 19, 1985, p. 4.
12. *MMWR* 1985; 34: 1-5; *MMWR* 1985; 34: 517-520.
13. *MMWR* 1985; 34:245.
14. "Special Report: The AIDS Epidemic," *New England Journal of Medicine* 1985; 312:523.
15. Colin Norman, "AIDS Trends: Projections from Limited Data," *Science* 230 (November 29, 1985), p. 1021.
16. One city jurisdiction reported an estimate of 200-250 cumulative total AIDS cases. We used the low end of the estimate in all of our calculations.
17. The incidence rates for correctional systems were calculated as follows:
 
$$\text{incidence rate} = \frac{\text{current AIDS cases in system} \times 100,000}{\text{current population of system}}$$

For example, in a jurisdiction with two current cases and a total correctional population of 5,872, the incidence rate calculation would be as follows:

$$\frac{2 \times 100,000}{5,872} = 34.06$$

The reported number of *current* AIDS cases may slightly underestimate the total number of cases reported during 1985, but the latter statistic was not available in most systems. Thus, using the current number might slightly underestimate the real annual incidence rate in correctional systems.
18. Bureau of Communicable Disease Control, New York State Department of Health, *AIDS Surveillance Monthly Update: September 1985*, p. 12.
19. Maryland Division of Corrections, "Results of Surveillance for Serologic Evidence of Infection with HTLV-III/LAV in Inmates," presented at Press Conference, Baltimore, December 19, 1985.
20. These studies discovered seroconversion rates of 0.8 percent and 1.32 percent. H.F. Hull et al., "Incidence of Hepatitis-B in the Penitentiary of New Mexico," *American Journal of Public Health* 1985; 75:1213-1214; M.D. Decker et al., "The Incidence of Hepatitis-B in Tennessee Prisoners," *Journal of Infectious Diseases* 1985; 152:213-217.
21. P. Nacci and T. Kane. *Sex and Sexual Aggression in Federal Prisons* (Washington, Federal Bureau of Prisons, 1982), pp. 7-9.
22. *Ibid.*, p. 11.

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## **Part Two**

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# **Policy Options for Correctional Administrators**

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Part Two of this report covers the following major areas of correctional policy on AIDS: Education and Training; Screening and Testing; and Medical, Legal, and Correctional Management Issues. There is substantial debate in many of these areas. The report presents the rationales advanced for various policies as well as the results of the NIJ/ACA study on the prevalence of the major options identified.

Four major issues affect almost all aspects of correctional decisionmaking regarding AIDS.

1. The importance of effective education and training for both staff and inmates.
2. The relative importance of medical and correctional considerations in policy decisions.
3. The extent and nature of the correctional system's responsibility for preventing the transmission of AIDS.
4. The uniqueness of AIDS among communicable diseases as a problem for correctional policy-making.

To address the first issue, correctional administrators must develop a clear understanding of the concerns—both rational and irrational—of their inmates and staffs regarding AIDS. Once they have this understanding, they can develop educational programs that address those concerns and that offer practical means for preventing the spread of AIDS in correctional institutions.

To address the second issue, correctional administrators must decide whether to address AIDS purely as a medical problem and frame all their policies on screening, testing, housing, medical care and precautionary measures based on medical knowledge and advice, or whether (and how much) they should also take into account the special circumstances of the correctional environment. These circumstances include the potential concentration of persons with AIDS risk factors in the correctional population, the need to maintain the personal safety of the inmates, and the need to maintain the security and order of the institutions. For example, such perceived correctional considerations might suggest mass screening of inmates for antibodies to HTLV-III or administrative segregation of inmates with AIDS and ARC, even if medical authorities do not generally recommend such steps.

To address the third issue, decisionmakers must determine how much legal and ethical responsibility correctional systems should bear for preventing transmission of HTLV-III infection and whether their responsibilities should be more extensive in any way

than those borne by other institutions such as hospitals and schools. These decisions will determine, first, what procedures and precautions should be undertaken to prevent the spread of the AIDS virus in correctional institutions and, second, what notifications, if any, should be made to correctional staff, to previous and subsequent institutions, to public health agencies and to families and sexual partners regarding inmates with AIDS, ARC or HTLV-III seropositivity. For example, should correctional administrators institute mass screening of inmates for antibody to HTLV-III? Should correctional systems be responsible for notifying the county jail where an inmate with AIDS, ARC or seropositivity was previously held? Should correctional systems assume responsibility for notifying public health authorities, other agencies, or spouses/sexual partners when such inmates are released or transferred? No analogous screening programs or notifications have been implemented in the community at large.

To address the fourth issue, correctional administrators must decide whether AIDS is a unique disease requiring special policies and procedures or whether it ought to be addressed through correctional systems' existing policies for preventing transmission of communicable diseases and sexually transmitted diseases and for managing inmates with such diseases. Most correctional systems have communicable disease policies and some administrators believe that developing and implementing policies unique to AIDS only serves to draw undue attention to the AIDS issue and to increase concern among inmates and staff. Moreover, correctional legal staff point out that existing policies on communicable diseases generally have already been tested in court. This puts such policies at an advantage over newly promulgated policies which may be on uncertain legal ground.

Decisions on all four of these issues hinge, in large part, on the intrinsic risk posed by the correctional setting in transmitting or spreading AIDS. If the correctional environment is not more conducive to transmission of AIDS than other environments, then the correctional system's response to AIDS, like that of the outside community, should probably be based purely on effective education, medical considerations, and existing policies regarding communicable diseases (the only exception might be the institution of measures necessary to protect infected or ill inmates from other inmates). Moreover, if this is the case, then correctional administrators' responsibilities for protecting public health in the society at large (through notifications and other measures) should probably be no broader than those of officials in other settings.

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It is interesting to note that in the four systems which collectively have experienced almost three-fourths of the correctional AIDS cases in the United States (New York State, New York City, New Jersey, and Florida), there is a remarkable consistency of policy:

- extensive education on the means of transmission of the virus;
- no mass screening for antibody to HTLV-III;
- centralized medical evaluation and careful tracking of all inmates suspected of having ARC or AIDS;
- no non-medical segregation of ARC or seropositive inmates; and

- medical segregation of all confirmed AIDS cases.

With the exception of the centralized evaluation and medical segregation of AIDS cases, these policies are very similar to the policies followed in the community at large. Under these policies, all four systems have reached an equilibrium regarding the AIDS problem. There is no longer widespread fear among staff or inmates concerning transmission of the virus within the institutions. Inmate and staff education have been critical to the success achieved by all of these systems in establishing stability, allaying concerns, and promoting responsible behavior.

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## Chapter 2: Education and Training

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### Overview of the Issues and NIJ/ACA Study Results

Education and training programs are the cornerstone of efforts to prevent transmission of AIDS in prisons and jails, as well as in the population at large. In fact, the actual and potential role of education affects decisions on virtually all of the other issues and policy options discussed in this report. For example, the effectiveness of educational programs may play a major role in deciding whether AIDS, ARC or seropositive inmates should be administratively segregated.

Many correctional administrators feel strongly that education and training are not options but absolute requirements. Ninety-three percent of jurisdictions responding to our questionnaire currently offer or are developing some AIDS training or educational material for staff; 83 percent offer or are developing such programs for inmates. Over 90 percent of both federal/state and city/county systems offer or are developing staff education programs. However, the rates are not so uniformly high for inmate programs. Ninety percent of federal/state systems have instituted or are developing inmate education, as opposed to 73 percent of the responding city/county systems. The somewhat smaller percentage of jail systems providing inmate training is probably a result of the high inmate turnover rates.

Education and training are particularly necessary because of the prevalence of misinformation on AIDS. The NIJ/ACA study documents the persistent fears among inmates and staff that the AIDS virus is transmissible by "casual contact" and the widespread misunderstanding of the ways in which the virus is actually transmitted. Of the correctional systems responding to our questionnaire, 81 percent reported that inmates had expressed concern about AIDS and many of these respondents noted that inmates' concerns involved the possibility of contracting the infection through casual contact or types of contact not actually associated with its transmission. Ninety-three percent of the correctional systems reported staff concern and many of these also listed staff concern regarding "casual contact" or other contact never or very rarely shown to have transmitted the disease.<sup>1</sup>

Staff are reported to be particularly concerned about the possibility of contracting AIDS from aggressive inmates who may bite them, spit in their faces, throw

urine or feces on them, or jab them with sharp instruments. They are also concerned about risks involved in breaking up fights among inmates and providing CPR and other first aid to inmates. In general, correctional staff are troubled by the perceived risk that they could contract AIDS and transmit it to their families.

Such concerns have led staff in some jurisdictions to refuse to work in medical or non-medical units housing inmates with AIDS or ARC, to demand that all inmates be tested for antibody to HTLV-III, and to call for restrictions on the work assignments of inmates (e.g., no food service assignments) in all three AIDS-related categories. In some jurisdictions, correctional officers' unions have filed grievances and threatened strikes over the AIDS issue. In Minnesota, for example, the union has appealed the termination of a correctional officer who refused to conduct a "pat search" of an inmate with AIDS.

Inmates have reacted to the problem by demanding HTLV-III antibody testing of all inmates, refusing to take work assignments involving contact with AIDS inmates (e.g., hospital porters, laundry workers), demanding that seropositive inmates or homosexual inmates be excluded from food service assignments,<sup>2</sup> and calling for segregation of all high-risk inmates. There have also been isolated instances of threats and even actual violence against inmates with AIDS, ARC or HTLV-III seropositivity.

Such reactions among staff and inmates reflect serious misunderstandings of the documented means of AIDS transmission. Education and training programs may be able to counteract misinformation and rumors by carefully marshaling accurate information. Inmate educational programs in 47 jurisdictions had been in existence long enough at the time of the NIJ/ACA study to permit respondents to comment on their effectiveness. In 79 percent of these jurisdictions, respondents reported that the educational programs had been successful in reducing the fears of inmates. Eighty-five percent of jurisdictions able to make an assessment on the questionnaire reported success in reducing the fears of staff through training.

Many of the city/county jail systems reported that it is difficult to assess the effectiveness of inmate educational programs because of rapid population turnover. However, there are examples of successful training and education programs in jail systems. In New York City,

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a threatened walkout by correctional officers over the presence of inmates with AIDS was averted by a carefully designed education program. (This program is discussed in detail later in this chapter.) In fact, New York City correctional officials believe that their program has "put the AIDS hysteria to rest."

In New Jersey, timely educational efforts also prevented a threatened job action by the correctional officers' union and led staff to reverse an earlier refusal to transport inmates with AIDS. In another state, a union grievance was filed demanding that inmates be tested for antibody to HTLV-III before they could be assigned to work in food service. This dispute was also satisfactorily resolved through educational efforts without instituting a testing program. Arizona reports that correctional institutions with the most intensive training and education programs have the fewest problems with acceptance of inmates with AIDS, ARC and HTLV-III seropositivity. Similarly, Texas reports that there have been no major conflicts regarding the presence of AIDS and ARC inmates in prison units where education and training were provided on a timely basis.

While this reported experience is encouraging, it is still important to point out that the effectiveness of training and education depends on programs being planned and developed with sensitivity to the rational and irrational fears of all affected groups. A poorly designed education program may simply draw attention to the problem without allaying the concerns of staff and inmates.

Although the vast majority of correctional administrators agree that it is important to provide some education on AIDS for staff and inmates, there are a few who believe that these programs are counterproductive. In one California county, for example, policymakers have not instituted inmate education on AIDS because it "would most likely cause panic." Several other respondents noted that staff educational programs on AIDS may be ineffective because correctional officers are suspicious of any information coming from government agencies. Still, available evidence overwhelmingly supports the importance and potential effectiveness of education and training on AIDS for staff and inmates.

## **Key Issues and Options**

### **Staff and Inmate Educational Programs**

Most systems provide general training or informational materials on AIDS and its means of transmission to both staff and inmates. In addition, staff and inmates

may both receive more specialized training and information: staff training usually emphasizes ways to reduce risk during contact with inmates, while inmate training typically stresses avoiding behaviors such as sexual activities and needle-sharing that may result in transmission of the AIDS virus. While the content of much of the general information on AIDS presented to staff and inmates is usually very similar, training sessions for the two groups are always conducted separately.

Special individual counseling is typically provided to inmates found to be HTLV-III seropositive. Because of the risk of perinatal transmission of the HTLV-III virus, special counseling may also be provided to pregnant female inmates and staff or even to all women of childbearing age. Counseling for seropositive individuals is discussed in Chapter Four, and recommended counseling for pregnant women is discussed in recent CDC guidelines.<sup>3</sup>

### **Maximizing the Audience for Educational Programs**

Because of the widespread concern about AIDS, some correctional systems have instituted mandatory (or as close to mandatory as possible) education programs for inmates and staff on the subject. Every new staff member generally receives training on AIDS as a regular and required part of orientation. Many jurisdictions also require staff attendance at in-service sessions on AIDS.

Several states have instituted innovative approaches to maximizing the audience for inmate training on AIDS. In Minnesota, for example, videotaped training segments on AIDS were the only programs available on institutional closed-circuit television during certain time periods.

### **Records of Training Attendance and Receipt of Educational Materials**

When participation in inmate training programs is voluntary, it is wise for administrators to maintain a written record of those who did and did not choose to attend and those who received educational materials. In Maine, inmates may attend training or choose not to attend, but in either case they must acknowledge their choice in writing. Minnesota also has a sign-up system for AIDS training. New York City's Department of Corrections placed copies of its AIDS policy in each staff member's pay envelope and required each to sign for its receipt along with their check.

Such records may be useful in the event of a lawsuit. They may help the correctional system to build an "assumption of risk" defense to a suit alleging that its officials were negligent in the contraction of AIDS by an inmate or staff member. In other words, the system can demonstrate that the individual was offered education outlining the types of behaviors associated with transmission of the disease and the precautionary measures recommended to prevent acquisition of the virus. If the individual chose not to receive (or chose to ignore) this training and education, he or she assumed the risk of engaging in those behaviors and the system cannot be held responsible for the result. Of course, this defense would only be applicable if transmission of the infection occurred through a consensual act or through personal carelessness or negligence.

### **Timing and Frequency of Training**

Experience suggests that it is important to plan and institute educational programs on AIDS as early as possible—preferably before the first case is identified. Some physicians suggest that fear concerning transmission of the disease is greatest where there is the least actual experience with AIDS cases. As a result, it may be particularly important to institute education and training programs in jurisdictions that as yet have little or no direct experience with AIDS. In this way, education can help to eliminate many of the unfounded fears surrounding the disease before they have a serious negative impact.

It is important to maximize opportunities to provide educational information on AIDS. As noted above, each staff member should receive training on AIDS as part of the regular training program for new correctional officers/employees. However, NIJ/ACA study results reveal that only 33 percent of state and federal systems and only 15 percent of responding city and county systems provide or are developing programs on AIDS as part of the initial training of new employees.

Fifty-five percent of federal and state systems and 33 percent of responding city and county systems provide (or are developing) training on AIDS to all inmates at intake. In New York City, all inmates view a videotaped program on AIDS as part of their orientation. Intake procedures may also be modified to include an expanded physical examination and history-taking which focus on signs and symptoms of AIDS/ARC and on the presence of AIDS risk factors. This allows administrators to identify at-risk individuals and to re-emphasize important informational points regarding the means of transmission and appropriate preventive measures.

Training and education should also be presented to inmates and staff at regular intervals after intake or commencement of employment. Sixty-five percent of state and federal systems and 24 percent of responding city and county systems provide ongoing AIDS training to inmates at various intervals. Sixty-five percent of state and federal systems and 39 percent of responding city and county systems provide ongoing staff training.

The frequency with which education is presented depends on the mode of presentation. Pamphlets and brochures may be distributed or made available almost continuously. In most cases, live training sessions are only held every few months or as infrequently as every year, depending on the size of the system and the perceived need for training. Because of the changing nature of the AIDS situation, it is also important to present frequent updates on any new developments and to offer accurate and timely information to counteract unfounded rumors. Experience shows that if training and education programs are permitted to lapse, fears and concerns are quick to resurface among staff and inmates.

Inmate training and education just prior to release may also be extremely useful. Such sessions provide opportunities to make inmates fully aware of the risks and responsibilities they will face as they return to the community at large, with its broader range of personal freedoms and choices regarding sexual activities, drug abuse and other potentially dangerous behavior. Currently, however, only four percent of state and federal systems and three percent of responding city and county systems present training to inmates at the time of release.

Because of the rapid turnover in their inmate populations, jails face a more difficult problem in organizing their training and education programs. However, it may be feasible for jails to include a brief videotape or other presentation on AIDS in their orientation of all sentenced and detained inmates. Printed educational materials should also be regularly distributed to all inmates. New York City and several other major jail systems have developed effective educational programs for inmates.

### **Development of Educational Materials**

Many jurisdictions (55 percent of state/federal systems and 58 percent of responding city/county systems) have developed their own training materials and curricula, while others (39 percent of state/federal systems and 33 percent of responding city/county systems) have relied on materials developed by other correctional systems, CDC, or other national organizations.

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Educational programs should be targeted to the identified concerns and informational needs of staff and inmates. Thus, personnel responsible for developing AIDS training should gather systematic information on those concerns and knowledge gaps. One way to do this is through brief tests of knowledge and perceptions regarding AIDS. Some states already use these as pre- and post-tests during training sessions, but they might be even more effectively employed to inform the initial development and ongoing refinement of training programs. (An example of a pre/post test of AIDS knowledge is included in Appendix D.)

New York City used other approaches to obtain information on staff and inmate concerns about AIDS and to respond to those concerns. The city's Department of Corrections solicited specific questions on AIDS from the entire correctional staff as a first step in developing an extremely effective staff training videotape. The questions received were then distilled down into 10-20 key questions. The city's Commissioner of Corrections and Commissioner of Health were then brought together to respond to these questions. The discussion was videotaped and edited into a 40-minute program.

New York City prepared a second videotape from a discussion between the Director of Montefiore Medical Center-Rikers Island Health Services (a unit which provides 85 percent of all medical and mental health care services to inmates of the New York City correctional system) and the heads of eighteen inmate councils from institutions across the city. This was a spontaneous question-and-answer session on AIDS, during which the inmate representatives were able to pose any questions they wished.

Several jurisdictions, including New York state, have developed their own question-and-answer brochures specifically for correctional officers. New York's is based on "questions about AIDS asked most often by employees of the . . . Department of Correctional Services."<sup>4</sup> (This brochure is included in Appendix D and some of its specific content is described below.) Many other jurisdictions distribute question-and-answer brochures designed for general audiences, such as the U.S. Public Health Service's "Facts About AIDS," or have tailored such brochures to the correctional audience, whether staff or inmates or both. Question-and-answer segments have been added, deleted, or rephrased to make the material more relevant to the correctional setting. For example, an additional question might be: "Can I catch AIDS if I share a cell with a person who has AIDS?" In many of these brochures, the language has been simplified and preventive measures have been described in colloquial terms more

readily understandable to people in correctional institutions. (See, for example, the Cook County [Chicago] general brochure, "AIDS Questions and Answers," in Appendix D.)

Cook County has also prepared a special pamphlet for correctional health-care workers. It provides some basic information on AIDS—definitions, means of transmission and risk groups—but concentrates on practical measures for preventing transmission of the AIDS virus in the correctional health care setting and for protecting AIDS patients from infections. (The Cook County health-care workers brochure is also included in Appendix D.)

A common medium for inmate education on AIDS is inmate newspapers. In Connecticut, Illinois and other jurisdictions, correctional medical directors have solicited inmates' questions on AIDS and published written responses in the inmate newspaper. These questions and answers cover basic information on AIDS and present practical guidance for preventing transmission of the AIDS virus within the institution.

While many jurisdictions have prepared their own training materials, several state administrators believe that materials prepared by national organizations may be more credible than locally prepared materials. They feel that the correctional department may be perceived as having "an ax to grind" or something to hide, whereas a national organization may be viewed as more objective in its approach to the problem. The same may hold true for presenters of educational programs: outside speakers—for example, from the public health department or from the private sector—may be more credible to inmates and staff than speakers from the correctional department. Correctional administrators should consider all of these factors as they plan and develop their own training programs.

### **Mode of Presentation**

Live training sessions, brochures, pamphlets, articles in inmate and staff newspapers, posters, and audio-visual materials are widely used to present information on AIDS. Spanish-language versions of informational materials and training curricula have also been developed in Florida and other jurisdictions. Figures 2.1 and 2.2 summarize modes of AIDS training, based on responses to the NIJ/ACA questionnaire. The figures show that 37 percent of federal and state systems offer live training sessions for staff and 31 percent offer live training sessions for inmates. (Live training includes all types of lectures, seminars, classes, question-and-answer sessions and other programs involving live trainers.) Thirty percent of city or county

Figure 2.1  
**MODES OF AIDS TRAINING PRESENTATION  
 FOR INMATES**

Modes of Presentation	State/Federal Prison Systems		City/County Jail Systems	
	n	(n = 51) %	n	(n = 33) %
• Live Training	16	31%	8	24%
• Audio-visual Programs	14	28	10	30
• Written Materials	28	55	15	46

Figure 2.2  
**MODES OF AIDS TRAINING PRESENTATION  
 FOR STAFF**

Modes of Presentation	State/Federal Prison Systems		City/County Jail Systems	
	n	(n = 51) %	n	(n = 33) %
• Live Training	19	37%	10	30%
• Audio-visual Programs	17	33	12	36
• Written Materials	26	51	18	55

systems reported that they offer live training for staff, while 24 percent offer live training for inmates. More jurisdictions provide written educational materials to staff and inmates than provide live training.

There are numerous videotapes and slide-tape presentations available. The National Institute of Corrections prepared a videotape from a CDC presentation on the incidence and transmission of AIDS and is distributing the tape to all state correctional departments. City and county systems may request the tape from NIC. Individual states and jurisdictions, including New York City (as discussed above), have made videotapes of their own—showing staff, inmates, and physicians discussing rational concerns and irrational fears of AIDS. (A listing of available materials and ways to obtain them is included in the Resource List in Appendix A.)

Officials of the New York City Department of Corrections, who have extensive experience dealing with the AIDS problem, argue strongly that passive educa-

tional programs (such as printed materials, videotapes or slide-tape shows) are by themselves not enough. They believe that it is important to have live training sessions with trainers who are knowledgeable about the issues, sensitive to the concerns of all groups, and able to answer questions on the spot. Thus, New York City does not simply show its videotaped programs to staff and inmates; it supplements the videotapes with live question-and-answer periods.

Regardless of the media, experience suggests that all materials and presentations be in clear, simple, layperson's language which will be understandable to inmates and staff. Experience also suggests that presentations be kept brief. Some administrators suggest limiting live inmate training to ten minutes. Most staff training sessions appear to be about one hour long. All educational programs should emphasize key practical advice, rather than complex discussions of the epidemiology of AIDS. Question-and-answer formats like those discussed above can be very effective if they are based on a relatively small number of key questions—e.g., "How is AIDS transmitted?", "Can I contract AIDS through casual contact with another person?", and "What can I do to avoid contracting AIDS in the correctional institution?"

### Use of Training Teams

It appears that teams may be more effective than single trainers in presenting AIDS educational sessions, because of the range of issues and questions that may arise and the need to maintain credibility for all groups. Training teams for both inmates and staff should include knowledgeable medical professionals, because laypersons are less credible in responding to technical medical questions that are likely to arise. In addition, inmate training teams should include an inmate spokesperson and staff training teams should include a staff member. These representatives can respond to more practical issues and provide assurance that the training program is a cooperative effort to present accurate, fair and reasonable approaches to the problem rather than an attempt by the system to mislead inmates or staff about the true nature of the problem. Several states and jurisdictions have had success using such training teams to present AIDS educational sessions.

### Subjects Addressed in AIDS Training and Education

As noted above, inmate and staff education programs should cover basic information on the causes and transmission of AIDS—debunking myths and un-

founded rumors—and present practical, understandable guidance for preventing transmission and acquisition of the AIDS virus.

In addition, to overcome skepticism that inmates and staff are being given different stories on AIDS, several correctional systems (including New Jersey's) have staff representatives attend inmate training sessions and inmate representatives attend staff sessions. Correctional administrators stress that perhaps the most important quality of a successful education program on AIDS is that it be *truthful*. Any misrepresentation of the truth may totally undermine the effectiveness of an educational program. A selection of materials from well-conceived programs for inmates and staff is included in Appendix D. Selected examples from these programs are discussed below.

### *Inmate Education/Training*

Inmate training and educational materials almost always include a discussion of sexual and needle-sharing practices likely to result in transmission of the AIDS virus, and the responsibilities of all inmates regarding all types of sexual activity and other potentially dangerous behavior. It is important for training to stress the practical precautionary steps that everyone should take. Recognizing the fact that most inmates will return to the community where greater behavioral choice is available, correctional education programs on AIDS may include recommendations regarding "safe sex." The following excerpts effectively present the key information:

*From Questions and Answers on AIDS in an Illinois inmate newspaper*<sup>5</sup>

(answers prepared by the state's correctional medical director):

#### QUESTION:

What can inmates do to eliminate the possibility of getting AIDS?

#### ANSWER:

The only way to eliminate the possibility of getting AIDS . . . is [to] . . . avoid sexual contact with other inmates and . . . shar[ing] needles with other inmates. If inmates avoid these two things, it is virtually impossible for them to get AIDS.

*From Questions and Answers on AIDS in a Connecticut inmate newspaper*<sup>6</sup>

(answers prepared by the institution's medical director):

#### QUESTION:

How is AIDS spread?

#### ANSWER:

AIDS is spread from person to person through intimate sexual contact or through the use of shared needles for the injection of drugs. Amongst inmates, the most common risk factor (by far) is IV drug abuse. In my opinion, anyone who continues to "shoot up" (especially with a number of other users . . . e.g., attending a "shooting gallery") will undoubtedly be infected with the HTLV-III virus eventually. It is only a matter of time. Other modes of spread that may be important in prison include illegal tattooing (since the virus can be passed from one inmate to another via the needle used . . . not properly sterilized) and gay inmates that have multiple sexual contacts while in prison.

*From a Florida inmate training curriculum:*<sup>7</sup>

Responsibility for not contracting AIDS rests with you, the inmate, as an individual—homosexuality and IV Drug use are personal choices.

THE CHOICE IS YOURS—TO BE  
HEALTHY OR ILL

IT'S ALL UP TO YOU!

Training programs should avoid stating or implying that members of certain groups are at risk and that all other people are basically "safe." This might create a false sense of security which could undermine the behavioral circumspection that everyone should practice.

However, inmate training should also stress that the AIDS virus is not transmitted by casual contact or normal health-care procedures and that the correctional system is taking reasonable and prudent steps to prevent spread of the disease. The following excerpts effectively convey these messages:

*From a Connecticut inmate newspaper*

(prepared by the institution's medical director):<sup>8</sup>

There is no evidence that AIDS can be contracted through casual, non-sexual contact with a person who has AIDS or who carries the virus. AIDS virus is *not* spread by:

- sneezing, coughing or spitting
- handshakes or other non-sexual physical contact
- toilet seats, bathtubs or showers

- utensils, dishes or linens used by an infected person
- food prepared or served by an infected person
- being around an infected person, even on a daily basis over a long period of time

*From Questions and Answers on AIDS in an Illinois inmate newspaper*

(answers prepared by the state's correctional medical director):<sup>9</sup>

**QUESTION:**

Can AIDS be spread if someone were in the same cell with a person with AIDS?

**ANSWER:**

Everything we know indicates that AIDS can only be spread through [sexual contact and needle-sharing]. No one who has lived in the same house as an individual with AIDS including parents, brothers, sisters, friends, etc. has gotten AIDS from other household members. Even people who have kissed someone with AIDS and people who have shared the same glasses, eating utensils and bathrooms as someone with AIDS have not developed AIDS. This proves to us that it is very difficult to spread AIDS.

**QUESTION:**

Can AIDS be spread from a needle used by a nurse to draw blood or give a shot?

**ANSWER:**

Absolutely not, only new clean sterile needles are used for blood drawing and giving shots.

**QUESTION:**

What is being done within the prison system to find out if anyone has AIDS?

**ANSWER:**

Every individual who enters . . . the Department of Corrections has a complete history and physical as well as other tests. Any inmate who appears to be at greater risk of developing AIDS is put on a list and monitored very closely, including examination every 3 months. . . . When we identify someone who may, in fact, have AIDS we will enroll them in a special program so that they are followed up with other AIDS patients . . . .

It is important that inmate educational programs avoid

over-reactions to the AIDS problem and advocacy of unnecessary and inappropriate precautionary measures. For example, some educational materials urge inmates to avoid sharing cigarettes and drinking from cups which have been used by others. By recommending such precautions, training programs are likely to perpetuate the erroneous impression that the AIDS virus can be transmitted by casual contact. This is just the sort of misinformation that training programs are intended to overcome.

Inmate training can be effective in reducing fears and changing behaviors. Correctional administrators believe that sexual practices in prison (as in the society at large) are changing as a result of educational efforts. An AIDS education campaign in San Francisco was found to have significantly affected the behavior of gay and bisexual men. Major changes include increases in celibacy and monogamous relationships, declines in the numbers of partners outside a primary relationship, and reductions in virtually all potentially unsafe sexual practices.<sup>10</sup>

It is often suggested that intravenous drug abusers are especially difficult to influence with education regarding the dangers of AIDS because they are already engaged in (and, indeed, often addicted to) behavior which is dangerous to their health. However, recent trends among street drug users in New York City suggests that educational efforts may be resulting in desirable changes in behavior. In apparent response to increased demand from users, more drug dealers have begun to offer sterile needles.<sup>11</sup>

### *Staff Education/Training*

General training on the incidence and means of transmission of AIDS and on appropriate prevention measures should be provided to all line correctional staff. In addition, special training is often provided to staff who work closely with AIDS patients. This training typically includes procedures for dealing with violent incidents, as well as procedures for handling industrial accidents and other incidents requiring first aid or CPR.

It is important that staff training programs begin by setting the proper tone and present a convincing rationale for the material to follow. The following example is effective in this regard:

*From a Washington State Correctional Staff Training Curriculum:*<sup>12</sup>

#### RATIONALE FOR COURSE

As employees of the Department of Cor-

rections, it is imperative that all of us be knowledgeable about "Acquired Immune Deficiency Syndrome" — commonly referred to as "AIDS." The more we know about it, the better able we are to deal with the problems associated with it and to allay the fears and anxieties of those offenders for whom we are responsible.

As professionals, you have demanding jobs which involve a great deal of responsibility. At the institutional level, you are responsible for maintaining security and discipline, ensuring that a sanitary environment is maintained, keeping records, monitoring program activities, and so on. But, above all, you are "people workers" and, as such, you have a great deal of impact on the inmates for whom you are responsible. . . .

In terms of AIDS and the impact it has on the way in which you deal with offenders, a professional attitude is critical. As corrections employees you must be concerned with the welfare and well-being of inmates. If inmates sense that you are concerned about their health problems and that you know what to do to help, they will be more inclined to respect you and to give you their cooperation. As a professional, your attitude should make clear that you *do care*. If you do not convey that attitude, regardless of your personal feelings, you do nothing other than invite problems.

Just as with inmate training, it is important to advocate only measures designed to address known means of transmission or to prevent activities involving a significant risk of transmission. In general, this means applying routine infection control procedures applicable to any communicable disease. As noted earlier, precautions designed to prevent transmission of Hepatitis-B are more than sufficient to prevent transmission of AIDS, since AIDS is more difficult to transmit. Measures more restrictive than those applied to Hepatitis-B are unnecessary and inappropriate for addressing the AIDS risk. (Specific prevention measures are discussed in detail in Chapter Four of this report.) The following excerpt effectively captures some of the key precautions for health care workers:

*From a Cook County brochure for Health Care Workers:*<sup>13</sup>

**ALWAYS**

**Wash Hands**

before and after patient contact.

**Wear Gloves Only**

when directly exposed to blood or secretions from AIDS patients, e.g., when handling blood specimens or cleaning up stool or urine.

**Dispose of Needles Properly**

by placing them in a puncture-resistant container used solely for such disposal. Needles should not be reinserted into their sheaths before being discarded, since this is a common cause of puncture injury.

**AS NEEDED**

**Masks**

are necessary only when the patient has tuberculosis and is actively coughing.

**Linen**

precautions are necessary only when there are draining wounds or the patient is unable to control excretions. Then linen should be placed in specially marked bags and disposed of appropriately in accordance with hospital procedure.

**NONE NEEDED**

**No Dietary Precautions**

are needed since there is no evidence for the transmission of AIDS through food, dishes or utensils.

**Special precautions for pregnant women:**

Many AIDS patients excrete cytomegalovirus (CMV).<sup>14</sup> It is advisable for pregnant women who work in out-patient settings to meticulously adhere to the listed precautions when interacting with AIDS patients or other known cytomegalovirus (CMV) excretors.

**If the above precautions are followed . . .**

. . . health care workers face no risk of contracting AIDS. There is absolutely no need to put on full isolation gear when providing routine care to an AIDS patient. Besides, undertaking precautions over and beyond what is necessary can cause hysteria in fellow workers and non-medical staff and is psychologically damaging to the patient.

As with inmate training, staff educational programs should attempt to allay fears regarding casual contact and present practical measures for avoiding risk. The following are examples of accurate and reasonable presentations of risks and precautions:

*From a New York State brochure for correctional staff:*<sup>15</sup>

**QUESTION:**

I've been brown bagging it in case the cafeteria food or dishes are handled by AIDS patients. Am I being too cautious?

**ANSWER:**

Yes. Working in the same area, breathing the same air, touching the same things (such as dishes and eating utensils) will not give you AIDS.

**QUESTION:**

I've been assigned to work in a unit where AIDS patients are housed. Am I in danger of getting AIDS?

**ANSWER:**

You would be at risk *only* if your job placed you in situations in which body fluids from an AIDS patient could directly enter your body or bloodstream. There is no reason to believe, for example, that a person would get AIDS as a result of washing floors on an AIDS unit.

*From a training curriculum for jail officers in Phoenix, Arizona:*<sup>16</sup>

You will not contract the disease by having someone cough or sneeze in your direction, by using the same toilet, by handcuffing an inmate or by performing a routine search.

There are several very simple tasks which you can do that have been shown over and over again to prevent the spread of infectious diseases, AIDS included.

**FIRST:**

If you anticipate coming into contact with blood such as during an assault or an injury, put on disposable rubber gloves and avoid contact with your skin, especially if you have any open cuts or wounds.

**SECOND:**

After contact with suspected contaminated materials, *thoroughly wash* your hands and all areas which were exposed to contamination. A simple solution of household bleach diluted 1:10 is sufficient to kill the AIDS virus. Containers of bleach are available at several stations throughout each jail. Contaminated surfaces should be thoroughly cleaned with this dilute bleach solution.

**THIRD:**

Use extra care in handling objects which are contaminated with blood. Do not resheath needles but dispose of them in the proper impervious containers. Make sure you do not injure yourself with sharp objects such as razors or contraband weapons. When disposing of possibly contaminated material, ensure that it is properly wrapped and labeled so that others are not inadvertently injured.

These steps are so obvious that they are often neglected, yet they are your best defense against the spread of blood borne diseases. Should you ever encounter a situation where there may be contamination it pays to take your time and follow the above advice.

*From a Washington state correctional staff handout on AIDS:*<sup>17</sup>

**WHAT ARE THE PRECAUTIONS TO BE TAKEN WHEN GIVING . . . CPR?**

Cardiopulmonary resuscitation must be given to people in need of this life-saving procedure. While there is always some risk of being exposed to a communicable disease when giving CPR, the risk is considered to be small.

To minimize the risk of contamination, the Department will ensure that "pocket masks" are strategically located and readily available to all staff when emergency resuscitation must be initiated. However, if a mask is not immediately available, mouth-to-mouth must be initiated when necessary to save a life.

Finally, staff training should emphasize the importance of maintaining confidentiality regarding AIDS cases. The following excerpt effectively accomplishes this:

*From a Washington state correctional staff handout on AIDS:*<sup>18</sup>

**WHEN DEALING WITH AIDS, ARE THERE SPECIAL CONSIDERATIONS RELATED TO CONFIDENTIALITY?**

The answer to this question is "yes and no." No, in the sense that DOC requires confidentiality in all medical matters except on a "need to know" basis. Yes, in the sense that violating confidentiality concerning AIDS can have far greater consequences

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and cause a threat to the security and the welfare of offenders and staff. Violating an offender's right to confidentiality is in violation of law and makes the person who violates that confidentiality personally liable for the consequences.

## **Conclusion**

In sum, education and training are the keystone of the correctional system's response to AIDS. They are particularly necessary because of the prevalence of misinformation, as well as rational concerns, regarding AIDS.

There are a range of education and training options for correctional staff and inmates, including live training sessions, printed materials, and videotapes and other audiovisual programs. It is critical that training and education be instituted as early as possible, preferably before deep-seated fears have a chance to develop. Training should also be presented regularly enough to incorporate the most current information.

The most effective live training is targeted to the particular concerns and knowledge gaps in the audience,

presented by teams of trainers sensitive to the needs and fears of all groups, and collectively able to answer a range of technical and practical questions. While live training is considered essential by many correctional institutions, printed materials and videotapes can also be effective.

Whatever the mode of presentation, however, training and informational materials should be brief and should be presented in clear, straightforward language. They should describe the behaviors that pose a significant risk of transmitting the AIDS virus, emphasize the fact that everyone should avoid such behaviors, and should guard against the encouragement of a false sense of security in any group. On the other hand, education and training should not advocate unnecessary or inappropriate precautionary measures, because this only serves to spread misinformed theories regarding the transmission of AIDS and may cause needless fear. Thus, development of training and education should be guided by the most current medical knowledge so that the tone and content of these programs appropriately avoid both complacency and alarmism.

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## Footnotes

1. Note that the data on staff and inmate concerns come from responses prepared by administrators and senior staff.
2. Interestingly, there are no reports of similar demands for exclusion of intravenous drug abusers. This may suggest overemphasis of the AIDS risks associated with homosexual activity and underemphasis of the risks associated with intravenous drug abuse and needle-sharing activities.
3. *MMWR* 1985; 34:721-726.
4. New York State Health Department, "AIDS Information for New York State Correctional Services Department Employees," March 1985.
5. Ronald Shansky, M.D., Draft for Inmates News Paper (October 1985).
6. Edward Blanchette, M.D., "Weekly Scene," Somers CCI, August 25, 1985.
7. Florida Department of Corrections, "AIDS: Could You Be At Risk? You Make the Choice." (n.d.).
8. Blanchette, "Weekly Scene," August 25, 1985.
9. Shansky, Draft for Inmates News Paper, October 1985.
10. Research and Decisions Corporation, *Designing an Effective AIDS Prevention Strategy for San Francisco: Results from the Second Probability Sample of an Urban Gay Male Community* (Prepared for the San Francisco AIDS Foundation, June 1985).
11. D.C. Des Jarlais et al., "Correspondence: Free Needles for Intravenous Drug Users at Risk for AIDS: Current Developments in New York City," *New England Journal of Medicine*, December 5, 1985, p. 1476.
12. Washington Department of Corrections, "AIDS Lesson Plan," (November 14, 1985).
13. Cermak Health Services, Cook County (Chicago), "Precautions for Health Care Workers and Protection for AIDS Patients" (n.d.).
14. Cytomegalovirus is one of a group of herpes viruses also termed salivary gland virus. It may cause birth defects and has been associated with a syndrome resembling infectious mononucleosis.
15. New York State Department of Correctional Services, "AIDS Information for New York State Correctional Services Department Employees" (March 1985).
16. Correctional Health Services, Phoenix, Arizona, "AIDS and Your Job," (November 18, 1985).
17. Washington Department of Corrections, "AIDS Lesson Plan," (November 14, 1985).
18. *Ibid.*

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## Chapter 3: HTLV-III Screening and Testing

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This chapter addresses the controversial issues of whether and under what circumstances the HTLV-III antibody test (the ELISA test) should be used in the correctional setting. As emphasized in Chapter One, the test does not detect the presence of the virus itself—only the presence of antibody to the virus. A positive test result only confirms that the person was infected sometime in the past. Current CDC estimates suggest that 5-6 percent of confirmed seropositives actually develop AIDS, while about 25 percent may develop the complex of AIDS-related symptoms known as ARC. However, recently published research suggests that the fraction of seropositive individuals who develop AIDS may be as high as one-third. In any case, because the incubation period of AIDS is both prolonged and uncertain, it is impossible to predict either how many or which particular seropositive persons *will* develop symptoms. For counseling and public health purposes, CDC recommends that all seropositive persons be considered infected and potential carriers of the virus.

The major applications of HTLV-III antibody testing in the correctional environment are discussed below. Included is a review of the perceived advantages and disadvantages of mass screening programs, as well as a summary of the testing procedures actually adopted by state and local corrections authorities.

### Mass Screening: The Debate

Mass screening means testing individuals for antibody to HTLV-III in the absence of any clinical indications of disease, in order to identify specific individuals who may be infectious. Mass screening usually involves testing all inmates or all new inmates; a more limited form of screening is to test all members of high-risk groups (e.g., homosexual/bisexual males, intravenous drug abusers, pregnant women).

Because of rapid population turnover in jails, screening to identify carriers is probably unnecessary and infeasible in these institutions. This is particularly true of jails housing only (or primarily) pretrial detainees. Indeed, no city or county jail system responding to the NIJ/ACA questionnaire has implemented or is planning to implement mass screening of inmates.

At the state level, only four systems have instituted or are planning to institute mass screening of inmates. Nevada is the only system that has implemented a mass screening program for *all* inmates. The screening has

just been completed and the seropositive rate is about 2.5 percent (100 of slightly over 3800 inmates). Colorado is now testing all new inmates, and Iowa will also commence testing all new inmates in 1986. Finally, Missouri is planning to institute screening of all new inmates and, ultimately perhaps, all current inmates. Nebraska had planned to begin testing all inmates in 1986 but has now postponed implementation of this policy.

In deciding to institute mass screening programs, each of these states has been persuaded that identification of seropositives is necessary to prevent transmission of the disease within its institutions and provide effective treatment and improved medical management of its inmates. Iowa, for instance, indicated in its questionnaire response that screening was consistent with its policy of "preventing new inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population, and where indicated, to promptly provide necessary health services."

As reflected in responses to the NIJ/ACA questionnaire, most correctional systems have decided that the disadvantages of mass screening outweigh the potential benefits. For instance, Oregon reported that its decision not to institute a screening program was based on the equivocal results of the ELISA test, the logistical and cost problems caused by the need for repeat testing, the inability to guarantee the confidentiality of test results, and the fact that the corrections division would have no support for a decision to screen inmates, since screening was not required by the state Health Division.

As these two positions suggest, the decision on whether or not to institute a mass (or high-risk group) screening program involves a number of important considerations. The central issues in the debate are reviewed below.

### Should Correctional Systems Be Taking Steps Not Taken in Society at Large?

Mass screening clearly raises the issue of whether correctional systems should be taking steps not generally being taken in the community at large, or even in other long-term care facilities such as hospitals and mental institutions. Apart from screening donated blood and blood products, the only mass screening program currently in progress outside corrections is the routine

testing of all prospective armed forces recruits. The Defense Department has announced that it will also institute mass screening of current active-duty and reserve personnel. Two arguments have been used to support these procedures. First, the armed services need a "walking blood bank" that is absolutely safe in case of a combat deployment. In other words, it must be perfectly safe to obtain donated blood from any individual in order to transfuse another. The second military argument is that all military personnel must be vaccinated against various diseases, but that immuno-suppressed individuals might develop these diseases from the vaccine itself. (Notably, however, this argument is disputed by some physicians on the ground that the HTLV-III antibody test is not a true test of immuno-suppression.)

Neither of the military rationales is relevant to corrections populations. The primary argument for mass screening in the correctional setting rests on the assumption that rates of seropositivity and of HTLV-III transmission are likely to be higher among prison inmates than in the population at large. In this view, since rates of intravenous drug abuse among criminal offenders are higher than those of the general population, seropositivity rates among incoming inmates may be significant. There may also be opportunities for inmates to transmit the infection through sexual activity and intravenous drug abuse while incarcerated.

Critics of mass screening point out that there is no evidence of higher rates of HTLV-III transmission in correctional institutions than in the general population. Advocates respond that it is a logical possibility that must be considered. Indeed, some advocates of screening contend that for those involuntarily confined under its supervision, the state bears a special responsibility for preventing the spread of a disease with such serious consequences as AIDS. Given the current state of medical knowledge, proponents argue, this responsibility can best be fulfilled by identifying seropositive inmates and taking appropriate preventive actions. As subsequent discussions will suggest, however, opponents of testing believe that the goal of preventing transmission can be more effectively achieved by other, less intrusive, measures.

### **What Are the Policy Implications of Identifying Seropositive Individuals?**

Proponents argue that HTLV-III antibody screening is necessary so that seropositive individuals may receive special supervision, counseling, and other programming. From a containment or prevention perspective, these advocates suggest that mass screening would of-

fer the opportunity to identify and segregate seropositive inmates and thus provide the surest means of preventing transmission within the institution, as well as a basis for notifying public health agencies and corrections authorities upon the inmate's release.

Critics suggest, however, that it may be very difficult for correctional systems to deal with HTLV-III seropositives once they have been identified. Issues arise concerning special housing and programming that may not be medically necessary but may be considered appropriate to maintain institutional security and order. This is a particularly serious concern for systems that are likely to have large numbers of seropositive inmates and may be unable to meet demands for segregated housing.

Specific policy options for managing HTLV-III seropositives (such as administrative segregation, single-celling, and maintaining them in the general population) will be discussed in Chapter Four. The key point to be made here is that decisions about the programmatic implications of testing must be reached before any large-scale testing program is initiated. In New Jersey, for instance, the implications of having to deal with expected large numbers of seropositives seem to have heavily influenced the state's decision not to undertake a mass screening program. In other systems, however, particularly those where rates of seropositivity are expected to be low, corrections authorities may believe that the benefits of identifying seropositives will outweigh the negative consequences of a screening program.

### **Will Mass Screening Support or Undermine the Effects of Education and Prevention Programs?**

Proponents of mass screening argue that correctional systems must identify potentially infectious inmates, in order to target educational programs and other preventive measures to maximum effect. In this view, the information is also essential to target measures for preventing the transmission of the virus after an inmate is released.

Opponents of mass screening argue that it is unnecessary and possibly counterproductive to target educational programs and preventive measures to seropositive individuals. They believe that such targeted programs may stigmatize one class of inmates, subjecting them to potential intimidation and violence. Targeted programs might also give insufficient attention to the real risks, and associated precautions, applicable to all inmates. Seronegative inmates might be

considered "safe" for sexual victimization by others or they might unjustifiably consider themselves "safe" from infection and thus pay little or no attention to the recommendations of educational programs on AIDS. Thus, screening might lull seronegatives into a false sense of security and undermine the important educational message that *everyone* needs to be very careful about behaviors known to be associated with transmitting the AIDS virus.

### **Is It Possible to Develop Reliable and Confidential Antibody Testing Procedures?**

It is often argued that the initial results of the ELISA test are unreliable because of the relatively high incidence of false positives and false negatives, as well as the often equivocal results. Blood bank studies have shown that the actual HTLV-III virus could not be cultured in 10 percent-30 percent of specimens testing positive for antibody. This suggests a false positive rate for an initial ELISA test in the same 10 percent-30 percent range.

On the other hand, CDC believes that the ELISA test is very reliable, particularly if initial positives are subjected to a second ELISA test and a Western Blot test. CDC researchers argue that you will always have a certain number of false positives when you test large populations with low actual incidence of the condition you are seeking to identify. Indeed, because the original purpose of the test was to screen the blood supply, it was designed to have a high sensitivity — that is, to err on the side of safety, thus producing more false positives. However, CDC believes that the ELISA test has a 93.4 percent sensitivity (i.e., positive test result vis-a-vis true positives) and 99.2 percent specificity (negative test result vis-a-vis true negatives). According to research on the blood supply, there is a statistically significant correlation between strong positivity on an initial ELISA test (defined as an optical density of 6-7) and both the ability to culture the virus in the specimen and the subject's membership in a known AIDS risk group.

The real problem with the "reliability" of the antibody test may not be false positives and false negatives vis-a-vis actual presence and absence of infection; rather, it may be the relationship of HTLV-III seropositivity to actual development of AIDS or ARC. ELISA test results cannot identify those persons who will actually develop symptoms of the disease.

Related to the issue of reliability are questions regarding the confidentiality of test results. If a mass screening program is instituted in a correctional setting, it

may be impossible to maintain confidentiality, as Oregon's Corrections Division noted in its questionnaire response summarized earlier in this chapter. Moreover, correctional administrators interviewed for this study maintain that, even if confidentiality could be assured, any individual might be rumored to be seropositive, regardless of actual test results. The possible problem of false positives would only add to the difficulty. If actual or inferred test results become known to the correctional population at large, seropositive inmates may face intimidation, threats, or actual violence from others concerned about the possible spread of AIDS. Moreover, revelation of positive test results could subject inmates to serious discrimination in employment, housing, and insurability after they are released from the institution.

### **What Are the Legal Implications of Mass Screening?**

Mandatory mass screening programs may be impossible to implement under existing laws or policies in some jurisdictions. For example, recently passed laws in California and Wisconsin prohibit HTLV-III antibody testing without the informed consent of the subject. As a matter of policy, Louisiana and Montgomery County, Maryland do no testing without informed consent. As already noted, one of the reasons for Oregon's decision not to institute mass screening was that since the antibody test is not required by the state's Health Division, there would be no support in this key agency for a decision to screen prison inmates.

On the other hand, some correctional administrators and their legal counsel are concerned that if they fail to identify seropositive inmates and to take action to prevent their transmitting the virus to others, the jurisdiction and its officials will be subject to lawsuits. Such suits might be filed by inmates or staff who acquire the virus or actually contract ARC or AIDS and allege that the correctional system was negligent in not identifying and segregating seropositive inmates or taking other measures to prevent transmission of the virus.

Many correctional lawyers, however, point out that the two primary methods of HTLV-III transmission — sexual contact and intravenous drug use — are already prohibited in correctional institutions, and thus it is only the victim of a forced sexual assault who could bring such a claim. These lawyers believe that established policies and procedures to prevent sexual victimization — if appropriately developed and enforced — would be sufficient to defend against a charge of negligence.

At the same time, other lawyers respond to the concern about lawsuits by noting that it is extremely difficult to establish exact causation in the development of AIDS, ARC, or HTLV-III seropositivity. If it is difficult to identify the specific incident responsible for transmission of the virus, it is even more difficult to claim that the system was negligent in failing to prevent that incident. (Chapter Four discusses these legal implications in greater detail.)

### **How Costly Are Mass Screening Programs?**

While proponents argue that screening could be accomplished economically, some correctional administrators argue that such programs would be prohibitively expensive. There are really two major cost components that must be considered: the actual costs of testing, and the costs of implementing any policy decisions regarding seropositive individuals.

Each ELISA test costs about \$5-\$6 if done in an in-house laboratory or blood bank, and about \$10 for the commercial test kit. There may be ways to reduce the cost per test: for example, a particular manufacturer offered Nebraska the necessary equipment at no charge if the state would agree to use the company's reagent. According to Nebraska officials, the cost would amount to about \$2.75 per test. While the cost per ELISA test may not be particularly high, critics argue that the total cost of administering and re-administering tests to a large inmate population may be significant. Repeat testing of initial positives and initial negatives may be necessary. An initial positive specimen is usually subjected immediately to a second ELISA test and to a Western Blot test as well. The cost of the confirmatory Western Blot averages about \$75 per test, with a range of \$25-\$150. This would add significantly to the total cost, particularly if a large number of inmates tested positively on the ELISA. Initial negatives pose more difficult problems: should the system retest to determine if seroconversion has occurred and, if so, at what intervals? Critics of mass screening argue that the need for repeat testing creates almost insurmountable logistical and cost problems.

Added to the costs of testing must be the costs of implementing any policy decision regarding seropositives. These might include construction or renovations required for separate housing units, as well as the costs of counseling, additional supervision, or other precautionary/preventive measures.

### **Will Mass Screening Allay or Inflame the Fears of Inmates, Staff, and the Public?**

Some of those who favor mass screening suggest that

the results of such programs may serve to allay fears of AIDS within correctional institutions more effectively than any education program. These advocates espouse mass testing as a means of demonstrating to the general public, inmates, and correctional staff that prisons and jails are not hotbeds for AIDS transmission.

Critics point out that this outcome depends on discovering low rates of HTLV-III seropositivity. Publicizing high rates adds no information of value and, in fact, may greatly and needlessly increase fear among inmates and staff and undermine the salutary effect of educational programs. The New York City Department of Corrections has a very strong policy against HTLV-III antibody testing. Officials there estimate that there are large numbers of seropositive inmates in the system's institutions. However, they note that without a mass screening program to call attention to this fact and to identify and stigmatize seropositive inmates, but with a strong educational program for all inmates and staff, there has been a minimum of fear and disruption.

In considering the public's reaction to the problem of AIDS in prisons and jails, proponents of mass screening suggest that it is the responsibility of correctional systems to know the prevalence of HTLV-III seropositivity in their institutions and to determine whether seroconversion (and thus perhaps the transmission of HTLV-III infection) is occurring in those institutions. They suggest that failure to institute mass screening may undermine the system's credibility and create a serious public relations problem. Proponents of screening are concerned that the public might criticize the correctional system for "not instituting policies that address the problem head-on" and conclude that "if they aren't testing, they must have something to hide." These views, in turn, may feed a general public perception that prisons and jails are "breeding grounds" for evils such as AIDS — a perception that correctional administrators are not eager to encourage.

Critics respond that there are better policies than mass screening for addressing the problem of AIDS in prisons and jails. They argue that the public can be convinced of this fact by judicious presentations of the risks and benefits of mass screening programs and the alternatives available to address the problem.

### **Are There Feasible Alternatives to Mass Screening?**

Proponents argue that mass screening is the best way to identify high-risk and potentially infectious inmates,

in order to determine the prevalence of HTLV-III seropositivity and transmission of the virus, to target preventive programs, and to provide more effective medical care. For example, seropositive inmates could be provided special counseling on behaviors that might transmit the virus and they could be more carefully supervised to minimize their opportunities to engage in such behavior. Moreover, advocates suggest that test results may improve the clinical management of inmates. Knowing this information might lead to more timely and effective treatment of opportunistic diseases and would be contraindications for certain medications as well as for organ donation.

Critics do not so much dispute the potential utility of these applications as to argue that there are better ways to obtain the necessary information which avoid the negative effects of antibody testing. Astute medical surveillance, creative diagnostic procedures and carefully designed epidemiological studies are commonly discussed alternatives.

### *Surveillance and Diagnostic Procedures*

During interviews conducted for this study, physicians serving inmates in the correctional departments of Cook County (Chicago), New York City, and other jurisdictions argued strongly that HTLV-III antibody testing should not even be used to support diagnoses of AIDS or ARC, let alone to screen inmates for seropositivity. These physicians suggest that there are better and truer tests of immuno-suppression than the antibody test—for example, the complete blood count (CBC) and anergy screen. T-Cell studies are more expensive than the CBC anergy screen but may provide more specific results for the purposes of diagnosing AIDS and ARC.

In general, physicians who oppose HTLV-III testing for diagnostic purposes argue that medical surveillance and diagnosis must be seen as a process that involves asking the right questions in history-taking, performing the correct physical examinations, and being carefully attuned to the signs and symptoms of ARC and AIDS. HTLV-III antibody testing cannot substitute for this total and ongoing process. If properly done, history-taking and physical examinations may be viable alternatives to HTLV-III screening and may avoid the potential negative effects of screening. History-taking and physical examinations may help to identify those inmates at highest risk of being seropositive or developing ARC/AIDS and may also yield opportunities to provide important educational information regarding the transmission of HTLV-III infection and AIDS.

Careful and complete history-taking includes standardized questions on ARC symptoms and questions on lifestyle and health habits. It should be noted, of course, that information provided by inmates regarding their lifestyles — particularly intravenous drug use and sexual activity — may not be fully reliable. Therefore, particular attention must be paid to physical indicators and other clues to the presence of risk factors. An expanded physical examination for AIDS-related factors includes more careful oral/pharyngeal examination, lymphnode search, and anal examination. (An example of an expanded history-taking protocol is included in Appendix F.)

Followup on the history-taking and physical examination includes astute medical surveillance of signs and symptoms and tracking of high-risk individuals. Several jurisdictions have instituted comprehensive programs for identifying and tracking high-risk inmates in clear preference to large-scale antibody testing. For example, Illinois medically monitors all inmates with histories of intravenous drug abuse who have lymphadenopathy, as well as all homosexual and bisexual inmates. These inmates all receive a physical examination (including white blood count) every three months. Illinois has a "tickler file" system to ensure that all identified high-risk inmates are examined every three months as scheduled. New York City and New Hampshire also identify and monitor high-risk inmates.

### *Epidemiological Studies*

Carefully designed epidemiological studies can provide incidence information of great value to correctional administrators while avoiding some of the potential problems of mass screening. Such epidemiological studies can help correctional administrators to assess the prevalence of seropositivity and HTLV-III transmission in their institutions. They can also help to identify the epidemiological correlates of seroconversion in the correctional setting. Finally, such studies can be used to project future incidence of AIDS and ARC and thus inform budgeting for treatment and possible facility expansion.

Epidemiological studies can be done anonymously so that no one knows who was tested and what their results were. The most commonly recommended model for blind epidemiological studies is to test a sample of inmates from an incoming cohort and to retest samples from the same cohort at regular intervals thereafter. Another approach is to test inmates continuously incarcerated since before AIDS first appeared in the United States. These are the methods used in the Maryland studies discussed earlier.

Figure 3.1

**SUMMARY OF RESPONDING JURISDICTIONS' POLICIES ON HTLV-III  
ANTIBODY TESTING AND RELATED PROCEDURES FOR INMATES<sup>a</sup>**

Policies	State/Federal Prison Systems		City/County Jail Systems	
	(n = 51) n	%	(n = 33) n	%
• Expanded history-taking/ physical examinations/other blood tests	18	35%	11	33%
• HTLV-III screening				
– Mass screening (all or all new inmates)	4	8	0	0
– Screening of high-risk groups <sup>b</sup>	2	4	7	21
• Testing of any inmate on request	9	18	11	33
• Testing high-risk inmates or those with clinical indica- tions, on request <sup>c</sup>	7 <sup>c</sup>	14	3 <sup>c</sup>	9
• Testing to assist in diag- nosing AIDS/ARC	44	86	27	82
• Testing in response to incidents	4 <sup>d</sup>	8	4 <sup>d</sup>	12
• Testing for epidemiological studies	2	4	0	0
• No testing	5	10	5	15
• Written policies regarding testing in place/under development	39	77	20	61

<sup>a</sup> Includes actual and planned policies.

<sup>b</sup> Mandatory testing of all members of at least one high-risk group (e.g., homosexuals, intravenous drug abusers) regardless of whether the individual displays clinical indications. The Federal Bureau of Prisons tests pregnant women. Orange County, California tests prostitutes and other risk group members.

<sup>c</sup> Includes New Hampshire and Harris County (Houston), Texas, where high-risk group members are counseled but not required to take the test. Also included are Delaware and Arkansas, which test inmates on request, but only if a physical examination reveals clinical indications for testing.

<sup>d</sup> While a total of only eight jurisdictions specifically mentioned this, we believe that many jurisdictions would perform tests in such circumstances.

Because of inter- and intra-jurisdictional variations in socio-economic and demographic characteristics, as well as in the prevalence of AIDS risk factors, results of one epidemiological study may not accurately reflect conditions elsewhere. This is not to suggest that epidemiological studies be conducted in every jurisdiction. Rather, epidemiologists suggest that conducting studies in a relatively small sample of representative systems might provide the desired information base.

The next section reviews the testing policies of the correctional systems that responded to the NIJ/ACA questionnaire.

### Summary of NIJ/ACA Study Results

While only four states and no city or county correctional systems have instituted or planned mass screening of all inmates or all new inmates, testing does occur on a more limited basis in almost 90 percent of the jurisdictions responding to the NIJ/ACA questionnaire. Figure 3.1 summarizes the questionnaire responses on the types of screening/testing programs currently in place or planned for the near future. The figure shows that four percent of state/federal systems and 21 percent of responding city/county systems screen all members of at least one high risk group

Figure 3.2

**MUTUALLY EXCLUSIVE CATEGORIZATION OF RESPONDING JURISDICTIONS' SCREENING/TESTING POLICIES FOR INMATES<sup>a</sup>**

Policy Category	State/Federal Prison Systems		City/County Jail Systems	
	n	%	n	%
• Mass screening (all or all new inmates)	4	8%	0	0%
• Screening of risk groups (including pregnant women)	2	4	7	21
• Testing <i>only</i> for diagnoses, incident response or epidemiological studies	39	77	20	61
• Testing <i>only</i> on inmate request	1	2	1	3
• No testing	5	10	5	15
<b>TOTAL</b>	<b>51</b>	<b>101%<sup>b</sup></b>	<b>33</b>	<b>100%</b>

<sup>a</sup> Includes actual and planned policies. This is a hierarchical categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that do screening of all members of at least some risk groups, but no mass screening, are placed in the "screening of risk groups" category regardless of whether they also do testing for diagnosis, incident response, or epidemiological studies.

<sup>b</sup> Due to rounding.

regardless of whether these individuals display clinical indications. On the other hand, the vast majority of both state/federal (86 percent) and responding city/county (82 percent) systems use the HTLV-III antibody test to assist in diagnosing AIDS or ARC.

Some correctional systems provide testing to any inmate on request. (18 percent of state/federal systems and 33 percent of responding city/county systems). Several other systems counsel risk-group members to be tested or test inmates on request if they are in a high-risk group or if a physical examination reveals clinical indications for testing. Only a small fraction of the state/federal systems use (or plan to use) HTLV-III antibody testing for anonymous epidemiological studies (4 percent) and none of the responding city/county systems report testing for epidemiological studies.

Figure 3.1 also shows that significant fractions of state/federal correctional systems (35 percent) and responding city/county systems (33 percent) have instituted expanded history-taking and physical examinations or employ other blood tests to identify and monitor inmates at risk of developing AIDS or ARC. Many of these procedures have been developed in response to the perceived need for alternatives to HTLV-III antibody screening. Finally, over three-fourths of the state/federal systems (77 percent) and

almost two-thirds of the responding city/county systems (61 percent) have written policies regarding testing and related procedures in place or under development. The numbers in Figure 3.1 add to more than the total number of jurisdictions responding because the policy categories shown are not mutually exclusive.

Figure 3.2 places the screening/testing policies of the responding jurisdictions into mutually exclusive categories. This shows that most jurisdictions (77 percent of state/federal systems and 61 percent of responding city/county jurisdictions) test inmates only to assist in diagnosing AIDS or ARC, in response to incidents, or in support of epidemiological studies. Ten percent of state/federal correctional systems and 15 percent of responding city/county jail systems have decided to do no testing whatsoever. The following sections describe some of the applications of testing that are being used in the respondent jurisdictions and discuss implementation considerations for jurisdictions that elect to perform any testing.

### **Applications of the HTLV-III Antibody Test**

#### **Testing of Correctional Staff**

Virtually all of the screening and testing programs

identified in our questionnaire responses involved inmates. Most correctional systems have no involvement in the medical care of staff. In such jurisdictions, any testing of staff is strictly a matter between the staff member and his or her personal health care provider. One county jail system responding to the NIJ/ACA questionnaire has implemented screening of all new correctional staff. In addition, Iowa is considering drawing a blood specimen from each staff member and freezing it for possible testing later in the event of an incident or other circumstance in which testing might be indicated.

Some systems did report that they would test staff members who had been involved in incidents during which transmission of the AIDS virus might have occurred. Finally, several systems noted that they would offer antibody testing to staff under other circumstances—if, for instance, they experienced symptoms of ARC or AIDS. In Michigan, the correctional officers union obtained a commitment from the state that any staff member would be provided an antibody test on request.

### **Testing High-Risk Inmate Groups**

Screening of high-risk groups is a limited form of mass screening. However, it may be very difficult to define the groups to be tested. The most commonly defined high-risk groups for AIDS or ARC are intravenous drug abusers, homosexual and bisexual men, and certain pregnant women. In some jurisdictions it would be difficult to define a set of high-risk groups that did not collectively cover virtually all inmates in the system. If this is the case, high-risk group screening in effect becomes screening of all inmates, with the concomitant stigmatization and other ill effects for large segments of the inmate population. Indeed, any screening of groups, however designed, may have negative effects for all members of such groups.

The question of whether to test pregnant women, or even all women of childbearing age, has arisen because of the possibility of perinatal transmission of the AIDS virus. CDC has recently recommended that pregnant women in the following categories be counseled and offered the HTLV-III antibody test: 1) those with evidence of HTLV-III infection; 2) those with a history of intravenous drug abuse; 3) those born in countries where heterosexual transmission of the AIDS virus is thought to play a major role; 4) those who have engaged in prostitution; and 5) those who are or have been sex partners of males in high-risk groups or with evidence of HTLV-III infection.<sup>1</sup> Several systems have instituted testing of more broadly defined groups of

women inmates. For example, the Federal Bureau of Prisons tests all pregnant women inmates.

Finally, in response to concerns about AIDS, many jurisdictions have eliminated plasmaphoresis programs or prohibited inmates from donating blood. Fifty-five percent of state/federal systems and 61 percent of city/county systems reported prohibitions on inmate blood donation, but several of these had instituted the prohibitions before AIDS appeared. In states that have maintained their plasmaphoresis programs (e.g., Louisiana), all inmate participants must be tested. This is clearly an absolute requirement rather than an option, because of the very real public health and legal liability concerns regarding the blood supply.

### **Testing in Response to Incidents**

Individuals may be tested if they are involved in a particular incident in which exposure may have occurred. In correctional institutions, such incidents include needlesticks or other sharp instrument injuries, forcible rapes, biting incidents, and other situations in which there may have been blood-to-blood contact or exposure to other bodily fluids of an individual known or suspected to have AIDS, ARC, or HTLV-III seropositivity.

Correctional systems' policies in these instances vary considerably. If testing is to be done at all, it is generally agreed that individuals involved in incidents should be tested immediately to determine whether or not they were seropositive at the time of the incident. If so, they obviously could not seroconvert as a result of the incident. Followup testing on initial negatives may be performed anywhere from 1-3 months after the incident, as it takes at least one month for the antibody to appear if infection has occurred.

### **Testing in Support of Epidemiological Studies**

As indicated earlier in this chapter, epidemiological studies are a useful alternative to mass screening for identifying rates of seropositivity and assessing the extent of HTLV-III transmission in institutions. Such studies have been conducted in Maryland, and Iowa plans to undertake such studies in the near future. As discussed in Chapter One, the Maryland study found low rates of seropositivity among new inmates and an extremely low rate of HTLV-III transmission among long-term inmates.

### **Implementation Policies**

Several implementation issues were also addressed by responses to the NIJ/ACA questionnaire. Discussed

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below are policies regarding the timing and location of testing as well as policies pertaining to the mandatory or voluntary basis of testing programs.

### **When Are Tests Administered?**

Some states routinely obtain results of tests performed before the inmate entered their institution. These results may come in the inmate's medical record from a previous institution or from other sources. As already noted, some jurisdictions test inmates at intake. Intake testing may be undertaken to identify potentially infectious inmates at the earliest opportunity or to provide baseline data for epidemiological studies of HTLV-III transmission within correctional institutions. For the latter application, of course, testing may be limited to samples of inmates.

When a specimen initially tests positive, the same specimen is generally retested immediately. If the second ELISA test is also positive, most jurisdictions follow up with a Western Blot test to confirm seropositivity. In several jurisdictions, high-risk individuals initially testing negative for antibody to HTLV-III are routinely retested at regular intervals to identify seroconverters.

Finally, there have been some suggestions that inmates be tested just prior to discharge in order to target counseling on the risks of acquiring and transmitting HTLV-III infection in the community at large. However, no jurisdictions responding to the NIJ/ACA questionnaire have implemented this form of mass screening.

### **Where Are Testing and Laboratory Analysis Performed?**

Tests may be performed within the institution, at a medical facility in the community, or at one of the alternative test sites funded by CDC. Confidentiality and cost may be major issues here. While the alternative test sites generally guarantee the anonymity of subjects, the costs of transporting inmates to and from these sites may preclude this option for any substantial numbers of inmates. Moreover, anonymous testing would defeat one of the correctional system's major purposes in seeking to have inmates tested—namely, identifying specific seropositive individuals. Clearly, testing at alternative sites is relevant only to testing for diagnostic purposes and in support of epidemiological studies.

Analysis of the specimens may be performed within the institution, at a blood bank, or in a private laboratory. Cost and turnaround time appear to be the major considerations in these decisions.

### **Is Testing Mandatory or Voluntary?**

These decisions may be guided in large measure by law, policy, and ethical considerations. Figure 3.3 shows that in 57 percent of state/federal systems and 64 percent of responding city/county jurisdictions, testing is conducted only on a voluntary basis or on request. By contrast, 20 percent of the state/federal systems and nine percent of the city/county systems make all HTLV-III antibody testing of inmates mandatory. Each of these categories is discussed below.

#### *Mandatory Testing*

The key issues here are whether there is a right of refusal based on law, policy, or ethical considerations. Those who oppose HTLV-III antibody testing argue that because of the potentially very serious negative effects of test results, medical ethics require that there be a right of refusal, regardless of law or policy. They liken this right to a patient's right to refuse a potentially risky surgical procedure, such as open-heart surgery.

Recently passed laws in several states, including California and Wisconsin, specifically prohibit HTLV-III antibody testing without informed consent. A number of other states prohibit drawing blood for any purpose without informed consent. As a matter of policy, Louisiana and Montgomery County, Maryland do no testing without informed consent. If informed consent is to be obtained, it is important to have a consent form that clearly lays out all the implications of being tested, including an enumeration of those entitled to receive the results, a realistic assessment of the possibility that confidentiality may be breached, and a statement of the likelihood that special housing or programming will be necessary for seropositive individuals. In addition, inmates should be clearly advised of the possible negative effects of test results on their ability to obtain housing, employment, and insurance after they are discharged.

On the other hand, in some states correctional systems can legally institute mandatory testing (e.g., Missouri, Colorado, Iowa). Iowa intends to place any inmates who refuse to cooperate with the testing program into medical segregation. Some jurisdictions subject only certain inmates to mandatory testing. For example, Iowa currently has mandatory testing for all inmates in identified AIDS risk groups and for all inmates in detention for aggressive behavior. (As noted earlier in this chapter, Iowa plans to begin screening all new inmates early in 1986.)

Lawsuits may affect policies on mandatory testing. For example, three suits have been filed by inmates in

Figure 3.3

**MANDATORY, VOLUNTARY, AND ON-REQUEST TESTING OF INMATES<sup>a</sup>**

Policies	State/Federal Prison Systems		City/County Jail Systems	
	n	%	n	%
• All inmate testing is mandatory	10 <sup>b</sup>	20%	3 <sup>c</sup>	9%
• Any combination of mandatory/voluntary/on request	2	4	3	9
• All testing is voluntary or on request	29	57	21	64
• Not specified/undecided	5	10	1	3
• No testing	5	10	5	15
Total	51	101% <sup>d</sup>	33	100%

<sup>a</sup> Includes actual and planned policies.

<sup>b</sup> Includes three state prison systems in which testing is ostensibly "voluntary," but inmates who refuse the test are segregated from the general population until they agree to submit to it. Also included is a state which responded to the questionnaire that testing is mandatory but noted that an inmate may refuse medical treatment. All four of these policies lie between mandatory and voluntary, but operationally seem closer to the former than to the latter.

<sup>c</sup> Includes one county jail system in which testing is ostensibly "voluntary" but inmates who refuse to be tested are segregated until they submit to the test.

<sup>d</sup> Due to rounding.

Oregon demanding mandatory testing of all state inmates.<sup>2</sup> Decisions for the plaintiffs in such cases may create conflicts with existing state laws requiring informed consent.

### *Voluntary Testing*

In voluntary testing programs, the correctional system may request all or certain inmates to be tested, but cannot or will not attempt to compel cooperation. In Montgomery County, Maryland, for example, all members of known high-risk groups are requested to submit to the antibody test, but no testing is performed without informed consent.

There can be forms of coercion, such as threats of segregation, applied even in ostensibly voluntary testing programs. The director of New York City's Montefiore Medical Center/Rikers Island Health Services emphasizes that no one should be coerced or pressured into being tested and that the anonymity of anyone who is tested should be assured by using alternative test sites.

### *Testing on Request*

Nine states, including Arizona, provide testing to any inmate on request, while others, including Indiana, test members of high-risk groups on request. Two impor-

tant questions arise here: first, do correctional systems have a legal obligation to provide testing on request? and, second, is anyone entitled to testing on request, or only those with a supportable reason for desiring the test (e.g., involvement in an incident, membership in a high-risk group, or presence of symptoms)? There are lawsuits pending on these issues in several states. However, there may already be an important precedent in *Estelle v. Gamble*,<sup>3</sup> one of the leading cases on correctional health care standards. While this decision establishes that correctional systems have an obligation to respond to the medical needs of inmates, it does not give inmates the right to dictate the quantity or quality of the medical care provided. According to *Estelle v. Gamble*, this must remain a medical decision. This seems to support the position that correctional systems could deny HTLV-III antibody tests to inmates, at least where there were no apparent clinical indications or other legitimate reasons for testing.

Another issue affecting testing on request is the type of counseling that is provided both before and after the test is administered. In Utah, any inmate requesting to be tested is advised that the state health department will be informed of the results, that any seropositive inmate can expect stringent administrative sanctions for engaging in intravenous drug use or homosexual

activity, and that seropositive inmates may be assigned to special housing units. As discussed above, inmates should be counseled regarding the potential personal and psychological costs, as well as the potential benefits, of being tested.

### Who Receives Test Results?

The important and complex issue of who is notified of inmates' HTLV-III antibody test results is discussed in Chapter Four, as part of an overall discussion on confidentiality and disclosure of AIDS-related medical information.

### Conclusion

This chapter has discussed the major applications of HTLV-III antibody testing in the correctional setting and the perceived advantages and disadvantages of the range of testing options open to correctional administrators. The most controversial testing application is mass screening of inmates in the absence of clinical indications. In the correctional setting, we define mass screening as the testing of all inmates or all new inmates. A more limited form of screening is the testing of all members of high-risk groups.

Four state correctional systems have implemented or are planning to implement mass screening programs for inmates; no city or county systems have instituted or planned such programs for inmates. However, almost 90 percent of the jurisdictions responding to the NIJ/ACA questionnaire do employ testing for more limited purposes.

The issue of mass screening for antibody to HTLV-III in correctional institutions has sparked a lively debate, involving the following major questions:

- Why should correctional systems take steps not being taken in the community at large?

Proponents of testing argue that rates of HTLV-III seropositivity are higher among inmates and that the virus is likely to be transmitted within institutions; screening is necessary to identify infectious individuals and to target prevention programs.

Opponents argue that there is no proof of higher rates of HTLV-III transmission in prison and therefore there is no legitimate reason to screen.

- What are the policy implications of identifying seropositive individuals?

Proponents of screening argue that seropositive individuals must be identified

so they can be given special supervision, counseling, and other programming.

Opponents argue that mass identification of seropositives would serve no purposes not better addressed by educational programs and would, in fact, create significant correctional management problems—particularly if large numbers of seropositives were identified and there was irresistible pressure to segregate them.

- How would mass screening affect education and prevention programs?

Proponents argue that screening is necessary to inform and target education and prevention programs.

Opponents argue that screening undermines education and prevention programs by needlessly and misleadingly dividing the inmate population into a stigmatized class and a "safe" class. This undermines the important educational message that everyone should be careful.

- Is it possible to develop a reliable and confidential screening program?

Proponents argue that the antibody test is reliable and that confidentiality of results can be maintained.

Opponents argue that the test results are often unreliable and that real and rumored results would inevitably become known to the inmate population and others in the outside world, subjecting actual or supposed seropositives to threats and intimidation while in prison and to discrimination in housing, employment, and insurability after discharge.

- What are the legal implications of screening?

Proponents argue that mass screening is legal and proper and, in fact, that serious legal liabilities may be associated with failure to screen.

Opponents point out that laws and policies requiring subjects' informed consent for HTLV-III antibody testing preclude mass screening and suggest that any liability issues can be effectively managed.

- What are the costs of mass screening?

Proponents of screening argue that the test can be economically administered.

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Opponents argue that when the costs of repeat and confirmatory tests and the costs of correctional programming for seropositives are figured in, the total price could become prohibitive, particularly for large systems and/or those likely to identify large numbers of seropositive inmates.

- Will mass screening allay or inflame fears?

Proponents argue that screening could help to calm the concerns of inmates and staff if it found low rates of seropositivity. Moreover, regardless of the seropositivity rates, failure to screen could cause serious public relations problems.

Opponents argue that mass screening will needlessly inflame fears, particularly if the seropositivity rate is found to be high.

- Are there feasible alternatives to screening?

Proponents argue that screening is the best method of obtaining the necessary information on HTLV-III seropositivity and transmission.

Opponents argue that there are better ways to identify high-risk individuals and diagnose AIDS and ARC that avoid the

negative consequences of mass screening. These include astute medical surveillance and alternative laboratory work for diagnoses.

There are a variety of possible applications for the antibody test besides mass screening. These include testing of high-risk group members (although there may be problems in defining such groups and negative effects of testing entire groups in the absence of clinical indications), testing in response to incidents in which transmission of the virus may have occurred, and testing in support of epidemiological studies. Such anonymous studies of samples of inmates may permit estimation of HTLV-III seropositivity and transmission rates while avoiding the correctional management and confidentiality problems of mass screening.

Finally, correctional administrators who decide to implement any type of testing program face a range of issues, including when and where to administer the test, where to conduct the laboratory analysis, and whether testing should be voluntary, mandatory, or on request. There are serious legal and ethical issues involving both whether inmates can be compelled to submit to testing and whether they have a right to testing on request.

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## Footnotes

1. *MMWR* 1985; 34:721-727.
2. *Herring/Luke v. Keeney* (U.S.D.C., Oregon, filed September 17, 1985); *Sheppard v. Keeney* (U.S.D.C., Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C., Oregon, filed October 11, 1985).
3. 429 U.S. 97 (1976).

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## Chapter 4: Medical, Legal, and Correctional Management Issues

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Because AIDS is relatively difficult to detect, develops only after a long—potentially indefinite—incubation period, and is almost invariably fatal, it has presented an unprecedented challenge to the medical community, federal, state and municipal policymakers, and individual citizens. Within the correctional setting, the challenge of AIDS is, if anything, more severe. Inmate populations may include a higher than usual proportion of individuals at risk for developing AIDS. In addition, during the time the correctional system has jurisdiction over an inmate, the system has responsibility for the provision and financing of all medical care. Finally, the correctional system has certain other responsibilities concerning inmate safety and maintenance of security and order of the institution. When responding to the challenging problem of AIDS in prison and jails, administrators must not only deal with the difficult medical issues; they must also balance medical considerations and medical advice against complex correctional management factors. Medical guidelines and correctional considerations may sometimes be at odds. Finally, decision-making is further complicated by legal and cost concerns. The key medical, legal and correctional management issues include the following:

### MEDICAL ISSUES

- Detection, diagnosis and medical surveillance
- Counseling and other support services

### CORRECTIONAL MANAGEMENT ISSUES

- Housing policies for inmates with AIDS, ARC, or HTLV-III seropositivity
- Precautionary measures to prevent spread of the disease
- Notifications and confidentiality
- Duration of incarceration: executive clemency versus extended custody
- Costs of medical care and ancillary services
- Responsibility for aftercare

### LEGAL ISSUES

- Standards for correctional medical care
- Equal protection
- Quality of care
- Failure to protect others from AIDS

### Medical Issues

Perhaps the highest priority in the correctional response to AIDS is providing timely, professional and

compassionate medical care to inmates who become ill with the disease. However, effective medical care must not be simply reactive; it must also include programs for the timely detection, diagnosis and regular surveillance of the full spectrum of HTLV-III infections. Finally, because of the painful uncertainties and psychological stresses caused by these conditions, support counseling and services are also critical.

### Detection, Diagnosis and Medical Surveillance

Within the correctional institution, the basic medical issues posed by AIDS are identical to those outside the institution. Prompt detection and diagnosis are needed to minimize spread of the disease and alleviate the suffering of patients. As noted in Chapter Three, the HTLV-III antibody test may offer one means of screening and diagnosis, though the test presents many controversial practical, medical and legal issues. Whether or not such screening procedures are used, appropriate diagnostic workups (including complete blood count and other blood work and energy screens) are necessary to identify immuno-suppression, ARC and AIDS. There are also certain tests that may be able to detect early evidence of opportunistic infections typically seen in AIDS patients (e.g., the gallium scan for detecting early *Pneumocystis Carinii* pneumonia).

Careful surveillance and regular followup are extremely important for patients with AIDS, ARC and HTLV-III seropositivity because serious, life-threatening symptoms can develop very quickly. Many correctional agencies have specific protocols for followup and medical surveillance. For example, Nevada does a monthly followup on all seropositive inmates and Illinois monitors high-risk inmates through white blood counts and physical examinations every three months. Iowa checks all seropositives and risk-group members every three months and Connecticut evaluates all ARC cases every three months. The details of these protocols may vary, but their basic intent is the same: to facilitate timely medical intervention.

Some correctional systems, including New Jersey's, believe that it is extremely important to maintain a centralized diagnosis and evaluation function for all inmates suspected of having ARC or AIDS. Inconsistent theories and practice regarding diagnosis and treatment could create confusion and fuel the fears of staff and inmates. New Jersey administrators emphasize the im-

portance of "telling a consistent story" and "using a common vocabulary" to an effective strategy for managing the AIDS problem within correctional institutions.

The nature of medical treatment will depend on the inmate's health as well as on the medical capabilities available to the correctional system. Many inmates with HTLV-III seropositivity or ARC require only routine monitoring of their health status. However, inmates with extreme manifestations of AIDS almost invariably require intensive medical treatment, either within the correctional system's medical facilities or in a community hospital.

Innovative treatments are available for certain of the opportunistic diseases associated with AIDS. Not only will this improve the quality of medical care, but it may also reduce the ultimate costs of care by keeping the inmate healthier for a longer time. The director of Montefiore Medical Center/Rikers Island Health Services in New York City suggests that inmates should be made eligible for clinical trials of innovative treatments for AIDS. This would require a "compassionate exception" to the federal regulations restricting human experimentation with prison inmates.

### **Need for Counseling and Other Support Services**

Because AIDS is an extremely serious psychological as well as physical problem for those with the disease, counseling and support systems are also considered an important component of care. Minnesota has recognized this requirement by constituting a support team for each inmate with AIDS, ARC and HTLV-III seropositivity. This team includes a psychiatrist, psychologist, nurse, chaplain, patient advocate, family member, and correctional counselor. Connecticut's correctional system makes social and psychiatric services, including support groups, available to AIDS patients.

Because of the painful uncertainties involved, counseling is just as important for HTLV-III seropositives and ARC cases as for confirmed AIDS cases. Most jurisdictions provide such counseling to affected inmates. In addition, it is important to counsel potentially infected and infectious persons regarding the risks of transmitting the infection and means to prevent transmission. CDC has published guidelines that may form the basis of such counseling.<sup>1</sup>

Several states, including Louisiana and Oregon, have developed question-and-answer flyers for those who have been tested for antibodies for HTLV-III. These

flyers discuss the meaning of the test and its implications for the individual's future behavior. The Oregon state Health Division has developed three separate pamphlets for counseling those who have been tested: one for high-risk group members with positive tests, a second for high-risk group members with negative tests, and a third for low-risk individuals with positive tests. (These flyers are included in Appendix D.)

### **Correctional Management Issues**

Ironically, the medical treatment of AIDS victims may be the simplest issue confronting correctional administrators. Other questions—where to house and treat the inmate, how to prevent the spread of the disease, and how to pay for medical care—are likely to be even more difficult to resolve. In this section, we examine many of the ways that correctional administrators have responded to these institutional management issues, and where possible, we explore some of the advantages and disadvantages of these approaches.

### **Housing Policies for Inmates with AIDS, ARC, or HTLV-III Seropositivity**

Deciding where to house and treat inmates with AIDS, ARC, or HTLV-III seropositivity is one of the most critical and difficult decisions for correctional administrators. Of course, medical considerations are one of the most important factors in this decision. Most jurisdictions place inmates with confirmed diagnoses of AIDS in a hospital or infirmary setting, although the duration of such hospitalization varies considerably. In addition, preventing the spread of AIDS within the prison and protecting affected inmates must also be important considerations. Finally, the costs of care, availability and location of facilities able to provide appropriate care, costs of any new construction or renovations necessary to prepare special units, and staffing of any special AIDS units (correctional as well as medical) will all affect correctional decisions on treatment and housing.

Correctional administrators have a number of options concerning treatment and housing placements for inmates with AIDS, ARC, or HTLV-III seropositivity. Among those identified in responses to the NIJ/ACA questionnaire were the following:

- 1) maintaining inmates in the general population;
- 2) returning inmates to the general population when their illnesses are in remission;
- 3) administratively segregating inmates in a

Figure 4.1

**HOUSING POLICIES FOR INMATES WITH AIDS, ARC, AND HTLV-III  
SEROPOSITIVITY: STATE AND FEDERAL PRISON SYSTEMS (n = 51)<sup>a</sup>**

Policy	Jurisdictions Following this Policy for:					
	AIDS		ARC		HTLV-III Seropositive	
	n	%	n	%	n	%
• Maintain in general population	2	4%	8	16%	17	33%
• Maintain in general population with special programming	2	4	2	4	10	20
• Return to general population when in remission	1	2	4	8	0	0
• Case-by-case determination	12	24	9	18	7	14
• Administrative segregation/separation <sup>b</sup>	10	20	9	18	5	10
• Hospitalization (within or outside correctional system)	27	53	18	35	5	10
• Segregation (not specified whether medical or non-medical)	2	4	1	2	0	0

<sup>a</sup> This includes hypothetical policies in jurisdictions that as yet have no cases in a particular category.

<sup>b</sup> This category includes single-celling and housing inmates in medical units for administrative reasons. The latter policy, followed or planned in some jurisdictions, including Oklahoma, is generally intended to protect affected inmates from other inmates and/or to facilitate their supervision.

separate unit or relying on single-cell housing;

- 4) hospitalization; and
- 5) case-by-case determination of all housing and treatment decisions.

### **NIJ/ACA Study Results**

Figures 4.1 and 4.2 summarize responses to the NIJ/ACA questionnaire from federal and state systems (Figure 4.1) and city and county systems (Figure 4.2) regarding their use of these options for inmates with AIDS, ARC, and HTLV-III seropositivity. Two-thirds of the federal and state systems have written policies in place or in development for these categories of inmates. Among responding city and county systems, 70 percent have such written policies in place or under development.

Readers should note that the policy tabulations in Figures 4.1 and 4.2 are not mutually exclusive. For example, a jurisdiction may segregate ARC patients

when they are symptomatic but return them to the general population when their symptoms subside. Such cases would be included under both of those categories in Figures 4.1 and 4.2. Also, jurisdictions may have a basic policy of case-by-case determination but reach a variety of decisions in individual cases. Such jurisdictions would be included both under case-by-case determination and under the categories reflecting individual case decisions.

These NIJ/ACA study results reflect a broad diversity of policies for managing inmates with AIDS, ARC or HTLV-III seropositivity. The strongest agreement on particular policy options is that inmates with AIDS should be hospitalized; 53 percent of state and federal systems and 81 percent of city and county systems have this policy. Another significant finding of the study is that city and county systems are also more likely to hospitalize all ARC and seropositive inmates (55 percent and 42 percent, respectively) than are federal and state systems (35 percent and 10 percent, respectively).

Figure 4.2

**HOUSING POLICIES FOR INMATES WITH AIDS, ARC, AND HTLV-III  
SEROPOSITIVITY: CITY AND COUNTY JAIL SYSTEMS (n = 33)<sup>a</sup>**

Policy	Jurisdictions Following this Policy for:					
	AIDS		ARC		HTLV-III Seropositive	
	n	%	n	%	n	%
• Maintain in general population	1	3%	4	15%	6	18%
• Maintain in general population with special programming	0	0	3	9	5	15
• Return to general population when in remission	2	6	4	12	0	0
• Case-by-case determination	5	15	8	24	6	18
• Administrative segregation/separation <sup>b</sup>	2	7	4	13	5	16
• Hospitalization (within or outside correctional system)	25	81	17	55	13	42
• Segregation (not specified whether medical or non-medical)	2	6	2	6	4	12

<sup>a</sup> This includes hypothetical policies in jurisdictions that as yet have no cases in a particular category.

<sup>b</sup> This category includes single-celling and housing inmates in medical units for administrative reasons. The latter policy, followed or planned in some jurisdictions, including Maricopa County, Arizona, is generally intended to protect affected inmates from other inmates and/or to facilitate their supervision.

Figure 4.3 further summarizes the questionnaire responses, according to mutually exclusive categories. This attempts to capture the *basic* policy followed by each jurisdiction for each category of inmate. Figure 4.3 also reflects a significant lack of consensus. Most jurisdictions hospitalize or administratively segregate at least some of the three AIDS-related inmate categories. Again, city and county jurisdictions are more likely to use segregation: 39 percent of responding city and county jurisdictions segregate all three AIDS-related inmate categories as opposed to only 16 percent of state and federal systems. Almost one-third of all responding systems have basic policies involving case-by-case determination.

Otherwise, there is a great deal of variation in the particular policy combinations. In view of this nationally fragmented policy picture, it is worth mentioning again that the four jurisdictions with almost 75 percent of the correctional AIDS cases (New York State, New York City, New Jersey and Florida) all pursue the following combination of policies:

- medical segregation of AIDS patients, but

not inmates with ARC or HTLV-III seropositivity;

- careful evaluation and ongoing monitoring of inmates suspected of having ARC or AIDS;
- no mass screening for antibody to HTLV-III; and
- extensive staff and inmate educational programs.

In all four of these systems, equilibrium has been reached on the AIDS issue, with no widespread fear among staff or inmates regarding transmission of the virus within the institutions.

The specific correctional management considerations involved in each of the major housing options are examined below.

### *Maintaining Inmates in the General Population*

Decisions to keep inmates in the general population

Figure 4.3

MUTUALLY EXCLUSIVE CATEGORIZATION OF HOUSING POLICIES<sup>a</sup>

Policy Combination	State/Federal Prison Systems		City/County Jail Systems	
	n	%	n	%
• Segregate AIDS cases; ARC cases and seropositives maintained in general population	3	6%	3	9%
• Segregate AIDS and ARC cases; seropositives maintained in general population	10	20	3	9
• Segregate all categories	8	16	13	41
• No segregation of any categories	2	4	0	0
• No policy	8	16	1	3
• Combinations involving case-by-case determination	16	31	10	30
• Other policy combinations	4	8	3	9
Total	51	101% <sup>b</sup>	33	101% <sup>b</sup>

<sup>a</sup> For the purposes of this categorization, segregation means that the *basic* policy is to hospitalize (either within or outside the correctional system) or to segregate administratively the particular category of inmate, regardless of whether these inmates are returned to the general population when their symptoms subside. Single-celling is also included in segregation.

<sup>b</sup> Due to rounding.

involve consideration of measures necessary and appropriate to protect affected inmates from other inmates and to minimize the risk of the infection being transmitted. CDC guidelines recommend no special housing arrangements for AIDS or ARC patients except under certain clearly defined medical circumstances. These circumstances primarily involve protection of the *patient* from infection rather than protecting other people from the patient's infection. As shown in Figure 4.3, a number of systems maintain entire AIDS-related categories of inmates, particularly seropositives, in the general population without any special programming. For example, New York City estimates that its system has a significant number of seropositive inmates in the general population. However, largely due to extensive educational programs on AIDS, this has occasioned no panic regarding transmission of HTLV-III infection.

Several states, including Minnesota, believe that no special housing measures for administrative reasons are necessary for any AIDS-related category of inmates. Florida and Rhode Island house all ARC inmates in the general population unless and until they meet the CDC definition of AIDS. In Connecticut and Rhode Island, AIDS and ARC patients participate in

the daily routine of the institution unless they are unable to do so for medical reasons. In Rhode Island, inmates not meeting the CDC case definition of AIDS are returned to their institution and prior housing status after medical evaluation. The state's policy is that no isolation, segregation, or job restrictions shall be imposed unless the inmate exhibits any of the following conditions: open skin sores or mucous lesions; clinical presence of fever, malaise and weakness; cough; diarrhea or fecal and urinary incontinence; or any other condition requiring medical isolation.

### Hospitalization

Every jurisdiction places inmates with confirmed diagnoses of AIDS in some hospital or infirmary setting during the periods when they are seriously ill. The type of medical facilities used and the duration of hospitalization varies according to the seriousness of the illness or symptoms and the purpose of a medical placement— evaluation, treatment, or segregation from other inmates.

A variety of treatment settings are used for AIDS inmates. Some states place all inmates with AIDS in hospitals in the community (New Jersey), while others

maintain them in correctional medical facilities (California, Federal Bureau of Prisons) and still others use both community hospitals and correctional medical facilities (New York State). In several states, however, there have been difficulties finding community hospital placements for inmates with AIDS. At least two jurisdictions have centralized the treatment of all inmates with AIDS in a single correctional medical facility (California: Vacaville; and New York City: Rikers Island Hospital). All inmates with confirmed AIDS in these jurisdictions are permanently admitted to the centralized medical facility.

Though hospital and infirmary settings are designed for medical treatment and evaluation, some jurisdictions also use these facilities to isolate inmates with AIDS from the general correctional population. Thus, for example, some states permanently segregate AIDS cases in a hospital facility regardless of the degree of their illness (e.g., New Jersey). For this same reason, some jurisdictions also place inmates with ARC in such settings. Finally, eighteen jurisdictions, including California, Utah, Washington, D.C., Broward County, Florida, and San Diego, California, place seropositive inmates in prison infirmaries or hospitals.

States which use hospital facilities for evaluation and treatment will often admit AIDS inmates for limited periods of time. For example, Georgia hospitalizes AIDS patients when they are ill but returns them to single-cell housing when their disease is in remission. Other states, including New York and Pennsylvania, hospitalize AIDS cases in community hospitals until the disease is in remission, then return them to medical units in their original institutions. Finally, several systems have designated one medical facility to evaluate all suspected cases of AIDS and ARC, after which treatment and housing decisions are made on a case-by-case basis (e.g., Connecticut).

Within medical facilities, some jurisdictions have policies involving medical isolation and quarantine of inmates with AIDS. Such policies run counter to CDC's guidelines for care of AIDS patients. These guidelines state that medical isolation is not necessary in most instances. Private rooms are indicated only when the patient is too ill to use good hygiene (e.g., suffers from profuse diarrhea or fecal incontinence) or displays altered behavior as a result of central nervous system infection.<sup>2</sup> Connecticut and California have explicit policies against isolation of AIDS patients unless it is medically indicated.

### *Non-Medical Segregation/Separation*

Some correctional systems believe that it is necessary

to separate inmates with AIDS, ARC and/or HTLV-III seropositivity from the general correctional population for administrative and management (as opposed to medical) reasons. Some systems segregate all three major AIDS-related inmate categories (Arizona, Connecticut), and others segregate AIDS and ARC inmates, but not seropositives (Indiana, Pennsylvania). As noted above, some jurisdictions, including Oklahoma and Maricopa County (Phoenix), Arizona, use medical facilities for such administrative segregation.

Other non-medical housing options include administrative assignment to single-cell housing in the general population. For example, Texas single-cells all ARC inmates and seropositive inmates who are in high-risk groups and Nebraska single-cells all seropositive inmates. Such decisions represent efforts to prevent transmission of the infection to other inmates or to protect the affected inmates from others in the population, or both.

Though segregating inmates to prevent the spread of AIDS within prisons may be effective in controlling HTLV-III transmission and may help to reduce fear of AIDS within the institution, it has certain drawbacks and limitations. First, this policy will only be effective to the extent that AIDS, ARC, or seropositive cases are *known* to correctional administrators. In this light, other approaches, such as education on the means of HTLV-III transmission, surveillance for those behaviors known to be associated with transmission, and enforcement of disciplinary sanctions against those behaviors, may be more effective.

Second, correctional administrators may reduce their administrative options by adopting a policy of segregation. Once a category of inmates is separated from the general population, it may be difficult to reverse that decision and send them back, as this might cause concern among other inmates and staff. Still, there are cases of policy being changed without causing great difficulty. For example, in Michigan an inmate with AIDS was medically segregated, but then returned to the general population without incident when the disease went into remission. Michigan officials emphasize the importance of a concerted and continuous education program and the cooperation of the correctional officers' union in achieving this success.

Finally, development of separate housing for AIDS, ARC, or seropositive individuals may have considerable impact on correctional costs. Single-celling, development of separate units, and medical isolation are all expensive, especially if these placements are used

for inmates showing only HTLV-III seropositivity or ARC. Still, some states, such as Indiana, believe that segregation of all inmates with AIDS and ARC will be necessary until staff and inmate education programs have a chance to take effect.

Because many people are misinformed about AIDS and have undue fear of contracting the disease, inmates with AIDS, ARC, or HTLV-III seropositivity may actually be in some danger if left in the general correctional population, and in such cases, protective custody may be warranted. However, the decision to segregate inmates on this basis must rest on careful consideration of the situation in each institution. An alternative to blanket segregation may be to provide protective custody to inmates on request. It is important to re-emphasize that with appropriate educational programs, many correctional systems have successfully avoided all forms of administrative segregation and have separated inmates only when medically indicated.

### *Case-by-Case Determination*

Many jurisdictions, including New York and Minnesota, make all decisions case-by-case, strictly on the basis of medical advice. New York handles all ARC cases individually, depending on degree of illness: decisions range from placement in a community hospital to maintenance in the general population with no special programming.

Oregon and Wisconsin take into consideration a combination of medical and non-medical factors. Oregon makes case-by-case decisions based on balancing all the advantages and disadvantages of segregation. According to the Correctional Division's health services director, the state's policy is that "since non-infected individuals can avoid the major risk of exposure to the AIDS virus by abstaining from [sexual activity and needle-sharing], it is not medically necessary to separate infected individuals to avoid spread of the disease." However, individual decisions have been made to segregate particular inmates for their own protection, to prevent panic among the inmates, or in response to certain medical conditions.<sup>3</sup> In Wisconsin, recommendations for special housing must be based on the inmate's medical status and/or on the inmate's non-medical characteristics or behaviors which may present a risk of transmitting the infection to others.<sup>4</sup>

Case-by-case determination recognizes that each case is unique. It allows the flexibility to shape particular responses to the medical and non-medical characteristics of particular cases. On the other hand, the subjective judgments which may be made under a

case-by-case approach and the lack of uniform policies linked to clear AIDS-related categorizations of inmates may cause concern among staff and other inmates. Of course, educational programs may be able to allay such concerns.

A policy based on case-by-case decisionmaking may also be more vulnerable to legal challenges on the basis of adequacy and equitability of treatment. However, such problems should be minimized by careful attention to the medical and non-medical characteristics of each case.

### **Precautionary Measures**

Correctional agencies have instituted a wide range of precautionary measures to control the spread of AIDS within institutions. Some of these measures, especially those based on CDC guidelines for clinical staff, offer excellent protection while minimizing cost and inconvenience within the institution. Others go well beyond the CDC guidelines and are probably unnecessary and inappropriate.

### *CDC Guidelines for Clinical and Laboratory Staff*

CDC has promulgated guidelines for clinical staff who care for AIDS patients and laboratory staff who may come into contact with the blood or other body fluids of AIDS patients.<sup>5</sup> Many jurisdictions have made these CDC guidelines a part of their correctional policy regarding AIDS.

The CDC guidelines advise clinical and laboratory staff "to use the same precautions when caring for patients with AIDS as those used for patients with Hepatitis-B virus infection . . . Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin or mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS." Several physicians interviewed for this study believe that since the AIDS virus is less hardy and more difficult to transmit than the Hepatitis-B virus, precautions designed to prevent transmission of Hepatitis-B should be more than sufficient to prevent transmission of AIDS. Measures beyond those recommended for Hepatitis-B are considered unnecessary and inappropriate for addressing the AIDS risk.

The complete CDC guidelines are included in Appendix E to this report, but the following represents a summary of the precautionary measures recommended:

- avoidance of needlesticks and other sharp instrument injuries;

- wearing of gloves and gowns when there is potential for contact with blood or body fluids;
- handwashing after removing gloves and gowns and after leaving a patient's room; thorough washing after any contact with blood or body fluids;
- containering, labelling and other precautions for handling blood and other specimens;
- disinfecting and decontamination procedures;
- prompt cleanup of blood/body fluid spills;
- precautions for handling needles after use: not to be recapped or bent, but rather placed in puncture-resistant containers;
- use of disposable syringes and needles; and
- use of mouthpieces, resuscitation bags and other ventilation devices to minimize the need for emergency mouth-to-mouth resuscitation.

In addition to its guidelines for clinical and laboratory staff, CDC has recently promulgated guidelines for dental workers.<sup>6</sup> Several correctional systems have also implemented these precautions—not because of possible exposure to saliva, but because of the potential exposure to blood involved in scaling procedures and other routine dental work. New York City recommends that dental workers wear protective goggles, masks and gloves when treating inmates with AIDS or ARC or those in identified AIDS risk groups. Florida has gone beyond this to recommend that dental workers take these precautions when treating all inmates.

### *Additional Preventive Measures*

Some correctional agencies have instituted protective measures which go far beyond those recommended by CDC. Many of these measures are designed to limit exposure under extremely unusual circumstances or to prevent exposure through casual contact. However, all evidence indicates that AIDS cannot be transmitted by a single exposure of any kind or through casual contact, and these messages are, in fact, major themes in most AIDS education programs. Precautionary measures addressing very rare or casual modes of contact, even if implemented in a good faith effort to reduce the fears of staff and inmates, may ultimately increase those fears by encouraging the view that the disease is transmitted by the sorts of unusual or casual contact they address. Such a conflict between educa-

tional messages and practical measures may not only increase fear within the institution, but also foster suspicion of the correctional system for, in effect, saying one thing about the transmission of AIDS but doing something else. The CDC recommendations and correctional practice in several precautionary areas are summarized below.

**Special Clothing and Protective Equipment for Staff and Inmates.** Thirty-five percent of state/federal correctional systems and 52 percent of responding city/county jurisdictions make protective clothing and equipment available to staff for use when working with or transporting inmates who have AIDS or when restraining inmates with AIDS who become aggressive or violent. As noted above, CDC recommends use of protective clothing only when there is potential for exposure to blood or body fluids.

California has basically adopted the CDC recommendations. However, the state recommends use of masks by patients and staff in the case of respiratory infection or other potentially airborne disease. Connecticut policy states that no special clothing is required for inmates with AIDS involved in normal activities or for staff involved in transporting inmates with AIDS. New York City and Nevada make disposable gloves, gowns and plastic "flex-cuffs" available for staff who transport AIDS patients. Otherwise, New York City decided against recommending special clothing for staff working with AIDS patients because of the low probability that blood-to-blood contact would occur, and, even if it did, the low probability that the infection would be transmitted by an isolated exposure. In reaching this decision, New York City was heavily influenced by the studies showing virtually no transmission of infection to health-care workers who had suffered needlesticks and absolutely no transmission of infection to family members of AIDS patients.

**Procedures for First Aid and CPR.** About forty percent of state/federal systems and about sixty percent of responding city/county jurisdictions have developed special procedures to minimize the risk that HTLV-III infection will be transmitted during first aid or cardiopulmonary resuscitation—particularly mouth-to-mouth resuscitation. In many jurisdictions, masks and other devices are made available to prevent contact with saliva during mouth-to-mouth resuscitation. In addition, training and education are provided on avoiding contact with blood and body fluids while rendering first aid.

**Laundry Procedures.** CDC recommends no special handling of the laundry and linen of AIDS patients. Many jurisdictions, including Connecticut, follow this

recommendation. However, several other states have instituted special handling of laundry.

**Toilet and Personal Hygiene Procedures.** CDC recommends no separate toilet or shower facilities for AIDS patients and most jurisdictions conform to this guideline. Nevertheless, several jurisdictions have designated separate shower and toilet facilities for AIDS patients.

As discussed earlier, many jurisdictions provide personal toothbrushes (63 percent of state/federal systems and 82 percent of responding city/county systems) and disposable razors (63 percent of state/federal systems and 67 percent of responding city/county systems) to all inmates and encourage their use. This is because of the possibility of exposure to blood in sharing such items. For the same reason, 65 percent of state/federal systems and 61 percent of responding city/county systems have prohibited tattoo machines and tattooing in general.

**Food Service for AIDS Patients.** Because there is no evidence that the AIDS virus can be transmitted through food, CDC recommends no special provisions for food service and no special handling of utensils used in the preparation or service of meals for AIDS patients. California and many other jurisdictions follow these guidelines. However, some jurisdictions have instituted special food service procedures.

**Inmate and Staff Work Assignments.** In many correctional systems, the work assignments of AIDS, ARC and/or seropositive inmates are restricted. These systems generally acknowledge that restrictions on work assignments are not medically necessary except for confirmed AIDS cases who are very ill. Nevertheless, restrictions on assignments to food service, medical, dental and laundry duties have been instituted for administrative reasons.

Administrators must carefully weigh the medical and correctional considerations before instituting such restrictions. As noted earlier, unnecessarily extreme precautions may undermine educational programs designed to convince inmates and staff that the AIDS virus is not transmitted except through blood-to-blood contact.

Policy in virtually all jurisdictions is that staff shall not generally be excused from assignments to work with AIDS inmates. However, several jurisdictions have instituted special restrictions for some staff members. For example, in the California system no pregnant female employees may be assigned to duty involving close supervision or care of AIDS patients. This is because of the risk of being exposed to cyto-

megalovirus (CMV), which is commonly excreted by AIDS patients and which may cause birth defects. In addition, there is the general concern that a pregnant woman who contracted HTLV-III infection from any inmate through a job-related exposure to blood or body fluids might perinatally transmit the infection to her child.

### **Notification and Confidentiality**

One of the most difficult and sensitive issues regarding AIDS in corrections is who receives information on the medical status of inmates with AIDS, ARC, or HTLV-III seropositivity.

### **Legal and Policy Considerations**

Decisions regarding who should receive HTLV-III antibody test results and who should be notified regarding diagnoses of AIDS or ARC may be dictated by precise legal and policy standards, such as requirements for written authorization to release test results or other medical records. Two-thirds of state/federal systems and 91 percent of responding city/county systems have general or specific confidentiality policies covering AIDS-related medical information.

CDC has an extremely strict policy regarding its AIDS case reports. No names are ever reported to the CDC surveillance database; cases are reported by code number and date of birth only. The states maintain the names and other identifying information. At the same time, in some jurisdictions, such as New Jersey, the question of confidentiality of the medical records of inmates with AIDS is now under litigation. New Jersey inmates have filed suit seeking strict confidentiality of all AIDS-related medical records.<sup>7</sup>

Some argue that decisions regarding disclosure versus confidentiality of medical information in cases of AIDS or ARC should be based solely on legal requirements—that is, no information should be reported to anyone unless it is required by law. This position is based on the premise that correctional systems should bear no greater responsibilities for notification than do institutions in the community at large. It also seems to reflect skepticism that such notifications serve any useful or appropriate purpose.

Where law or policy allow any discretion, decisions regarding disclosure versus confidentiality invariably raise the question of which should take precedence: the inmate's right to have medical information kept confidential or the correctional system's perceived legal and moral responsibility to protect its staff and other

Figure 4.4

**POLICIES REGARDING DISCLOSURE OF INMATES' HTLV-III  
ANTIBODY TEST RESULTS<sup>a</sup>**

Who Receives Results?	State/Federal Prison Systems		City/County Jail Systems	
	(n = 51) n	%	(n = 33) n	%
• Inmate (and those authorized by inmate)	16	31%	17	52%
• Inmate's spouse/sexual partner	0	0	0	0
• Medical staff	36	71	20	61
• Correctional staff	13	26	10	30
• Public health department	16	31	9	27
• Previous correctional institution	0	0	0	0
• Subsequent correctional institution	6	12	7	21

<sup>a</sup>Includes immediate disclosures and disclosures on transfer/discharge.

inmates, as well as the public, from HTLV-III infection. There are valid claims on both sides of the argument. On the one hand, it is often argued that correctional staff have a right to know when they are dealing with inmates who may be infectious or who have a serious communicable disease, and that spouses have a right to know if a person with whom they may have sexual relations is carrying a sexually transmitted disease. Notification to public health departments and inmates' former and/or subsequent correctional systems may also be considered important to facilitate treatment, prevention measures, and contact tracing. Such disclosures may also be designed to reduce or eliminate the correctional system's legal liability should a released or transferred inmate transmit AIDS to others.

On the other hand, the most compelling reason for maintaining confidentiality is that persons known to have AIDS, ARC, or HTLV-III seropositivity may suffer ostracism, threats and possibly violent intimidation while in prison, and discrimination in employment, housing, and insurance availability after they are discharged.

Because of their rapid population turnover rates, jails face even more difficult policy decisions and logistical problems regarding disclosure and confidentiality of medical information.

Figures 4.4 and 4.5 summarize the responses to the

NIJ/ACA questionnaire regarding disclosure of HTLV-III antibody test results. Figure 4.4 presents a non-mutually exclusive summary of disclosure policies and Figure 4.5 offers a mutually exclusive categorization of these policies. The most notable features of these study results are the relatively small number of systems that provide test results to inmates (31 percent of state/federal systems and 52 percent of responding city/county systems). Figure 4.5 shows that no state/federal systems and a small fraction of city/county systems (19 percent) disclose results to inmates *only*. Larger percentages of the responding systems provide results to medical staff (71 percent of state and federal systems and 61 percent of responding city/county systems). However, the figures on notification of inmates may be somewhat misleading. In completing the questionnaire, some jurisdictions may have simply assumed that we knew that the inmate was notified and thus failed to mention this in their responses. In significant percentages of jurisdictions, correctional staff and public health departments are also notified of HTLV-III antibody test results.

At the same time, no jurisdictions responding to the questionnaire specifically reported that spouses or sexual partners or previous correctional facilities of seropositive inmates are notified of test results. While only a relatively small percentage of systems reported that inmates' subsequent correctional facilities are notified when the inmate is transferred, we believe that

Figure 4.5

**MUTUALLY EXCLUSIVE CATEGORIZATION OF DISCLOSURE POLICIES  
FOR INMATE TEST RESULTS<sup>a</sup>**

Who Receives Results?	State/Federal Prison Systems		City/County Jail Systems	
	n	%	n	%
• Inmate (and those permitted by inmate) <i>only</i>	0	0%	5	15%
• Medical staff <i>only</i>	13	25	4	12
• Inmate and medical staff <i>only</i>	5	10	2	6
• Medical and correctional staff <i>only</i>	4	8	0	0
• Inmate, medical and correctional staff <i>only</i>	0	0	2	6
• Combinations involving disclosure to public health departments	16	31	9	27
• All other combinations	8	16	6	18
• No testing	5	10	5	15
Total	51	100%	33	99% <sup>b</sup>

<sup>a</sup>Includes immediate disclosures and disclosures on transfer/discharge.

<sup>b</sup>Due to rounding.

the real figures are somewhat higher. If the test results appear in the inmate's medical record, the subsequent facility is almost certain to receive them.

Below, we discuss the range of options regarding disclosure of all types of AIDS-related medical information. The discussion references relevant legal and policy requirements.

### ***Range of Options Regarding Who Receives Information***

**Very Restrictive Provisions.** In some states, such as California and Wisconsin, there are very restrictive laws governing disclosure of HTLV-III antibody test results. Under California law, only the subject may receive the results of the test unless he or she gives written authorization for others to receive them. Written consent is required for each separate disclosure. Moreover, the law specifies that no one can be compelled to identify the subject or divulge the results of any test in a legal action without the written consent of the subject. Test results are not subject to disclosure under California's employee "right-to-know" law. Finally, in California, test results may not be used to reach any decision regarding employment or insurability.

Under Wisconsin's law, the only legal recipients of test results are the subject, the subject's health-care provider, laboratory personnel and other staff of health-care facilities, and the state epidemiologist. Any disclosure to others requires a court order. In states such as California and Wisconsin, the correctional department may not be able to obtain test results.

Several correctional medical staff interviewed for this study believe that any HTLV-III antibody testing of inmates should be done at one of the CDC-funded alternative test sites nationwide. All testing at these sites is anonymous; no names are recorded and results can only be obtained by using a code number known to the subject alone. According to NIJ/ACA questionnaire responses, no correctional systems currently restrict testing to alternative sites. However, several city/county systems limit notification of results to the inmate tested. A variation on this policy is employed in at least one state: there, no entry is made of the test results in the inmate's medical record and the results are conveyed orally to the inmate by medical staff.

**Notification of Correctional Authorities and Correctional Staff.** In contrast to those discussed above, several states, including Louisiana, require that correctional authorities be notified of the results of an-

tibody test results but prohibit notification of the inmate. The notification of correctional authorities and correctional staff raises several questions. For example, do correctional authorities have a need or a right to know the results of HTLV-III antibody testing in order to make correctional programming decisions? Do correctional staff have a right to know the HTLV-III serologic status of particular inmates with whom they must deal on a day-to-day basis? In Connecticut, for example, institutional heads and correctional staff are notified of the presence of any potential carriers of certain infectious diseases, including inmates with AIDS, ARC, or HTLV-III seropositivity. In Michigan, the correctional officers' union must be notified of the names of any inmates with AIDS housed in the institution.

In Massachusetts, all inmate medical records are considered confidential, with only medical staff entitled to routine access. However, the information is available to the Commissioner of the Department of Correction as well as to the superintendent of the inmate's institution on a "need to know" basis. It is likely that correctional staff in the institutions obtain information on diagnoses of AIDS or ARC through the superintendent.

When inmates are transferred, correctional systems generally send their full medical file to the new institution. This would include any diagnoses of AIDS or ARC, and, in some cases, information on HTLV-III seropositivity as well. In terms of disclosure to correctional authorities, an important issue is how far the chain of notification should extend. For example, should parole authorities be notified of a potential parolee's medical status? As discussed below, this may be questionable from a legal standpoint and no jurisdictions responding to the NIJ/ACA questionnaire reported making such notifications. Another question likely to arise is the following: if an intake test reveals seropositivity or an inmate develops AIDS or ARC, should the system notify the city or county jail from which the inmate came to determine if the inmate had sexual contact or shared needles with any inmates there? Other institutions and organizations outside the correctional system do not generally provide such notifications.

**Notification to Public Health Departments.** Thirty-one percent of state/federal systems and 27 percent of responding city/county systems routinely notify public health agencies when an inmate is diagnosed as having AIDS or ARC or when such an inmate is released. Under Colorado law, state and local public health departments must be notified of all positive HTLV-

III antibody test results. This law was passed so that public health authorities could be alerted to the presence of potentially infectious individuals and so that such individuals may be counseled regarding the meaning of their test and measures necessary to prevent transmission of the virus. However, under the Colorado law, public health departments must maintain the test results in strictest confidence. The information is not available to insurers or employers without permission of the subject.

**Notification of Spouse/Sexual Partners.** Although questionnaire responses revealed no official policies along these lines, some correctional administrators believe that they may have a moral responsibility to notify the spouse or sexual partner of an inmate with AIDS, ARC, or HTLV-III seropositivity prior to authorizing any conjugal visits or furloughs and prior to the inmate's discharge. The question that arises here again is whether correctional systems should bear more responsibility than do institutions in the community at large, which generally require no such notification. In other words, should correctional administrators rely on counseling and education on AIDS, as is the general procedure in the outside world, or do the particular characteristics of correctional inmates necessitate further interventions?

**Contact Tracing.** When certain communicable diseases are diagnosed, attempts are sometimes made to identify the source from whom the individual contracted the disease and anyone whom the individual might have exposed to the disease prior to his or her diagnosis. Such "contact tracing" is sometimes attempted in AIDS cases. For example, the Massachusetts Department of Correction immediately interviews all inmates diagnosed with AIDS regarding possible partners in sexual or needlesharing activities. While potentially useful in certain limited situations, such contact tracing may also produce a "Typhoid Mary" scenario: the number of individuals involved in the inquiry expands almost geometrically, and these individuals' privacy is invaded and their lives are disrupted out of all proportion to the real risk that they transmitted or acquired the AIDS virus. Indeed, some physicians and epidemiologists believe that contact tracing is not likely to work in AIDS cases because of the difficulty in pinpointing the specific incident resulting in infection and because there is no treatment which might provide an incentive for persons to admit contact.

### **Duration of Incarceration**

A few jurisdictions consider giving immediate ex-

ecutive clemency to inmates with AIDS as a gesture of humanity and mercy. In such cases, provision for appropriate aftercare is important. By contrast, several other systems believe that inmates with AIDS should be kept in the medical care of the system as long as possible (e.g., no parole, no transfer to minimum security institutions, no pre-release placement in halfway houses or community-based programs), to provide better care, to minimize the risk of HTLV-III transmission and to reduce the system's potential legal liability. However, this policy raises other serious legal issues. Indeed, a recently filed New York case alleges discrimination against inmates with AIDS in the granting of parole. (This case is discussed in more detail below.)

Mentally ill persons may be legally committed or otherwise segregated for extended periods if they are deemed to pose a threat to society or to themselves. However, the situation of the inmate with AIDS is different: the risk that he or she will transmit the infection largely involves consensual acts rather than forcible victimizations. A possible exception may be the violent sexual offender with AIDS, ARC, or HTLV-III seropositivity; the question logically arises whether such individuals' AIDS-related medical status should influence parole or release decisions. In general, such decisions should probably be based on a combination of medical and non-medical factors (e.g., the inmate's medical status and an assessment of the likelihood that the inmate would engage in violent or other non-consensual acts by which the infection might be transmitted). However, decisions that extend the period of incarceration can probably not be supported if based solely on medical factors.

### **Costs of Care and Associated Services**

Responses to the NIJ/ACA questionnaire showed that correctional systems are almost universally concerned about the costs of medical care and associated services for inmates with AIDS. However, the questions regarding range of costs elicited widely varying estimates. The only agreement seemed to be that medical care for AIDS patients is extremely expensive, whether it is provided in a correctional medical facility, in another public medical facility, or in a hospital in the community. The problem is exacerbated because medical services provided to correctional inmates are ineligible for Medicaid reimbursement.

One low estimate is that total hospitalization costs for all AIDS patients (i.e., not just correctional cases) average \$42,000 per case.<sup>8</sup> By contrast, the New Jersey Department of Corrections estimates a mean annual

(as opposed to total) cost of care for each AIDS inmate at \$67,000 and this figure rises to \$200,000 for inmates requiring long periods of acute medical care. Maryland estimates the annual cost of hospitalization at \$143,000 per inmate with AIDS. In New York City, hospitalization of inmates with AIDS costs about \$300,000 per inmate per year. The figures for hospitalization include all hospital and surgical charges, physicians' services, laboratory fees, and costs of prescription drugs.

Thus, correctional systems can plan on spending anywhere from \$40,000 to over \$600,000<sup>9</sup> for hospitalization and associated medical costs of caring for each inmate with AIDS. The cost will probably be higher if inmates are placed in hospitals in the community than if they are retained in correctional medical facilities or other public medical facilities. However, a number of factors besides cost will inform decisions on where to place inmates with AIDS. These include availability and location of necessary medical care capabilities, numbers of inmates in the system who require such care, and institutional security and management issues.

To the figures for hospitalization and medical care must be added costs of ancillary services such as counseling, possible legal costs, increased insurance costs (unless the system is self-insured), and funeral costs. Obviously, the total costs of medical care and associated services for inmates with AIDS could have serious budgetary implications for correctional systems. Because of budgetary overruns, New York state will soon cease paying for intensive care unit placements for correctional inmates and other indigent individuals with AIDS.

Correctional systems should develop as much information as they can, through epidemiological studies (as recommended earlier in this report) and other means, to project their future numbers of AIDS cases. Such projections will at least help administrators prepare timely requests for budgets to cover the costs of medical care and associated services for those inmates.

### **Responsibility for Aftercare**

A final issue regarding correctional policies for managing AIDS and ARC cases is the duration of the system's responsibility to provide care to such inmates: to what extent is it responsible for medical, psychological and other aftercare? This responsibility is probably limited to locating the appropriate services (hospice care, hospitalization, outpatient care,

counseling and other support services) and making the appropriate referrals for the former inmate, and should not include actual provision or financing of those services.

## Legal Issues

There is currently very little law specifically on correctional systems' policies regarding AIDS cases, though several cases have been filed in New York and other states. Otherwise, specific AIDS-related legal concerns remain largely hypothetical and speculative. Still, there is substantial caselaw on correctional medical care in general, which is important for administrators to consider in developing policies regarding AIDS. As already noted, AIDS should not necessarily be considered a unique correctional health issue; legal standards and correctional policies regarding communicable diseases in general may be applicable to AIDS and may have already been tested in court. Some legal counsel believe that these general standards and policies are sufficient to address AIDS cases. Indeed, some state correctional commissioners, including Thomas Coughlin of New York state, strongly recommend following standard procedures already in place for other communicable diseases. Commissioner Coughlin urges correctional systems not to develop "voluminous and probably unnecessary procedures that you may be held responsible to perform later just because you initiated them."<sup>10</sup> The major legal standards and causes of action on correctional health care are discussed below.

### Standards for Correctional Medical Care<sup>11</sup>

Suits on the quality of correctional medical care may be brought on the basis of federal constitutional standards, state law, or common law. Plaintiffs may seek judgments under 42 USC 1983, the provision which essentially gives citizens the legal right to sue the government.

There are three basic federal constitutional standards and principles relevant to correctional medical care. First, under the Eighth Amendment, inmates are entitled to a safe, decent and humane environment, although the Fifth Circuit has held that this does not mean they are legally entitled to rehabilitative or recreational programs while in prison.<sup>12</sup> Second, in *Estelle v. Gamble*,<sup>13</sup> "Deliberate indifference to serious medical need" was held to violate the Eighth Amendment protection against "cruel and unusual punishment." Finally, the federal constitutional guarantee of "equal protection of the laws" is relevant to correctional medical care cases, and particularly to cases in-

volving AIDS inmates, because of the segregation issues.

Medical care in correctional institutions is usually governed by the same state laws (e.g., Medical Practice and Nursing Practice Acts) that apply to care in the community at large. However, inmates are not necessarily entitled to all aspects of medical care available in the community at large—for example, the right to choose one's own physician and the right to a second medical opinion.

Finally, in some states, correctional medical care may be subject to suits for common law torts such as negligence. Medical malpractice suits are also a possibility.

Actions for injunctive relief from correctional policies allegedly inadequate to prevent transmission of the AIDS virus have been brought by inmates in some states. Such actions by staff are also possible in the future. However, some correctional legal staff believe that in all of these legal areas claims will be difficult to establish because of the perceived lack of clear medical standards for treating and preventing AIDS.

### Equal Protection

To date, several inmates have filed suits alleging that they were denied equal protection of the laws due to special conditions imposed on them because they had AIDS. In a New York case, *Cordero v. Coughlin*,<sup>14</sup> a group of segregated state inmates with AIDS sued the state's Department of Correctional Services alleging cruel and unusual punishment and deliberate indifference to their serious medical needs. They claimed that their segregation unconstitutionally fostered depression and deterioration in their medical condition. The inmates also argued that they had been deprived of equal protection of the laws by being medically segregated. While there is no absolute right to rehabilitation programs, exercise or visitation, the suit argues that inmates with AIDS must be accorded the same access to these as other inmates in the system. However, the plaintiffs alleged that by reason of their segregation, they were unconstitutionally deprived of such programs and benefits. Moreover, they claimed that they were forced to live under conditions worse than those in the disciplinary unit, without any finding of a disciplinary violation—simply because they had AIDS.

The court found for the Department of Correctional Services, holding that inmates have no constitutional right to freedom from segregation instituted to advance a reasonable correctional objective. Segregation

is proper if it is necessary for the protection of inmates with AIDS and other inmates in the institution. The court also held that there was no Eighth Amendment violation because the plaintiffs had not shown that they were denied adequate food, clothing or shelter. Finally, the equal protection claims were denied because the constitutional guarantee applies only to "similarly situated" groups or individuals, and the inmates with AIDS and the other inmates in the institution were not, in the view of the court, similarly situated.

An Oklahoma case raises some of the same issues as *Cordero v. Coughlin*. In this case, a seropositive but asymptomatic inmate filed suit alleging denial of equal protection in that he was isolated from the general population, constantly supervised, and denied access to worship and exercise. The major difference between this case and *Cordero* concerns the very different medical conditions of the plaintiffs.<sup>15</sup>

### Quality of Care

Another New York case, *Storms v. Coughlin*, focuses more on the quality of medical care afforded inmates with AIDS or ARC than on segregation policies, as in *Cordero v. Coughlin* and *Mtr La Rocca v. Dalsheim* (discussed below). The *Storms* case seeks injunctive relief against allegedly inadequate and discriminatory medical care and other policies: insufficient medical information provided to patients in violation of the Patients' Bill of Rights; insufficient diagnostic services; failure to identify and respond to medical needs in a timely manner; discrimination in admission to hospitals in the community; and discrimination in parole decisions.

New regulations to be promulgated by the New York State Department of Health will eliminate several areas of medical discrimination against prison inmates with AIDS—namely, access to community hospitals, diagnostic services, and hospice care. These regulatory changes may render the current lawsuit moot. However, the plaintiffs' attorney notes that since the effect of the new regulations is to equalize care at a lower level than before—in particular, inmates and other indigent persons with AIDS will no longer be entitled to treatment in hospital intensive care units—there may still be important quality of care issues to litigate.

A recent Illinois case, *Thagard v. County of Cook*,<sup>16</sup> also involves quality of medical care. An inmate with ARC filed a *pro se* suit for damages alleging inadequate medical care in that he was repeatedly denied an "AIDS examination" which he had requested. The

inmate had developed some symptoms of ARC but as of the time of the suit had not developed AIDS. The court found for the correctional department on the ground that the inmate had shown no actual injury to have resulted from the failure to provide the examination. The court noted that while good medical practice probably would have been to provide the requested examination, it could not enforce good medical practice.

Several of the cases discussed above involve claims of unconstitutional discrimination against inmates with AIDS in that they were not afforded the same rights and programs available to other inmates. Another possible legal issue affecting the correctional response to AIDS is just the reverse—namely, should AIDS patients be considered disabled or handicapped under state human rights laws and thus be entitled to certain special treatment?

### Failure to Protect Others from AIDS

Several suits have been filed by inmates seeking more protection from AIDS. In Oregon, inmates have filed suits demanding mass screening for antibody to HTLV-III and isolation of seropositives.<sup>17</sup> In New Jersey, inmates have filed suit seeking the isolation of inmates with both ARC and HTLV-III seropositivity.<sup>18</sup>

In New York, a group of healthy inmates sought injunctive relief from the policies of the Downstate Correctional Facility which allegedly provided inadequate protection against the spread of AIDS. However, the court held that the segregation policies and precautions followed at the institution were adequate to protect the inmates. Significantly, the court also declared that "[i]n view of the scientific uncertainty concerning . . . AIDS, and the reluctance of the court to intervene in the day-to-day management of a prison, no procedural regimen regarding the protection of the rights of AIDS-free inmates shall be judicially mandated."<sup>19</sup>

No cases have been filed thus far by inmates seeking damages for allegedly contracting AIDS while in a correctional facility. A possible basis of such suits in the future might be failure to provide protection from sexual assault. However, even in the case of non-consensual acts, correctional systems can generally only be held to a standard of reasonable care; they have not been held to be insurers of absolute safety for inmates. In the case of transmission by consensual acts, the correctional system would appear to be on even stronger ground, particularly if it could establish an "assumption of risk" defense by proving that the inmate had been given education and training on the

known means by which the infection is transmitted.

Moreover, there are likely to be serious problems establishing causation in any suit for damages brought by an inmate or staff member who develops AIDS, ARC, or HTLV-III seropositivity. In order to show that the correctional system provided inadequate protection, the plaintiff must establish that the infection was transmitted as the result of a behavior or activity that could reasonably be assumed to be under the control of the system. This, in turn, requires linking transmission of the infection with a specific episode or episodes, which is very difficult from a medical standpoint in almost all AIDS cases, except those associated with blood transfusions.

### Potential Suits by Correctional Staff

There are no known lawsuits on AIDS filed by correctional staff, although, as discussed in Chapter Two, staff in 93 percent of the correctional systems responding to the NIJ/ACA questionnaire have expressed serious concerns about the problem. There have also been union activities in this area, including several threatened strikes. Since, as yet, no correctional staff have contracted HTLV-III infection as a result of contact with inmates, there has been no basis for suits seeking damages. Legal action by staff is thus currently limited to actions for injunctive relief. The most likely basis of such actions appears to be the right to safe working conditions. If and when cases of AIDS or ARC appear among correctional staff, workmen's compensation issues are also likely to arise.

### Conclusion

This chapter has discussed a range of issues and options that correctional administrators must consider in formulating overall policies for managing inmates with AIDS, ARC and HTLV-III seropositivity. The areas of particular significance include the following: the nature and extent of medical care and ancillary services to be provided; the types of housing arrangements, precautionary measures, and other correctional programming that are necessary and appropriate; the often conflicting pressures for confidentiality and disclosure of medical information; and the legal and cost issues affecting all of these decision areas.

One way to conceptualize the policy options and their various implications is to develop a matrix which arranges the three AIDS-related inmate categories against the range of interventions: medical care; housing policies; clinical and other precautions; restrictions on

work assignments; notifications and so forth. In other words, the matrix depicts the range of interventions which are applied to each category of inmates. Such a summary description of policies and procedures may help the correctional administrator to assess the overall appropriateness of the system's response to the AIDS problem—in terms of legal issues, cost issues, and medical considerations. (Figure 4.6 presents a shell for such a policy matrix.)

The relative costs of different housing and treatment options will be extremely important. So will the legal considerations regarding housing, treatment, and confidentiality of information. Correctional administrators will not be able or willing to plan or implement policies that are prohibitively expensive, legally unacceptable, or both.

It might also be helpful for the correctional administrator to compare the summary matrix of policies and procedures with the guidelines that have been promulgated by CDC for the treatment of persons with AIDS, ARC and HTLV-III seropositivity in the society at large. This, in turn, would require the administrator to consider whether correctional considerations justify departure from medical guidelines directed to the community. For example, the following question might arise: since the consensus of medical advice for the population at large is against medical isolation of persons with AIDS, ARC, or HTLV-III seropositivity except to protect a patient from opportunistic infections, should correctional systems segregate inmates in any of these categories for administrative reasons? According to a draft policy on AIDS prepared by the Wisconsin correctional department, courts generally uphold housing arrangements that are based on the judgment of medical authorities—that is, on "clinically established indications and health concerns."<sup>20</sup> Courts may also uphold housing arrangements implemented in furtherance of a "reasonable correctional objective."<sup>21</sup> However, it is important for administrators to consider the relative importance of medical and correctional considerations in shaping their systems' policies regarding AIDS.

None of these decisions is easy. AIDS poses complex and difficult problems for correctional systems. The only certainty is that the problems will not disappear. It is imperative that every correctional system—whether it currently has no cases or 200 cases of AIDS—develop a comprehensive set of policies and procedures for managing the AIDS problem in its institutions.<sup>22</sup> These policies and procedures must be based on careful consideration of the range of options available and the strengths and weaknesses of each.

Figure 4.6

**MATRIX SHELL FOR ASSESSING CORRECTIONAL POLICIES  
REGARDING AIDS**

<u>Policy Options</u>	<u>Policies Followed For</u>			
	<u>CDC Guidelines for AIDS Patients</u>	<u>Inmates with AIDS</u>	<u>Inmates with ARC</u>	<u>HTLV-III Sero- Positives</u>
<ul style="list-style-type: none"> <li>• Medical Care and Associated Services               <ul style="list-style-type: none"> <li>– Diagnostic</li> <li>– Treatment</li> <li>– Counseling and support services</li> <li>– Aftercare</li> </ul> </li> <li>• Housing Policies               <ul style="list-style-type: none"> <li>– Maintain in general population</li> <li>– Return to general population when in remission</li> <li>– Case-by-case determination</li> <li>– Single-cell housing</li> <li>– Administrative segregation</li> <li>– Hospitalization</li> </ul> </li> <li>• Precautionary Measures               <ul style="list-style-type: none"> <li>– Blood/body fluid precautions</li> <li>– Special clothing/protective equipment</li> <li>– Laundry</li> <li>– Toilet/personal hygiene</li> <li>– Food service for patients</li> <li>– Inmate/staff work assignments</li> <li>– Other measures</li> </ul> </li> <li>• Notification/Confidentiality               <ul style="list-style-type: none"> <li>– HTLV-III antibody test results</li> <li>– Diagnosis of AIDS/ARC</li> </ul> </li> </ul>				

Note: The actual matrix would be prepared in a much larger format, leaving room for notation of relevant CDC guidelines as well as legal and cost implications of particular policy options.

## Footnotes

1. "Prevention of AIDS: Report of Inter-Agency Recommendations," *MMWR* 1983; 32: 101-103.
2. *MMWR* 1982; 31: 577-580.
3. Catherine M. Knox, Letter to Oregon State Representative Carl Hosticka, October 28, 1985.
4. Wisconsin Department of Health and Social Services, "Guidelines for Preventing Transmission of Infection with HTLV-III In Prisons," (Draft, December 30, 1985), pp. 26-28.
5. *MMWR* 1982; 31: 577-580; see also *MMWR* 1985; 34: 681-695.
6. *MMWR* 1985; 34: 681-695.
7. *Sheridan et al. v. Fauver et al.*, Civil Action No. 85-3042 (U.S.D.C., New Jersey, filed August 1985). This case is still pending.
8. "Special Report: The AIDS Epidemic," *New England Journal of Medicine* 1985; 312: 523.
9. Based on two years at New York City's \$300,000 per year figure.
10. Association of State Correctional Administrators Newsletter, December 1985, p. 3.
11. This subsection is based largely on the presentation of Clair Cripe, Esq. of the Federal Bureau of Prisons to the NIC Meeting of Correctional Commissioners on AIDS, Atlanta, Georgia, November 6, 1985.
12. See, e.g., *Rhodes v. Chapman*, 452 U.S. 337 (1981). On the lack of legal entitlement to rehabilitation and recreational programming, see *Newman v. Alabama*, 559 F 2d 283 (5th Circuit, 1977. Cert. denied in part, *Alabama v. Pugh*, 98 Sup. Ct. 3057 [1978]). See also *Hutto v. Finney*, 437 U.S. 678 (1978).
13. 429 U.S. 97 (1976).
14. 607 F Supp 9 (S.D.N.Y., 1984).
15. *Powell v. Department of Corrections* (filed August 29, 1985, U.S. District Court, N.D. Oklahoma). This case is still pending.
16. Unreported opinion: No. 85 C 4429 (N.D. Ill., May 20, 1985).
17. Oregon: *Herring v. Keeney* (U.S.D.C., Oregon, filed September 17, 1985); *Sheppard v. Keeney* (U.S.D.C., Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C., Oregon, filed October 11, 1985). These cases are pending.
18. *Telepo et al. v. Kean et al.*, Civil Action 85-1742A (U.S.D.C., New Jersey, filed May 1985). This case is pending.
19. *Mtr La Rocca v. Dalsheim*, 120 Misc 2d 697 (NY 1983).
20. Wisconsin Department of Health and Social Services, "Guidelines for Preventing Transmission of Infection with HTLV-III In Prisons," (Draft, December 30, 1985), p. 18.
21. *Cordero v. Coughlin*, 607 F Supp 9 (S.D.N.Y., 1984).
22. Wisconsin's comprehensive correctional policy on AIDS is included as Appendix G.

## APPENDICES

## **APPENDIX A**

### **Resource List**

- *Sources for Current Medical Information*
- *Sources of Additional Information Related to AIDS in Corrections*
- *Printed Informational Materials*
- *Audio-Visual Materials*

## RESOURCE LIST

### I. Sources for Current Medical Information

- AIDS Program  
Center for Infectious Diseases  
Centers for Disease Control  
Atlanta, GA  
(404) 329-3651

Contact: David Collie  
Senior Public Health Advisor

CDC produces a weekly publication, Morbidity and Mortality Weekly Report, which contains frequent updates on medical and epidemiological research on AIDS. A bound collection of articles entitled Reports on AIDS Published in the Morbidity and Mortality Weekly Report includes all MMWR articles relating to AIDS since 1981 and is available from CDC.

- National Cancer Institute  
National Institutes of Health  
Building 31  
9000 Rockville Pike  
Bethesda, Maryland 20205  
(301) 496-5583
- National Institute of Allergy and Infectious Diseases  
National Institutes of Health  
Building 31  
9000 Rockville Pike  
Bethesda, Maryland 20205  
(301) 496-5717
- U.S. Public Health Service  
Room 721-H  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 245-6867  
(800) 342-AIDS

National AIDS Hotline provides recorded message for general public 8:30 a.m. to 5:30 p.m.

- State and local public health departments may be contacted for more information.

## 2. Sources of Additional Information Related to AIDS in Corrections

- American Correctional Association  
4321 Hartwick Road, Suite L-208  
College Park, Maryland 20740  
(301) 699-7600
- American Correctional Health Services Association  
5530 Wisconsin Avenue, N.W., Suite 745  
Washington, D.C. 20815  
(301) 652-1172
- National Institute of Corrections  
320 First Street, N.W.  
Washington, D.C. 20534  
(202) 724-3106
- National Institute of Corrections  
Information Center  
1790 30th Street  
Boulder, Colorado 80301  
(303) 444-1101
- National Institute of Corrections  
Jail Division  
1790 30th Street  
Boulder, Colorado 80301  
(303) 497-6700
- National Institute of Justice  
National Criminal Justice Reference Service  
Box 6000  
Rockville, Maryland 20850  
(301) 251-5520  
(800) 851-3420
- National Institute on Drug Abuse  
5600 Fishers Lane  
Rockville, Maryland 20857  
(301) 443-6500
- American Civil Liberties Union  
National Prison Project  
1616 P Street, N.W.  
Washington, D.C. 20036  
(202) 331-0500

Contact: Ms. Urvashi Vaid  
Staff Attorney

### 3. Printed Information Materials

This section lists AIDS information resources and cites a number of documents currently available.

- "AIDS Update," "AIDS Fact Sheet"

American Federation of State, County and  
Municipal Employees, AFL-CIO  
1625 L Street, N.W.  
Washington, D.C. 20036  
(202) 429-1000

- "Information and Procedural Guidelines for Providing Health and Social Services to Persons with AIDS," September 1, 1985, HRS Pamphlet #150-3.

Florida Department of Health and Rehabilitative Services  
Tallahassee, Florida

- "Questions and Answers about the HTLV-III Antibody Test," pamphlet developed by HERO and other local agencies, March, 1985.

"DRUG USERS: Do Not Share Needles," pamphlet.

HERO (Baltimore Health Education Resource Organization)  
Medical Arts Building, Suite 819  
Cathedral and Read Streets  
Baltimore, Maryland 21201  
(301) 945-AIDS Information and Referral Line on AIDS

- AIDS Legal Guide, A Professional Resource on AIDS-Related Issues and Discrimination, 1984.

Lambda Legal Defense and Education Fund, Inc.  
132 West 43 Street  
New York, New York 10036  
(212) 944-9488

- Designing an Effective AIDS Prevention Campaign Strategy for San Francisco: Results from the Second Probability Sample of an Urban Gay Male Community, June 28, 1985. Report prepared for the San Francisco AIDS Foundation.

Research and Decisions Corporation  
375 Sutter Street, Suite 300  
San Francisco, CA 94108  
(415) 989-9020

- The San Francisco AIDS Foundation has published several dozen pamphlets and bulletins, and has designed 14 advertisements.

San Francisco AIDS Foundation  
 333 Valencia Street, 4th Floor  
 San Francisco, CA 94103  
 (415) 864-4376

- "What Everyone Should Know About AIDS;"
- "Why You Should Be Informed About AIDS;"
- "What Gay and Bisexual Men Should Know About AIDS;"
- "Lo que TODOS deben saber sobre AIDS" (in Spanish);
- "Facts About AIDS," January 1985.

The U.S. Public Health Service produces AIDS information bulletins and periodic updates on AIDS for general and professional audiences. Brochures used in many state and county correctional facilities incorporate material from the titles listed above.

Office of Public Affairs  
 U.S. Public Health Service  
 Room 721-H  
 200 Independence Avenue, S.W.  
 Washington, D.C. 20201  
 (202) 245-6867

#### 4. Audio-Visual Materials

##### Staff and Inmates

- "AIDS Videotape"

The Department of Corrections in New York City produced two different videotapes on AIDS. The more recent 1985 program is intended for inmates and provides general information about the illness. The other videotape, made in 1982-83, is for staff. (These are discussed in Chapter Two of the report.)

New York City Department of Corrections  
 100 Centre Street  
 14th Floor  
 New York, New York 10013  
 (212) 374-4541

Contact: Assistant Commissioner for Program Services  
 Health Services

- "AIDS Videotape"

This videotape for inmates and staff addresses general issues involving AIDS in prisons and work environments. Developed for the Corrections Service Division of Canada by The University of British Columbia's Department of Medicine, the program is also being used by the Washington State Department of Corrections.

Time: approximately 25 minutes

Constructional Resources Center  
University of British Columbia  
AV-TV Media Library  
Vancouver, British Columbia  
V6T1W5  
(604) 228-3467

Contact: Ms. Lee McCarvill  
Biomedical Communications

- "What If the Patient Has AIDS?"

This videotape was produced in association with the National Institutes of Health and is intended for health care workers.

"AIDS and Your Job"

This videotape was produced in association with the Centers for Disease Control and is intended for such workers as policemen and firemen.

These videotapes are currently being updated and will soon be available for distribution.

Time: 45 minutes

National Audio Visual Center  
(301) 763-1896

- "AIDS: Key Facts for Correctional Staff"

This package includes a brochure, poster and leader's guide.

Time: 35 minutes

"AIDS: Key Facts for Inmates"

This also includes a brochure, poster and leader's guide.

Time: 30 minutes

Capital Communications Systems developed these two videotapes and accompanying literature for the Federal Bureau of Prisons.

Capitol Communications Systems  
19 Chelsea House  
2411 Crofton Lane  
Crofton, Maryland 21114  
(301) 261-6770

Contact: Tom Suttly

Corrections Policymakers and Practitioners

- "AIDS: An Overview with Dr. Harold Jaffe"

This videotape records the presentation of Dr. Harold Jaffe of CDC at the NIC-sponsored November 6, 1985 meeting of State Directors of Corrections in Atlanta, Georgia. The videotape provides a medical update on AIDS and is available to all departments of corrections and correctional practitioners.

Time: 35.5 minutes

National Institute of Corrections  
Information Center  
1790 30th St.  
Boulder, CO 80301  
(303) 444-1101

## **APPENDIX B**

### **Definitions and Additional Categories of AIDS-Related Illness**

August 1, 1985

The Case Definition of AIDS  
Used by CDC for National Reporting  
(CDC-reportable AIDS)

For the limited purposes of national reporting of some of the severe late manifestations of infection with human T-lymphotropic virus, type-III/lymphadenopathy-associated virus (HTLV-III/LAV) in the United States, CDC defines a case of "acquired immunodeficiency syndrome" (AIDS) as an illness characterized by:

- I. one or more of the opportunistic diseases listed below (diagnosed by methods considered reliable) that are at least moderately indicative of underlying cellular immunodeficiency, and
- II. absence of all known underlying causes of cellular immunodeficiency (other than HTLV-III/LAV infection) and absence of all other causes of reduced resistance reported to be associated with at least one of those opportunistic diseases.

Despite having the above, patients are excluded as AIDS cases if they have negative result(s) on testing for serum antibody to HTLV-III/LAV\*, do not have a positive culture for HTLV-III/LAV, and have both a normal or high number of T-helper (OKT4 or LEU3) lymphocytes and a normal or high ratio of T-helper to T-suppressor (OKT8 or LEU2) lymphocytes. In the absence of test results, patients satisfying all other criteria in this definition are included as cases.

This general case definition may be made more explicit by specifying:

- I. the particular diseases considered at least moderately indicative of cellular immunodeficiency, which are used as indicators of AIDS, and
- II. the known causes of cellular immunodeficiency, or other causes of reduced resistance reported to be associated with particular diseases, which would disqualify a patient as an AIDS case.

This specification is as follows:

- I. Diseases at least moderately indicative of underlying cellular immunodeficiency:

In the following list of diseases, the required diagnostic methods with positive results are shown in parentheses. "Microscopy" may include cytology.

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\* A single negative test for HTLV-III/LAV may be applied here if it is an antibody test by ELISA, immunofluorescent, or Western Blot methods, because such tests are very sensitive. Viral cultures are less sensitive but more specific, and so may be relied on if positive but not if negative. If multiple antibody tests have inconsistent results, the result applied to the case definition should be that of the majority. A positive culture, however, would over-rule negative antibody tests.

A. Protozoal and Helminthic Infections:

1. Cryptosporidiosis, intestinal, causing diarrhea for over 1 month, (on histology or stool microscopy)
2. Pneumocystis carinii pneumonia, (on histology, or microscopy of a "touch" preparation, bronchial washings, or sputum)
3. Strongyloidosis, causing pneumonia, central nervous system infection, or infection disseminated beyond the gastrointestinal tract, (on histology)
4. Toxoplasmosis, causing infection in internal organs other than liver, spleen, or lymph nodes (on histology or microscopy of a "touch" preparation)

B. Fungal Infections:

1. Candidiasis, causing esophagitis (on histology, or microscopy of a "wet" preparation from the esophagus, or endoscopic or autopsy findings of white plaques on an erythematous mucosal base, but not by culture alone)
2. Cryptococcosis, causing central nervous system or other infection disseminated beyond lungs and lymph nodes (on culture, antigen detection, histology, or India ink preparation of CSF)

C. Bacterial Infections:

1. Mycobacterium avium or intracellulare (Mycobacterium avium complex), or Mycobacterium kansasii, causing infection disseminated beyond lungs and lymph nodes (on culture)

D. Viral Infections:

1. Cytomegalovirus, causing infection in internal organs other than liver, spleen, or lymph nodes (on histology or cytology, but not by culture or serum antibody titer)
2. Herpes simplex virus, causing chronic mucocutaneous infection with ulcers persisting more than 1 month, or pulmonary, gastrointestinal tract (beyond mouth, throat, or rectum), or disseminated infection (but not encephalitis alone)(on culture, histology, or cytology)
3. Progressive multifocal leukoencephalopathy (presumed to be caused by Papovavirus)(on histology)

E. Cancer:

1. Kaposi's sarcoma (on histology)
2. Lymphoma limited to the brain (on histology)

**F. Other Opportunistic Infections with Positive test for HTLV-III/LAV\*:**

In the absence of the above opportunistic diseases, any of the following diseases is considered indicative of AIDS if the patient had a positive test for HTLV-III/LAV\*:

1. disseminated histoplasmosis, (on culture, histology, or cytology)
2. bronchial or pulmonary candidiasis, (on microscopy or visualization grossly of characteristic white plaques on the bronchial mucosa, but not by culture alone)
3. isosporiasis, causing chronic diarrhea (over 1 month), (on histology or stool microscopy)

**G. Chronic lymphoid interstitial pneumonitis:**

In the absence of the above opportunistic diseases, a histologically confirmed diagnosis of chronic (persisting over 2 months) lymphoid interstitial pneumonitis in a child (under 13 years of age) is indicative of AIDS unless test(s) for HTLV-III/LAV are negative.\* The histologic examination of lung tissue must show diffuse interstitial and peribronchiolar infiltration by lymphocytes, plasma cells with Russell bodies, plasmacytoid lymphocytes and immunoblasts. Histologic and culture evaluation must not identify a pathogenic organism as the cause of this pneumonia.

**H. Non-Hodgkin's Lymphoma with Positive Test for HTLV-III/LAV\*:**

If the patient had a positive test for HTLV-III/LAV\*, then the following histologic types of lymphoma are indicative of AIDS, regardless of anatomic site:

1. Small noncleaved lymphoma (Burkitt's tumor or Burkitt-like lymphoma), but not small cleaved lymphoma,
2. Immunoblastic sarcoma (or immunoblastic lymphoma) of B-cell or unknown immunologic phenotype (not of T-cell type). Other terms which may be equivalent include: diffuse undifferentiated non-Hodgkin's lymphoma, large cell lymphoma (cleaved or noncleaved), diffuse histiocytic lymphoma, reticulum cell sarcoma, and high-grade lymphoma.

Lymphomas should not be accepted as indicative of AIDS if they are described in any of the following ways: low grade, of T-cell type (immunologic phenotype), small cleaved lymphoma, lymphocytic lymphoma (regardless of whether well or poorly differentiated), lymphoblastic lymphoma, plasmacytoid lymphocytic lymphoma, lymphocytic leukemia (acute or chronic), or Hodgkin's disease (or Hodgkin's lymphoma).

\* a positive test for HTLV-III/LAV may consist of a reactive test for antibody to HTLV-III/LAV or a positive culture (isolation of HTLV-III/LAV from a culture of the patient's peripheral blood lymphocytes). If multiple antibody tests have inconsistent results, the result applied to the case definition, should be that of the majority done by the ELISA, immunofluorescent, or Western Blot methods. A positive culture, however, would over-rule negative antibody tests.

## II. Known Causes of Reduced Resistance:

Known causes of reduced resistance to diseases indicative of immunodeficiency are listed in the left column, while the diseases that may be attributable to these causes (rather than to the immunodeficiency caused by HTLV-III/LAV infection) are listed on the right:

### Known Causes of Reduced Resistance

1. Systemic corticosteroid therapy
2. Other immunosuppressive or cytotoxic therapy
3. Cancer of lymphoreticular or histiocytic tissue such as lymphoma (except for lymphoma localized to the brain), Hodgkin's disease, lymphocytic leukemia, or multiple myeloma

### Diseases Possibly Attributable to the Known Causes of Reduced Resistance

Any infection diagnosed during or within 1 month after discontinuation of the corticosteroid therapy, unless symptoms specific for an infected anatomic site (e.g., dyspnea for pneumonia, headache for encephalitis, diarrhea for colitis) began before the corticosteroid therapy

or any cancer diagnosed during or within 1 month after discontinuation of more than 4 months of long-term corticosteroid therapy, unless symptoms specific for the anatomic sites of the cancer (as described above) began before the long-term corticosteroid therapy

Any infection diagnosed during or within 1 year after discontinuation of the immunosuppressive therapy, unless symptoms specific for an infected anatomic site (as described above) began before the therapy

or any cancer diagnosed during or within 1 year after discontinuation of more than 4 months of long-term immunosuppressive therapy, unless symptoms specific for the anatomic sites of the cancer (as described above) began before the long-term therapy

Any infection or cancer, if diagnosed after or within 3 months before the diagnosis of the cancer of lymphoreticular or histiocytic tissue

Known Causes of Reduced Resistance

4. Age 60 years or older at diagnosis
5. Age under 28 days (neonatal) at diagnosis
6. Age under 6 months at diagnosis
7. An immunodeficiency atypical of AIDS, such as one involving hypogammaglobulinemia or angio-immunoblastic lymphadenopathy; or an immunodeficiency of which the cause appears to be a genetic or developmental defect, rather than HTLV-III/LAV infection
8. Exogenous malnutrition (starvation due to food deprivation, not malnutrition due to malabsorption or illness)

Diseases Possibly Attributable to the Known Causes of Reduced Resistance

- Kaposi's sarcoma, but not if the patient has a positive test for HTLV-III/LAV
- Toxoplasmosis or herpes simplex virus infection, as described above
- Cytomegalovirus infection, as described above
- Any infection or cancer diagnosed during such immunodeficiency
- Any infection or cancer diagnosed during or within 1 month after discontinuation of starvation

Document #F-0312S

NIH's DEFINITION OF AIDS-RELATED COMPLEX\*

At least 2 of the following clinical signs/symptoms lasting 3 or more months PLUS 2 or more of the following laboratory abnormalities, occurring in a patient having no underlying infectious cause for the symptoms and who is in a cohort at increased risk for developing AIDS.

Clinical:

1. Fever:  $>100^{\circ}\text{F}$ , intermittent or continuous, for at least 3 months, in the absence of other identifiable causes.
2. Weight Loss: 10% or  $\geq 15$  lbs.
3. Lymphadenopathy: persistent for at least 3 months, involving  $\geq 2$  extra-inguinal node bearing areas.
4. Diarrhea: intermittent or continuous,  $\geq 3$  months, in the absence of other identifiable causes.
5. Fatigue, to the point of decreased physical or mental function.
6. Night Sweats: intermittent or continuous,  $\geq 3$  months, in the absence of other identifiable causes

Laboratory:

1. Depressed helper T-cells ( $>2$  standard deviations below mean).
2. Depressed helper/suppressor ratio ( $>2$  standard deviations below mean).
3. At least one of the following: leukopenia, thrombocytopenia, absolute lymphopenia or anemia.
4. Elevated serum globulins.
5. Depressed blastogenesis (pokeweed and PHA).
6. Abnormal skin tests (using Multi-Test or equivalent).

\*A revised definition is being developed.

### Additional Categories/Typologies Sometimes Used In Discussions of AIDS-Related Illnesses

These are presented to give a sense of the categorical complexities involved.

- a. Chronic lymphadenopathy syndrome: persistent enlarged lymph nodes in 2+ sites with no apparent cause<sup>1</sup> This is actually a part of the definition of ARC, but it is sometimes used as a separate category as well.
- b. Pre-ARC: patients who are HTLV-III seropositive and symptomatic, but not to the level of the NIH definition of ARC.
- c. Pre-AIDS: patients with ARC who appear likely to develop end-state AIDS; the use of this term is not recommended because insufficient data are available to predict with accuracy which ARC cases will develop into AIDS<sup>2</sup>
- d. A new typology of cases has been proposed for clinical trials: 11 categories running from asymptomatic to "AIDS with opportunistic infection with or without Kaposi's Sarcoma."<sup>3</sup>

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<sup>1</sup>Fauci, et al. "AIDS: An Update," Annals of Internal Medicine 1985; 102: 801.

<sup>2</sup>Fauci, et al., "AIDS: An Update."

<sup>3</sup>H. Haverkos et al., "Correspondence: Classification of HTLV-III/LAV-Related Diseases," Journal of Infectious Diseases 1985; 152: 1095.

## **APPENDIX C**

**List of City and County Jail Systems  
Receiving and Responding to the  
NIJ/ACA Questionnaire**

LIST OF CITY AND COUNTY JAIL SYSTEMS  
RESPONDING TO NIJ/ACA QUESTIONNAIRE

- |  |   |
|--|---|
| 1. Arizona, Maricopa (Phoenix) County Jail                                 | 18. Illinois, Cook County (Chicago) Department of Corrections     |
| 2. California, Alameda County (Oakland) Sheriff's Department               | 19. Indiana, Marion County (Indianapolis) Sheriff's Department    |
| 3. California, Contra Costa County Sheriff's Department                    | 20. Maryland, Baltimore City Jail                                 |
| 4. California, Los Angeles County Sheriff's Department                     | 21. Massachusetts, Suffolk County (Boston) Sheriff's Department   |
| 5. California, Orange County Sheriff's Department                          | 22. Minnesota, Hennepin County (Minneapolis) Sheriff's Department |
| 6. California, Riverside County Sheriff's Department                       | 23. Michigan, Wayne County (Detroit) Sheriff's Department         |
| 7. California, Sacramento County Sheriff's Department                      | 24. New Jersey, Essex County (Newark) Jail                        |
| 8. California, San Bernardino County Sheriff's Department                  | 25. New Jersey, Hudson (Jersey City) Jail                         |
| 9. California, San Diego County Sheriff's Department                       | 26. New York City, Department of Corrections                      |
| 10. California, San Francisco County Sheriff's Department                  | 27. New York, Westchester County Department of Correction         |
| 11. California, Santa Clara County Sheriff's Department                    | 28. Ohio, Cuyahoga County (Cleveland) Sheriff's Department        |
| 12. California, Ventura County Jail  | 29. Pennsylvania, Allegheny County (Pittsburgh) Jail              |
| 13. Colorado, Denver County Jail   | 30. Pennsylvania, Philadelphia Department of Human Services       |
| 14. District of Columbia, Department of Corrections                        | 31. Tennessee, Shelby County (Memphis) Jail                       |
| 15. Florida, Broward County (Fort Lauderdale) Jail                         | 32. Texas, Harris County (Houston) Central Jail                   |
| 16. Florida, Dade County (Miami) Corrections and Rehabilitation Department | 33. Washington, Seattle Department of Adult Detention             |
| 17. Georgia, Fulton County (Atlanta) Jail                                  |   |

## **APPENDIX D**

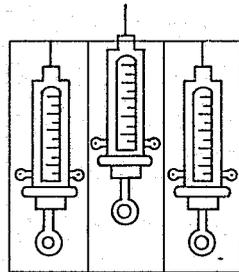
### **Training, Education and Counseling Materials**

- *Staff Training Materials*
- *Inmate Training Materials*
- *Health-care Worker Educational Materials*
- *General Educational Materials*
- *Counseling Materials*
- *Pre/Post Test of AIDS Knowledge*

*Staff Training Materials*



This is not a setting for AIDS.



No AIDS cases have developed through accidental puncture.

**Q.** "I've been brown bagging it in case the cafeteria food or dishes are handled by AIDS patients. Am I being too cautious?"

**A.** Yes. Working in the same area, breathing the same air, touching the same things (such as dishes and eating utensils) will *not* give you AIDS.

**Q.** "I work in the prison laundry. Can I get AIDS from handling soiled bed sheets and towels? I have too many years with the State to quit, but I don't want to take chances either."

**A.** Laundry from an AIDS unit is clearly marked and kept separate. You will receive special guidelines on how to handle it. That is, you should wear gloves when you handle soiled sheets and towels, and wash your hands as soon as you remove the gloves and before leaving the laundry area. If you have a cut or sore on your hands or arms, make sure it's well-protected with a bandage or sterile gauze.

**Q.** "I heard that an officer at one facility was stabbed with a hypodermic needle that had been used on an AIDS patient. Will the officer get AIDS now?"

**A.** To date, *no one* exposed to AIDS through an accidental puncture, and this includes numerous hospital workers, has developed AIDS, nor have any family members.

**Q.** "I'm aware that the whole picture of AIDS diagnosis and treatment is changing fast. How can I stay up-to-date?"

**A.** Call the New York State AIDS Hotline, toll-free:

**1-800-462-1884**

OR WRITE TO:  
**THE AIDS INSTITUTE**  
New York State Health Department  
Empire State Plaza  
Corning Tower — Rm. 1931  
Albany, NY 12237

### HTLV-III

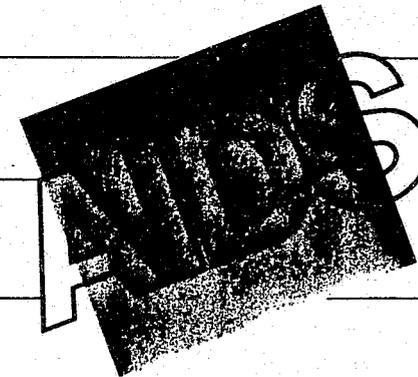
Recently, a blood test was licensed to detect antibodies to HTLV-III, a virus which is believed to be associated with AIDS. The test will help protect the nation's blood supply. Donor blood that tests positive will not be used for transfusion. However, this test is *not* medically effective as a screening device for AIDS. For more information, call **1-800-462-1884** toll-free.



State of New York  
Mario M. Cuomo, Governor

New York State Health Department  
David Axelrod, M.D., Commissioner

The AIDS Institute  
9/85



**INFORMATION  
FOR N.Y.S.  
CORRECTIONAL  
SERVICES  
DEPARTMENT  
EMPLOYEES**



## A

Here are some answers to questions about AIDS asked most often by employees of the New York State Department of Correctional Services.

**Q.** "Everyone here at the facility seems scared of AIDS. Just what is AIDS?"

**A.** AIDS — Acquired Immune Deficiency Syndrome — causes the body to lose its natural defenses against disease. The body then becomes open to attack by a whole set of illnesses — ranging from mild infections to life-threatening conditions.

Some people with AIDS develop a rare form of pneumonia (*Pneumocystis carinii* pneumonia), caused by an organism that has no ill effects on healthy people. Other persons with AIDS develop Kaposi's sarcoma (KS), a type of cancer that affects the skin and lining of the blood vessels, and may spread throughout the body. Also, unusual bacterial and fungal infections are often found in persons who have AIDS.

**Q.** "How widespread is AIDS inside prison? I can't seem to get any numbers."

**A.** Fortunately, AIDS is very rare. To date, of the more than 33,000 inmates in prisons across the State, only 175 have developed AIDS. Most were intravenous drug abusers before they entered the facility. No employee of the Department of Correctional Services has developed AIDS.

## I



This won't open the door to AIDS.

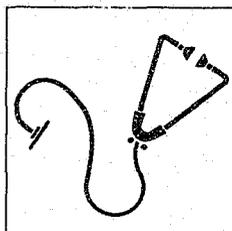
**Q.** "I heard on TV that researchers now think they have identified the cause of AIDS. What is it? Will it help those people who already have AIDS?"

**A.** No one knows for sure what causes AIDS. Antibodies to a recently discovered virus (HTLV-III/LAV) have been found in the blood of most AIDS patients. It is not known whether this virus is the direct cause of AIDS or is a result of having a damaged immune system. But, further research will hopefully lead to early diagnosis, treatment and prevention of AIDS.

**Q.** "If I touch someone who has AIDS, will I get it?"

**A.** There is no evidence that a person can get AIDS from dishes, food, doorknobs, toilet seats or from daily contact with a person who has AIDS. Scientific research indicates that gay and bisexual men exposed to the repeated exchange of certain body fluids (semen, feces, blood) are at highest risk. Persons who share needles to inject drugs are also at high risk.

## D



Health care workers are at little or no risk of contracting AIDS.

**Q.** "What happens to inmates who have AIDS? Are they treated in prison?"

**A.** An inmate who has been diagnosed as having AIDS can continue to be part of the general prison population as long as his or her symptoms are not disabling. (Remember, there is no risk from casual, daily contact with a person who has AIDS.) A patient who has difficulty functioning, however, or who develops a life-threatening complication, such as Kaposi's sarcoma, will be transferred to a back-up treatment facility, apart from the prison. The reason for the transfer is to ensure the availability of specialized medical care and service to the patient.

**Q.** "I've been assigned to work in a unit where AIDS patients are housed. Am I in danger of getting AIDS?"

**A.** You would be at risk *only* if your job placed you in situations in which body fluids from an AIDS patient could directly enter your body or bloodstream. There is no reason to believe, for example, that a person

## S



This won't lift the lid on AIDS.

would get AIDS as a result of washing floors on an AIDS unit.

Health care workers are more likely to have repeated contact with the body fluids of an AIDS patient. However, according to a recent study in the *New England Journal of Medicine*, even health care workers are at little or no risk of contracting AIDS: as part of the study, workers who had been exposed to specimens of AIDS patients (including workers who were victims of accidental needle-sticks) were tested for the HTLV-III antibody; *not one* of them had it.

Nonetheless, health care workers should observe the special precautions they have been instructed to take. These include the following:

- wear protective clothing (gloves, gowns, goggles) if there's danger of splashing;
- dispose of body fluids, blood and blood products in sealed containers;
- report accidents at once to the unit supervisor, or in accordance with established procedures at the facility;
- use the "buddy system" when working around patients with a current history of violent acts against staff.

CONTINUED

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## Staff Training Materials Maricopa County, Arizona

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CORRECTIONAL HEALTH SERVICES  
225 West Madison Street  
Phoenix, AZ 85003

### Course Objectives

In-service education regarding the disease Acquired Immune Deficiency Syndrome will be given to the Detention Officers. The purpose of the in-service is to acquaint the officers with the disease, its mode of transmission, high risk groups, what can be done to reduce the chances of contracting the disease on the job and what a positive HTLV III antibody test means.

Our purpose is to present medical knowledge to the officers in such a way as to educate and allay fears about the disease AIDS. The intent is to allow the officers to continue with current jail duties unencumbered by questions regarding the risk of contracting the disease.

The in-service will be approximately two hours with a 10-15 minute break period. Instruction will be provided by a trained nurse counselor from either the State or Maricopa County Bureau of Disease Control. Also, a Correctional Health Service physician will attend the in-services. The class will make use of videotapes, slide shows, pamphlets and handouts. It will become a permanent part of the First-Aid portion of the D.O. Training Academy. Also, the counseling will be made available throughout the year to those staff requesting further information or updated facts.

Equipment needed for the in-service includes a blackboard, VCR with monitor, slide projector and screen.

10.37

November 18, 1985

#### AIDS AND YOUR JOB

The Acquired Immune Deficiency Syndrome is caused by a virus which is known to be spread by intimate sexual contact, illicit use of intravenous drugs, blood and blood product transfusions and during the pregnancy of an infected mother. The virus has been found in saliva and other body fluids, but to date no definite transmission from saliva has been reported.

It is quite certain that the virus is not spread by casual contact. That is, you will not contract the disease by having someone cough or sneeze in your direction, by using the same toilet, by handcuffing an inmate or by performing a routine search.

There are several very simple tasks which you can do that have been shown over and over again to prevent the spread of infectious diseases, AIDS included.

First: If you anticipate coming into contact with blood such as during an assault or an injury, put on disposable rubber gloves and avoid contact with your skin, especially if you have any open cuts or wounds.

Second: After contact with suspected contaminated materials, thoroughly wash your hands and all areas which were exposed to contamination. A simple solution of household bleach diluted 1:10 is sufficient to kill the AIDS virus. Containers of bleach are available at several stations throughout each jail. Contaminated surfaces should be thoroughly cleansed with this dilute bleach solution.

Third: Use extra care in handling objects which are contaminated with blood. Do not resheath needles but dispose of them in the proper impervious containers. Make sure you do not injure yourself with sharp objects such as razors or contraband weapons. When disposing of possibly contaminated material, ensure that it is properly wrapped and labeled so that others are not inadvertently injured.

These steps are so obvious that they are often neglected, yet they are your best defense against the spread of blood borne diseases. Should you ever encounter a situation where there may be contamination it pays to take your time and follow the above advice.

# DEPARTMENT OF CORRECTIONS

Amos E. Reed  
Secretary



ACQUIRED IMMUNE DEFICIENCY SYNDROME

LESSON PLAN

November 14, 1985

## PERSONAL INTRODUCTION

Instructor/facilitator should introduce him/her self and briefly describe:

1. Job Title and Functions.
2. Experience.
3. Training and or research you have been involved with concerning AIDS, if applicable.
4. Additional personal comments related to backgrounds and AIDS.

## INTEREST INTRODUCTION

It is appropriate at this time for the facilitator to discuss generally the concerns and fears surrounding AIDS and the "panic" that can result when people -- both staff and inmates -- do not understand the problem and its many ramifications.

The purpose of this training session is to provide staff with information on what AIDS is, how it is contracted, and how it can be prevented. As staff are informed and educated, fear and apprehension are reduced.

When fear and apprehension are kept at a minimum, people are better able to concentrate on their job duties. And, as staff are better educated and informed, their ability to deal with the fears and apprehensions of offenders is greatly enhanced.

## RATIONALE FOR COURSE

As employees of the Department of Corrections, it is imperative that all of us be knowledgeable about "Acquired Immune Deficiency Syndrome" -- commonly referred to as "AIDS." The more we know about it, the better able we are to deal with the problems associated with it and to allay the fears and anxieties of those offenders for whom we are responsible.

As professionals, you have demanding jobs which involve a great deal of responsibility. At the institutional level, you are responsible for maintaining security and discipline, ensuring that a sanitary environment is maintained, keeping records, monitoring program activities, and so on. But, above all, you are "people workers" and, as such, you have a great deal of impact on the inmates for whom you are responsible.

Dealing effectively with human beings in any capacity requires skill, patience, and the right frame of mind. Because you work so closely with inmates every day, you can have significant impact on the attitudes and behavior of those inmates -- for better or for worse. Your own attitudes and behavior can make offenders feel less hostile, less resentful toward authority, and more willing to work toward his or her own best interests. The reverse is also true. Your attitudes and behavior can cause offenders to feel more hostile and more resentful toward authority. When this occurs, it accomplishes nothing other than to make your job more difficult.

The way you feel about your job and the way you act on the job has immediate and direct impact on how you perform. Knowing this, you need to be constantly aware that, as professional public servants, you represent the department in everything you say and do.

In terms of AIDS and the impact it has on the way in which you deal with offenders, a professional attitude is critical. As corrections employees you must be concerned with the welfare and well-being of inmates. If inmates sense that you are concerned about their health problems and that you know what to do to help, they will be more inclined to respect you and to give you their cooperation. As a professional, your attitude should make clear that you do care. If you do not convey that attitude, regardless of your personal feelings, you do nothing other than invite problems.

## PRESENTATION

### I. Acquired Immune Deficiency Syndrome (AIDS).

#### A. Pre/Post Test.

1. The instructor/facilitator should distribute the AIDS Pre-Test to all participants. It should be explained that the test is for informational purposes only and will not be graded or collected. The test serves only to give students an overview of the level of information they have on AIDS.
2. After the video and class discussion, students will have the opportunity to retake the test and discuss the questions.

#### B. Participant Handouts.

1. Inform participants that handouts will be distributed after the class is finished.

### II. History of AIDS.

- A. AIDS is believed to have begun in Africa and been carried to Haiti, and then on to Florida, with refugee immigration. Currently 36 percent of the cases in the U.S. are reported from New York State and about 23 percent from California. The cases reported in Washington account for a small percentage of the total reported in this country. AIDS cases have now been reported in all fifty states, the District of Columbia and more than 35 countries.
- B. Washington state first reported its first case of AIDS in 1982. As of October 9, 1985, 168 AIDS cases have been reported in Washington. The mortality rate for AIDS cases in Washington reported prior to 1985 is 52 percent (43 of 82).

### III. Who Gets AIDS?

A. 95 percent of the AIDS cases have occurred in the following groups of people:

- \* Sexually active homosexual and bisexual men with multiple partners, 73 percent
- \* Present or past abusers of intravenous drugs, 17 percent
- \* Persons with hemophilia or other coagulation disorders, 1 percent
- \* Hetrosexual contacts of someone with AIDS or at risk for AIDS, 1 percent
- \* Persons who have had blood transfusions, 2 percent
- \* Some 6 percent of patients do not fall into any of these categories, but researchers believe that transmission occurred in similar ways.

### IV. AIDS Video.

1. Preface the showing of the AIDS video by explaining that the presenter is Dr. Miller, Medical Advisor for the Monroe Command.
2. Suggest to the students to take notes or write down questions they might have that can be discussed when the video is done.

### V. Review AIDS Video.

1. The instructor/facilitator should review the video with participants, encouraging questions, and providing answers when known.
2. Major review points that should be covered, include:

1. What causes AIDS? (See paragraph 1 of handout)
2. How is it contracted? (See paragraph 6 of handout)
3. Who is at risk to contract AIDS? (See paragraph 5 of handout)
4. What precautions should be taken in Corrections?  
(See paragraph 13 and 14 of handout)

VI. AIDS Information on Frequently Asked Questions.

1. Instructor/facilitator should refer to handout, indicating that points brought out in the film. The questions addressed in the handout also provide for ready reference in the future.

VII. AIDS, CPR and First Aid.

1. Instructor/facilitator should refer and discuss the precautions used when administering CPR and First Aid, as noted in the handout.

VIII. Department of Corrections Instructions.

1. Review the Departments current directive in detail.

IX. Confidentiality.

1. Stress the importance of paragraph 15 in handout as well as what is stated in directive.

X. Post Test.

1. Pass Out Post Test.
2. Instructor/facilitator should go over the Post Test as a final review, and ask if there are any further questions.

XI. Myths and Realities of AIDS.

1. Attached to your handout is a copy of the AFSCME ALERT ON AIDS.  
This is a publication which you will find helpful in dealing with some of the myths that are circulating today.

# DEPARTMENT OF CORRECTIONS

Amos E. Reed  
Secretary



AIDS TRAINING PARTICIPANT'S HANDOUT

November 14, 1985

## INTRODUCTION

As employees of the Department of Corrections, it is imperative that all of us be knowledgeable about "Acquired Immune Deficiency Syndrome" -- commonly referred to as "AIDS." The more we know about it, the better able we are to deal with the problems associated with it and to allay the fears and anxieties of those offenders for whom we are responsible.

As professionals, you have demanding jobs which involve a great deal of responsibility. At the institutional level, you are responsible for maintaining security and discipline, ensuring that a sanitary environment is maintained, keeping records, monitoring program activities, and so on. But, above all, you are "people workers" and, as such, you have a great deal of impact on the inmates for whom you are responsible.

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The way you feel about your job and the way you act on the job has immediate and direct impact on how you perform. Knowing this, you need to be constantly aware that, as professional public servants, you represent the department in everything you say and do.

In terms of AIDS and the impact it has on the way in which you deal with offenders, a professional attitude is critical. As corrections employees you must be concerned with the welfare and well-being of inmates. If inmates sense that you are concerned about their health problems and that you know what to do to help, they will be more inclined to respect you and to give you their cooperation. As a professional, your attitude should make clear that you do care. If you do not convey that attitude, regardless of your personal feelings, you do nothing other than invite problems.

## AIDS INFORMATION ON FREQUENTLY ASKED QUESTIONS

### 1. WHAT IS ACQUIRED IMMUNE DEFICIENCY SYNDROM (AIDS) AND HOW IS IT CAUSED?

Acquired Immune Deficiency Syndrome (AIDS) is a disease that is caused by a virus. AIDS damages the body's immune system, resulting in infections and cancers that would not usually be a threat to healthy people. These illnesses are referred to as "opportunistic" infections and malignancies.

### 2. HOW IS AIDS TRANSMITTED?

The AIDS virus is transmitted sexually or by direct contact with blood or body secretions (e.g. semen, feces). AIDS IS NOT TRANSMITTED BY CASUAL CONTACT. It has been described as a disease which is not "easy to come by."

### 3. HOW IS AIDS DIAGNOSED?

There is currently no single test that can determine if a person has AIDS. The diagnosis of AIDS is based on the person's overall medical history, the findings on a physical examination, and the presence of certain tumors or opportunistic infections when no other known cause for an immune deficiency can be found. Certain tests of immune functions may also give evidence suggesting immune deficiency.

### 4. WHY SHOULD I BE CONCERNED ABOUT AIDS?

AIDS usually occurs in previously healthy people in the prime of life. It has a very high fatality rate; almost all persons die within three years from the time of diagnosis. However, few persons have survived for three or more years. Researchers do not know of any person with AIDS who has regained lost immunity. Thus, AIDS survivors continue to face a high risk of developing opportunistic infections and cancers.

Very large direct health care costs are required for the treatment of AIDS. The average AIDS patient spends two months of the remainder of his or her life in the hospital, at a total cost of over \$100,000. Aside from the direct medical costs associated with AIDS, the other costs -- economic, psychological, and personal -- are inestimable.

### 5. WHO IS AT RISK OF GETTING AIDS?

In the United States, about 73 percent of those affected are sexually active homosexual and bisexual men, and about 18 percent are persons who abuse drugs by needle infection. About 1 percent of the reported cases have occurred in persons who have received a blood transfusion; about 1 percent are persons with the blood disorder called hemophilia; and another 1 percent have occurred in heterosexual women who were intimate contacts of persons infected with the AIDS virus.

The risk of developing AIDS appears to be extremely low for people who do not have intimate sexual contact with persons infected with the AIDS virus. Even health professionals who care for persons with AIDS are at low risk when reasonable infection control precautions are taken.

## 6. HOW IS AIDS CONTRACTED?

AIDS is transmitted only by direct intimate contact with infected blood or body secretions; it is not acquired by casual contact. The ways that AIDS may be acquired are:

- a. By sexual contact with body secretions of a person who is infected with the AIDS virus. This person may look and feel well.
- b. By sharing unsterile hypodermic needles used with illegal drugs such as heroin, thereby receiving small amounts of blood from a person who may be a carrier of the AIDS virus.
- c. AIDS has been acquired through transfusions of infected blood or blood products. Now, however, this is rare, since current blood bank testing procedures are effective in preventing contaminated blood from being used for transfusion. In this regard, it should be noted that the transfusion of blood or blood products is important in the treatment of many serious or life-threatening conditions, and the extremely small risk of contracting AIDS should not prevent anyone from consenting to blood transfusion when it is necessary. Also, it should be pointed out that there is no risk whatsoever, insofar as AIDS is concerned, in donating blood to a hospital or blood bank.

## 7. WHAT IS THE AIDS VIRUS ANTIBODY TEST?

Blood tests to detect antibodies to the AIDS virus indicate whether a person has been exposed to the virus. The tests currently in use do not indicate whether the person does or does not have AIDS or whether it will be contracted in the future. A positive test result means only that the individual has been exposed to the AIDS virus and that the body has developed antibodies in response to that exposure. In fact, even with those who have a positive test result, most will not contract AIDS, based on what we know now.

A number of health departments, to include the Seattle-King County Department of Public Health, are offering the blood test to persons who wish to have it, and will treat all test results with strict confidentiality. Some may restrict testing to those whose histories suggest they are in a high-risk category. Persons who consider themselves to be in a high risk category and who wish to be tested, should contact their local health department or a physician.

A negative blood test means that the blood does not contain antibodies to the AIDS virus at this time. This probably means that exposure to the virus has not yet occurred; however, in some cases of actual viral infection, antibodies are not produced or do not remain in the blood. A negative result also does not mean that infection could not occur in the future. Therefore, even those individuals who have a negative blood test should be aware of precautions which should be taken by any prudent person.

Again, a positive blood test result means only that, at some point in time, the individual has been exposed to the AIDS virus, and that the body produced antibodies in response to that exposure. It does not necessarily mean that AIDS will develop. Only a small percentage of people with antibodies will develop AIDS. The tests cannot determine when the exposure to the virus took place. However, most persons with positive blood test are carrying the AIDS virus and are capable of transmitting it to others by intimate contact with infected blood or body secretions. Therefore, individuals with positive blood test results must be aware of the steps they can take to prevent the likelihood of spreading the virus. Despite a positive test result, day to day contact with other people at work and in the community can continue as usual. Relations with family and friends can be normal; hugging and kissing on the cheek do not spread the virus.

#### 8. CAN AIDS BE PREVENTED?

Since AIDS is a communicable disease that is sexually transmitted, common sense, as well as results of scientific studies, support the following recommendations:

- a. The most certain way to avoid exposure to the AIDS virus is to abstain from sexual activity that permits contact with blood or body secretions (including semen, saliva, urine, and feces) of any person at high risk of AIDS. A current mutually monogamous homosexual relationship introduces no new risk factors provided that neither partner has other sexual partners. There is a great deal of risk in having casual sexual relationships with men who have ever been homosexually active with many partners; this places an individual in an especially high risk category.
- b. If an individual decides to continue casual encounters or non-monogamous relationships, limiting sexual practices to those that do not permit direct contact with secretions probably reduces the likelihood of transmitting the virus. Condoms do not guarantee safety, but they may reduce the degree or risk associated with vaginal and rectal intercourse as well as oral-genital contact, and they should be used for any sexual contact that is expected to result in ejaculation. Since the AIDS virus has been found in saliva of some persons who have AIDS, open-mouthed ("French") kissing also may carry some risk.
- c. Drug abuse by the use of unsterile or shared needles must be avoided. Tattooing may cause similar contagion.

#### 9. IS AIDS KILLED BY USING SOAP AND WATER?

The AIDS virus dies quickly outside the body and is easily killed by soap and by common cleansers and disinfectants. Also, infection may require exposure to large amounts of the virus or repeated exposure. AIDS is not spread by casual contact, such as shaking hands, hugging, touching objects handled by a person with AIDS, or by spending time in the same house, business, or public place. People need not worry about "catching AIDS" from mere casual contact. Also, it is not appropriate to assume that someone has AIDS just because they may be a homosexual

or a drug user, or even if they appear to have symptoms linked with AIDS. But, if this is someone with whom a close physical relationship exists, the preventive measures described above should be heeded.

10. WHAT IS KNOWN ABOUT THE OPPORTUNISTIC INFECTIONS AND CANCERS SEEN WITH AIDS?

The opportunistic infections and cancers seen with AIDS are not new. Kaposi's sarcoma (KS), a type of cancer, was described over 100 years ago. Prior to 1980, KS primarily affected elderly men and was seldom fatal, even 5 to 10 years after diagnosis. It is also seen among children and young adults in some parts of equatorial Africa and a few other locations. Pneumocystis carinii is a small protozoan (one-celled) parasite that is common in the environment. However, it causes pneumonia only in patients with AIDS or with other severe underlying illness (such as leukemia) or in patients receiving intensive therapy with drugs that suppress the immune system (such as those used with kidney transplant patients).

11. IS THERE A RELATIONSHIP BETWEEN LIFESTYLE AND AIDS?

Except for what we have already discussed -- homosexuality, casual sex with many partners, IV drug use, tattooing, etc., it is not known whether specific lifestyle habits contribute to AIDS. However, physical and emotional stress may hamper the body's ability to fight infections. The drugs that people use, and one's general physical and mental health, all have a significant impact on the body's ability to heal itself. A good diet, getting enough rest, and taking good care of yourself, can help your body stay in good condition. This is important, even though it may not necessarily protect one from contracting any illness. Also, it is not a substitute for the preventive measures which have been discussed. The age-old recommendations of "moderation in all things" and "healthy mind in a healthy body" probably still hold. In summary, be caring of yourself and others.

12. WHAT ARE THE SYMPTOMS OF AIDS?

The symptoms of AIDS are similar to those associated with other less serious diseases. However, the presence of these symptoms does not necessarily mean that a person has AIDS. However, it would be wise for persons, especially those in high-risk groups, to consult with a doctor when one or more of the following symptoms seem to be persistent:

- a. A fever without a known cause which has persisted for 2 weeks or more. Also, fever with breathing difficulty can be symptomatic of AIDS.
- b. Night sweats, that is, being awakened by sudden onset of severe sweating that soaks the bedsheets when the room is not hot and heavy covers are not being used.
- c. A persistent dry cough, not due to smoking, that has lasted too long (more than two weeks) to be due to a cold or the flu, or any cough accompanied by shortness of breath.

- d. Loss of appetite severe enough to cause unintentional weight loss of 10 or more pounds.
- e. Unexplained diarrhea that persists for more than two weeks.
- f. Swollen lymph nodes or glands. Abnormal swollen glands are usually not painful and may occur in more than two areas of the body. They appear as lumps that can be felt under the skin, most commonly in the neck, the armpits, or the groin.
- g. Unexplained skin lesions, especially when there are newly-appearing painless pink, brown or purple spots or bumps. The lesions may appear anywhere on the skin, or on the inside of the mouth, nose, eyelids, rectum, or feet. They often look like a bruise, but instead of getting better and going away, they gradually get larger. They may feel harder than the skin around them but are not usually painful and do not itch.
- h. Yeast (fungus) infections that keep recurring or that persist for several weeks. Yeast infections appear as white patches, usually in the mouth or throat, or cause itching, soreness and sometimes cracking of the skin, especially around the anus or the corners of the mouth.

13. WHAT ARE THE PRECAUTIONS TO BE TAKEN WHEN GIVING FIRST AID OR CPR?

The following special precautions are not related solely to AIDS. Rather, they should be observed when working with any offender or member of the general public in order to reduce the chance of catching any one of several communicable diseases.

a. CPR

Cardiopulmonary resuscitation must be given to people in need of this life-saving procedure. While there is always some risk of being exposed to a communicable disease when giving CPR, the risk is considered to be small.

To minimize the risk of contamination, the Department will ensure that "pocket masks" are strategically located and readily available to all staff when emergency resuscitation must be initiated. However, if a mask is not immediately available, mouth-to-mouth must be initiated when necessary to save a life.

b. FIRST AID

It is always wise to be cautious and aware of infection control measures when assisting trauma victims. If contact with human blood, urine, feces, or other body secretions occur, thorough washing with soap and water is important, and soiled clothing should be changed as soon as practical. We know, for example, that the AIDS virus is readily killed by soap and water and by common disinfectants. You should avoid touching your mouth or eyes with your hands or any items contaminated by blood, feces, or other body secretions. Personnel with wounds or abrasions on exposed body surfaces, such as the hands or face, should try to protect those areas from contact with blood or secretions when emergency treatment is being given. It is good practice to wear disposable gloves while handling items contaminated by blood, feces, or body secretions; this is especially important for personnel with wounds or abrasions on the hands. The Department will ensure that these are readily available also.

14. WHAT PRECAUTIONS SHOULD BE TAKEN WHEN DEALING WITH BELLIGERENT INDIVIDUALS?

When confronted with an uncooperative person, it is prudent to avoid contact of saliva or blood with the eyes or mouth, and to avoid being bitten. If an altercation results in contact of your hand or other body parts with blood, saliva, or feces, the same precautions previously described should be observed.

If the mouth, eyes, or an unprotected cut are directly exposed to blood, saliva, urine, or feces, then the workers should thoroughly wash the area(s), inform their supervisor, and consult with a physician. In some cases, it may be important to learn about the health status of the person who was the source of the blood or secretions in order to determine if any protective measures should be taken.

15. WHEN DEALING WITH AIDS, ARE THERE SPECIAL CONSIDERATIONS RELATED TO CONFIDENTIALITY?

The answer to this question is "yes and no." No, in the sense that DOC requires confidentiality in all medical matters except on a "need to know" basis. Yes, in the sense that violating confidentiality concerning AIDS can have far greater consequences and cause a threat to the security and the welfare of offenders and staff. Violating an offenders right to confidentiality is in violation of law and makes the person who violates that confidentiality personally liable for the consequences.

*Inmate Training Materials*

## LESSON SUMMARY

**SUBJECT TITLE:** A.I.D.S.: COULD YOU BE AT RISK?  
**TOPIC TITLE:** INMATE INFORMATION PROGRAM ON AIDS

**TARGET POPULATION:**  
INMATE POPULATION OF D.O.C.

**TIME ALLOCATION:**  
ONE (1) HOUR

**CLASSROOM OR AREA REQUIREMENTS:**  
LARGE ROOM SUFFICIENT TO ACCOMODATE 20-30 PERSONS

**PERFORMANCE OBJECTIVES:** At the completion of the program the attendee will be able to:

1. Define AIDS
2. Know the high risk groups
3. Know symptoms and what to do when they occur
4. Explain how you avoid or lower risk of acquiring AIDS
5. Be aware that the only cure at present--is prevention

**EVALUATION PROCEDURES:**

Group Discussion  
Question & Answer

**METHODS:**  
Lecture, group discussion, video tape material when available.  
Information handout

**TRAINING AIDS, SUPPLIES, AND EQUIPMENT:**  
VIDEOTAPE (WHEN AVAILABLE)  
HANDOUTS  
BLACKBOARD & CHALK



STRUCTURAL CONTENT	NOTES TO TRAINER
<p>II. Symptoms of AIDS</p> <p>A. <del>There is no specific test to prove or disprove AIDS. In its early stage it may not cause symptoms.</del></p> <p>B. Symptoms that eventually develop are often related to other disease which attack them because of their lack of ability to fight infections.</p> <p>C. Symptoms may include:</p> <ol style="list-style-type: none"> <li>1. extreme fatigue (tiredness)</li> <li>2. continued fever or night sweats</li> <li>3. loss of appetite and weight loss of more than 10 pounds not associated with dieting or increased physical activity</li> <li>4. enlarged glands in neck, armpits or groin</li> <li>5. blue-violet or brownish spots/growths on the skin or mucus membranes (may occur in mouth, nasal passages or anus). Maybe overlooked due to resemblance to a bruise</li> <li>6. dry cough that is continuous and lasts 2 weeks or more</li> <li>7. frequent bouts of diarrhea</li> <li>8. fungal growth (thrush) on tongue. It appears as a thick whitish coating and may be accompanied by a sore throat.</li> <li>9. unexplained bleeding from growths on the skin, mucus membranes, or body openings.</li> <li>10. bruising more easily than usual</li> <li>11. increasing shortness of breath</li> </ol> <p>D. If you have any one or more of these symptoms for a period of time and the cause cannot be identified - please contact your institutional health department.</p> <ol style="list-style-type: none"> <li>1. Note: each of the symptoms can appear in illness not connected with AIDS - everyone occasionally experiences a headache, a fever, diarrhea or tiredness.</li> </ol>	<p>is discussed under</p> <p>NOTE:</p> <p>Incubation period (time between infection and onset of symptoms) is from a few months to two years.</p> <p>LIST SYMPTOMS ON BLACKBOARD</p> <p>Appendix D 119</p>

STRUCTURAL CONTENT	NOTES TO TRAINER
<p>III. How do you catch AIDS</p> <ul style="list-style-type: none"> <li>A. Current medical information indicates that it is spread by intimate person to person contact (sexual contact) through body fluids (saliva, urine, semen, sweat, etc.).</li> <li>B. It is also believed to be spread via the use of contaminated needles (shared needles) for injection of drugs.</li> <li>C. There is no evidence that AIDS is spread by:               <ul style="list-style-type: none"> <li>1. casual contact (hand shake or other non-sexual contact)</li> <li>2. toilet seats, bathtubs, showers</li> <li>3. utensils, dishes, or linens</li> <li>4. food prepared or served by an infected person</li> <li>5. contact with mosquito or other insects</li> <li>6. being in close proximity to an infected person, even if on a daily basis for a long period of time</li> </ul> </li> </ul> <p>IV. Why do we isolate AIDS patients in the Hospital?</p> <ul style="list-style-type: none"> <li>A. By state law, every hospital must carry out Infection Control Procedures when any patient has a potentially contagious disease.               <ul style="list-style-type: none"> <li>1. Health Staff come into direct contact with blood and other body fluids and excrement (wastes) that can spread disease.</li> <li>2. Special care must be taken in the disposal and handling of these materials.</li> <li>3. We must also protect the victim of AIDS, from infectious germs which may be present in the hospital. Remember his immune system cannot fight infection.</li> </ul> </li> </ul>	<p>EMPHASIZE! ! !</p> <p>REPEAT! ! ! YOU CANNOT ACQUIRE AIDS THROUGH CASUAL CONTACT</p>

STRUCTURAL CONTENT	NOTES TO TRAINER
<p>V. Treatment of AIDS</p> <ul style="list-style-type: none"> <li>A. No known cure for AIDS at present.</li> <li>B. Mortality rate is very high                             <ul style="list-style-type: none"> <li>1. 20-80%</li> <li>2. Researchers do not know of any AIDS victim who has regained their lost immunity</li> </ul> </li> <li>C. Treatment can be given for the different infections and diseases that attack AIDS victims.                             <ul style="list-style-type: none"> <li>1. Since the immune system is damaged they will continue to be a risk, developing other serious infections, diseases, and cancers.</li> </ul> </li> </ul>	<p>EMPHASIZE THAT THERE I NO KNOWN CURE AT PRESE</p>
<p>VI. Diseases Affecting AIDS Victims</p> <ul style="list-style-type: none"> <li>A. 90% have either or both of two rare diseases:                             <ul style="list-style-type: none"> <li>1. Kaposi's Sarcoma - a rare type of cancer</li> <li>2. Pneumocystis Carinii Pneumonia - a parasitic infection of the lungs.</li> </ul> </li> <li>B. Other opportunistic infections that occur due to damaged immune system                             <ul style="list-style-type: none"> <li>1. Yeast infections (thrush)</li> <li>2. Herpes simplex I &amp; II</li> <li>3. Cytomegalovirus (CMV) similar to herpes viral disease</li> <li>4. Toxoplasmosis - a parasitic disease producing encephalitis, convulsions, eye disease, hydrocephalas, mental retardation, and/or death</li> </ul> </li> </ul>	<p><u>EXPLAIN:</u></p> <p>Kaposi's Sarcoma - a skin cancer that usually affects elderly men and was seldom fatal - It a affected children and young adults in equatorial Africa</p> <p>PCP - affects a few hundred children and adults-but is usuall only seen in persons with severe underlyi illness (ie: leukemi or in patients receivi intense therapy with drugs known to suppr immune system - such as kidney transplant patients to prevent organ rejection</p>



# **PARTICIPANT HANDOUTS**

INMATE INFORMATION

B U L L E T I N O N A I D S

Q: What is AIDS?

A: AIDS stands for Acquired Immune Deficiency Syndrome. It is a recently identified disorder that damages the body's natural immune system, reducing the ability to fight off infections and disease. As a result, persons with AIDS may develop rare forms of cancer, pneumonia or other serious infections which generally don't affect healthy adults. These illnesses are referred to as opportunistic infections.

Q: What causes AIDS?

A: The exact cause of AIDS is not yet known. Many medical researchers believe AIDS may be caused by a virus that attacks the body's immune system.

Q: Who is at risk of getting AIDS?

A: Sexually active male homosexuals and users of intravenous drugs run the greatest risk for AIDS.

Of the approximately 1,400 persons who have developed AIDS in the U.S., 70-75 percent are homosexuals or bisexual men; 15-20 percent are admitted users of intravenous drugs such as heroin or cocaine. Some cases also have been found among Haitian immigrants. A few women who use IV drugs, or who have sexual contact with bisexual men, have developed AIDS.

Q: How is AIDS spread?

A: All current medical information indicates that AIDS is spread from person to person through intimate sexual contact or through the use of shared needles for injection of drugs.

There is no evidence that AIDS is spread by:

--handshakes or other non-sexual contact; toilet seats, bathtubs or showers; utensils, dishes or linens used by an infected person; food prepared or served by an infected person; being around an infected person, even on a daily basis over a long period of time; and/or by contact with a mosquito or other insects.

Q: Why are homosexual men at high risk for AIDS?

A: Homosexual men who have intimate sexual contact with a large number of partners, increase the probability of coming into contact with infected individuals. Most male homosexuals who have developed AIDS are from large cities (New York, San Francisco, Los Angeles, Miami) with large gay communities, where sexual contact with a large number of individuals occurred.

Q: Why are IV drug users at high risk for AIDS?

A: The high risk for intravenous drug users is almost certainly due to sharing or reusing unclean needles for injecting the drugs. Blood serum from a person with AIDS can be injected into the blood stream of a healthy person if the same needle is used.

Q: What are the symptoms of AIDS?

A: In its early stages, immune deficiency may not cause any symptoms. The symptoms that AIDS victims eventually develop are often related to other diseases or infections which attack them because of their inability to fight off infection.

These symptoms may include:

1. extreme tiredness, sometimes combined with headache
2. continued fever or night sweats
3. weight loss of more than 10 pounds which is not due to dieting or increased physical activity
4. swollen glands in the neck, armpits or groin
5. purple or discolored spots or growths on the skin or the mucous membranes (inside the mouth, anus or nasal passages)
6. heavy, continual dry cough that has lasted over 2 weeks
7. frequent bouts of diarrhea
8. thrush, a thick whitish coating on the mucous membranes of mouth, tongue or throat which may be accompanied by sore throat
9. unexplained bleeding from any body opening or from growths on the skin or mucous membranes
10. bruising more easily than usual
11. progressive shortness of breath

Q: What should someone do who has these symptoms?

A: Each of the symptoms listed above can appear in illnesses that are not associated with AIDS. For example, everyone occasionally experiences tiredness, headaches, fevers and diarrhea.

Anyone who has had one or more of the listed symptoms for a period of time and cannot identify another cause for the problem is advised to contact the institutional health department.

Q: Can AIDS be cured?

A: At the present time there is no known treatment that can restore the body's immune system to normal once it has been damaged by AIDS. Treatment can be given for the various diseases and infections that attack AIDS victims. However, since the immune system remains damaged, a person with AIDS will continue to be at risk of catching other serious infections and cancers.

Q: How can the risk of AIDS be reduced?

A: All information to date indicates that AIDS is spread by homosexual contact and by the use of injectable drugs. Therefore, the risk of getting AIDS can be reduced by:

1. Avoiding illicit drug use, especially IV drugs
2. Refraining from homosexual contacts

REMEMBER: THE CHOICE IS YOURS. IT IS ONE OF THE FEW CHOICES YOU CAN MAKE FOR YOURSELF WHILE INCARCERATED - THE CHOICE TO BE HEALTHY OR TO TAKE YOUR CHANCES WITH DISEASE AND MAYBE DEATH.

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**Inmate Training Materials**  
**Illinois Department of Corrections**

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**DRAFT**

**Inmates NewsPaper**

Several inmates have asked some very good questions about the AIDS or Acquired Immune Deficiency Syndrome. I'm taking this opportunity to answer some of these questions.

Ronald M. Shansky, M.D.  
Medical Director  
October, 1985

Question: 1

What causes AIDS?

Answer:

AIDS is caused by a virus. Fortunately, this virus is not easily spread from person to person. Unlike the cold virus which can be spread through coughing or sneezing, in order to spread this virus from one person to another there must be intimate sexual contact between 2 people. The virus can also be spread by blood transfusion from a person who has had AIDS. Although now that there is a test for the antibody to the virus and all blood is screened for this, at this point it is virtually impossible for anyone to get AIDS from a blood transfusion. The final way AIDS can be spread is through sharing a needle when injecting a drug, such as heroin.

Question: 2

Can AIDS be spread if someone were in the same cell with a person with AIDS?

Answer:

Everything we know indicates that AIDS can only be spread through the ways I listed above. No one who has lived in the same house as an individual with AIDS including parents, brothers, sisters, friends, etc. has gotten AIDS from other household members. Even people who have kissed someone with AIDS and people who have shared the same glasses, eating utensils and bathrooms as someone with AIDS have not developed AIDS. This proves to us that it is very difficult to spread AIDS. If by chance someone were in the same cell as another person with AIDS, the only way they could get AIDS is if they had sexual contact with the person with AIDS.

Question: 3

Is there a treatment for AIDS?

Answer:

As of this date, there is no treatment for AIDS and most of the people who develop AIDS will, in fact, die. The reason they die is that their body's immune system, which fights off infections, is destroyed by the AIDS virus, so they get all kinds of infections like colds and other things and they get much sicker than the average person would. In fact, a person with AIDS has more to fear in terms of getting sick from infection from other people than do other people have to fear of getting AIDS from the individual with AIDS.

Question: 3a

Can AIDS be spread from a needle used by a nurse to draw blood or give a shot?

Answer:

Absolutely not, only new clean sterile needles are used for blood drawing and giving shots.

Question: 4

Do only homosexuals get AIDS?

Answer:

In fact, AIDS is spread through homosexual as well as heterosexual sexual contact. Those groups that have had the highest number of cases of AIDS in the population are very active homosexuals who have multiple partners and drug addicts who share needles with individuals who have had AIDS.

Question: 5

What is being done within the prison system to find out if anyone has AIDS?

Answer:

Every individual who enters the system, the Department of Corrections, has a complete history and physical as well as other tests. Any inmate who appears to be at greater risk of developing AIDS is put on a list and monitored very closely, including examination every 3 months. There is no specific test to screen to determine if someone has AIDS. It is thought that up to a million people may have had the AIDS virus in their system, but out of these million people in the entire country, only about 50,000 will actually get the AIDS sickness. This means 95% of the people who have the AIDS virus in their system will not get sick with AIDS. However, they may carry the virus in them for long periods of time. When we identify someone who may, in fact, have AIDS we will enroll them in a special program so that they are followed up with other AIDS patients and as soon as new medicine is available we will make that medicine available to them.

Question: 6

How many cases of AIDS have been found in the Illinois Department of Corrections?

Answer:

To this date we have had only 1 case of AIDS and he died within about 2 weeks of developing the sickness. He was hospitalized within a day of becoming sick but despite our hospitalizing him and diagnosing him correctly the treatments that were utilized were not effective.

Question: 7

Can we take a blood test to see if we have AIDS?

Answer:

There currently is no test to show if someone has AIDS. There is a blood test that shows whether someone has an antibody to the AIDS virus but most of the people that have the antibody to the AIDS virus in them do not, in fact, necessarily have the AIDS virus itself in them. Therefore, it would do no good to do that test on everyone. When there is an available test for the AIDS virus we will perform it.

Question: 8

What can inmates do to eliminate the possibility of getting AIDS?

Answer:

The only way to eliminate the possibility of getting AIDS and this will guarantee 100% that an inmate will not get AIDS is if the inmate avoids sexual contact with other inmates and if they do not share any needles with other inmates. If inmates avoid these two things, it is virtually impossible for them to get AIDS.

Question: 9

Do all homosexuals have AIDS?

Answer:

A very small percentage of homosexuals have AIDS. Probably less than 1%; however, we are unable to determine who has AIDS before the individual becomes extremely sick.

Question: 10

Can inmates get AIDS from medical staff?

Answer:

No medical personnel who have taken care of AIDS patients have ever gotten AIDS, therefore, it would be impossible for inmates to get AIDS from medical personnel.

If inmates have questions about other diseases they may write me at the Department of Corrections, Health Services Administration, 100 W. Randolph St., Suite 4-200 Chicago, Illinois 60601, and I will answer them either by mail or in future articles.

**Inmate Training Materials**  
**Connecticut Department of Corrections**

Inmate Information

WEEKLY SCENE

8/25/1985

From: Edward A. Blanchette, M.D., Medical Director, Somers-CCI

To: Whom It Concerns...

Subject: Article concerning AIDS for inmate information and education

In an attempt to address the many concerns about the AIDS problem, both in the prison and in society in general, I would like to submit the following article for publication. If the response is favorable, I would also like to continue this attempt at medical education with articles appearing about twice a month. Topics other than AIDS could also be discussed.

/ MEDICAL INFORMATION -- AIDS /

In the past few months many questions were addressed to the Medical Department at CCI-Somers with regards to the AIDS problem. It seems clear that the general community as well as the Department of Corrections will see greater numbers of patients infected with this virus in the future. To promote further medical education, I will try to answer the most pertinent and the most frequently asked questions about AIDS (and possibly other topics) on a monthly basis in this newsletter. Please feel free to write me C/O the Medical Department with any questions you may have about this problem. All names, numbers, and residence will remain confidential (unless notified).

The following are a number of questions sent to my office in the past month:

1. What is AIDS and what causes AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome. It is caused by a special kind of virus called HTLV-III. This virus destroys a certain type of cell in the body that is important in fighting off certain types of infections. Because it destroys a part of the immune system, persons with AIDS may develop serious types of infections, especially pneumonia. It can also cause certain types of rare cancer e.g. Kaposi's Sarcoma. These infections and cancers are the type that are almost never a problem in normal adults.

2. Who is at risk of getting AIDS?

Sexually active male homosexuals and IV drug abusers run the greatest risk of acquiring AIDS. Other groups at risk include hemophiliacs, sexual partners of those people who carry the AIDS virus (HTLV-III), and those people receiving contaminated blood transfusions. At this time, the state of Connecticut is testing donated blood for the HTLV-III antibody, which should greatly reduce blood transfusion as a risk factor.

### 3. How is AIDS spread?

AIDS is spread from person to person through intimate sexual contact or through the use of shared needles for the injection of drugs. Amongst inmates, the most common risk factor (by far) is IV drug abuse. In my opinion, anyone who continues to "shoot up" (especially with a number of other users...e.g. attending a "shooting gallery") will undoubtedly be infected with the HTLV-III virus eventually. It is only a matter of time. Other modes of spread that may be important in prison include illegal tattooing (since the virus can be passed from one inmate to another via the needle used...not properly sterilized) and gay inmates that have multiple sexual contacts while in prison.

There is no evidence that AIDS can be contracted through casual, non-sexual contact with a person who has AIDS or who carries the virus. AIDS virus is not spread by:

- sneezing, coughing or spitting
- handshakes or other non-sexual physical contact
- toilet seats, bathtubs or showers
- utensils, dishes or linens used by an infected person
- food prepared or served by an infected person
- being around an infected person, even on a daily basis over a long period of time.

The virus can be isolated in certain body fluids including blood, plasma, semen, and in certain body tissues. It is not known if inmates kissing can transmit the virus, but it is known that some virus can be detected in saliva. In view of these facts, it would be unwise to share toothbrushes, razors, or other articles that can be contaminated with blood. (I personally would not lend my toothbrush or razor anyway...hepatitis and herpes simplex were reason enough not to do this years ago.)

REMEMBER there is no evidence that being in prison increases the risk of AIDS. Your risk of developing AIDS is directly dependent on your previous activity before incarceration and your present activity here at Somers-CCI... If you engage in certain prohibited activities while in prison (namely the use of illegal intravenous drugs, obtaining an illegal tattoo, engaging in homosexual activity), infection with the virus that causes AIDS is a risk you take.

Edward A. Blanchette, M.D.  
Medical Director, Somers-C.C.I.

*Health-care Worker Educational Materials*

## AIDS information: The professional antidote to unwarranted fear

This brochure can be considered as only the beginning of a longer process of education regarding AIDS. More information is available now, and may be received through local AIDS foundations, or similar organizations, in major cities across the country.

### Call these national, or local hotlines:

Department of Health and Human Services,  
Washington D.C.,  
AIDS Information Hotline  
800-342-2437  
Mon-Fri 8:30 A.M.-5:30 P.M. EDT.

Chicago Medical Society - 607-3670  
AIDS Information Tape - #571

Howard Brown Hotline - 871-5696

Sable-Sherer Clinic - 633-7810  
Cook County Hospital  
Fantus Clinic

Chicago Department of Health  
AIDS Activity Office - 744-4372

Illinois state wide AIDS  
Hotline 1-800-AID-AIDS

This brochure was adapted from a brochure produced by the AIDS Education Committee of the Service Employees International Union (SEIU) Local 250, Hospital and Institutional Workers Union, S.F., CA.

# AIDS

## AND THE HEALTH CARE WORKER AT CERMAK HEALTH SERVICES

A guide to the  
problems and needs  
of AIDS patients.

## All of us, by now, have heard of AIDS. . .

... Acquired Immune Deficiency Syndrome. In the individual with AIDS, the normal functioning of the immune system is severely impaired, and the body becomes more susceptible to infections and other illnesses. The most serious of these include Kaposi's sarcoma (an unusual form of cancer) and Pneumocystis carinii pneumonia (an uncommon infection of the lungs).

Beyond this definition, few of us know very much about AIDS. This brochure is designed to help health care workers address the problems and needs of those who have AIDS more effectively, sensitively and safely.

## AIDS: Who is at risk?

The medical condition which has come to be known as AIDS first began to appear in 1979. Over 3600 cases had been reported by early 1984. Approximately 50% of these cases had been diagnosed in 1983. At that time, the number of new cases reported were doubling about every six months.

The method of transmission of AIDS is thought to be a viral agent, and particular groups appear to be at increased risk.

**73.4%**  
homosexual and  
bisexual men

**17%**  
intravenous drug users

**2.1%**  
hemophiliacs and  
other recipients of  
blood transfusion  
products

**7.5%**  
other (includes people  
who are reluctant to  
reveal their sexual  
orientation and use of  
intravenous drugs, sex  
partners of people at  
risk for AIDS, Haitians).

Medical evidence indicates that the AIDS agent is transmitted through blood and semen. Although casual contact with an AIDS patient presents **no danger** of infection to health care workers, hospital infection control guidelines have been designed to protect workers from direct exposure to blood-contaminated bodily secretions of an AIDS patient.

## Precautions for health care workers and protection for AIDS patients:

### ALWAYS

#### WASH HANDS

before and after patient contact.

#### WEAR GLOVES ONLY

when directly exposed to blood or secretions from AIDS patients, e.g. when handling blood specimens or cleaning up stool or urine.

#### DISPOSE OF NEEDLES PROPERLY

by placing them in a puncture-resistant container used solely for such disposal. Needles should not be reinserted into their sheaths before being discarded, since this is a common cause of puncture injury.

Contaminated surfaces and objects are to be cleaned with Sodium Hypochlorite "household bleach" in a 1:10 dilution with water, or 70% alcohol.

### AS NEEDED

#### MASKS

are necessary only when the patient has tuberculosis and is actively coughing.

#### LINEN

precautions are necessary only when there are draining wounds or the patient is unable to control excretions. Then linen should be placed in specially marked bags and disposed of appropriately in accordance with hospital procedure.

### NONE NEEDED

#### NO DIETARY PRECAUTIONS

are needed since there is no evidence for the transmission of AIDS through food, dishes or utensils.

#### Special precautions for pregnant women:

Many AIDS patients excrete cytomegalovirus (CMV). It is advisable for pregnant women who work in out-patient settings to meticulously adhere to the listed precautions when interacting with AIDS patients or other known cytomegalovirus (CMV) excretors.

#### If the above precautions are followed . . .

. . . health care workers face no risk of contracting AIDS. There is absolutely no need to put on full isolation gear when providing routine care to an AIDS patient. Besides, undertaking precautions over and beyond what is necessary can cause hysteria in fellow workers and non-medical staff and is psychologically damaging to the patient.

#### What about the risk of health care workers?

Not one of some 4,000,000 health care workers who was not already at high risk, has contracted the disease.

#### The need for open, rational and informed discussion about AIDS:

There is a very real need for increased AIDS awareness and education using the resources of the government, AIDS-related organizations, hospitals and unions. Once accurate information has been distributed, the fear generated by this sudden health epidemic will begin to subside, and health care workers will be better able to carry out their responsibilities professionally to all patients.

Any concerns should be addressed openly on an individual and small group basis. Time should be set aside at the workplace to allow for the free expression of our feelings. This also provides an excellent opportunity for co-workers to share important information, enhance professional expertise, and offer increased emotional support for AIDS patients, their visitors and each other.

#### Protecting the patient's right to privacy

Information regarding a patient's diagnosis, sexual orientation or general medical condition is confidential.

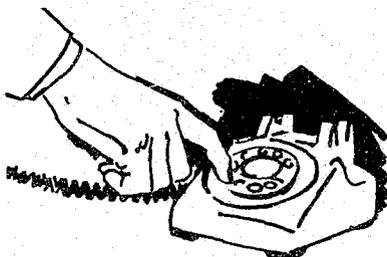
Furthermore, infection control precautions should be indicated only by generic labels posted on charts and doors (e.g. "blood/secretion precautions").

# AIDS

*General Education Materials*

**AT THIS MOMENT THERE IS  
NO BLOOD TEST FOR AIDS**

The test now used to screen blood at blood banks does not tell a person if he or she does or does not have AIDS.



**REDUCE YOUR RISK,  
PROTECT YOURSELF &  
YOUR FRIENDS FROM AIDS**

The safest —  
Don't use drugs with a needle!

- If you continue to inject drugs
- Don't share needles with anyone
- Don't go to shooting galleries
- Buy unused "works" and don't share them with anyone

**Practice safer sex!**

If you or your sexual partners are at risk (gay, bisexual, shoot drugs, hemophiliacs, etc.)

- Don't allow blood, semen, urine, or stool to enter you or your partner's body through the mouth or vagina, rectum, or open cuts and sores.
- Use a condom (rubber) — it may prevent the spread of AIDS

Even if you don't think that you are at risk

- Limit sexual activity to fewer partners
- Choose partners who are not at high risk for AIDS
- Practice safer sex

**WHERE TO GET HELP  
IN COOK COUNTY**

Howard Brown Hotline  
1-800-AID-AIDS

Sable-Sherer Clinic  
Cook County Hospital  
633-7810

Chicago Department of Health  
AIDS Activity Office  
744-4372

Chicago Medical Society  
670-3670  
Ask for AIDS Information Tape #571

**AT CERMAK HEALTH SERVICES**

Request to see your doctor in sick call and tell him or her your concerns about AIDS.

This brochure was prepared by Cermak Health Services AIDS Committee with assistance from The Chicago Department of Health.

Any opinions expressed herein are the AIDS committee's alone and do not necessarily reflect the opinions or policies of the Chicago Department of Health.

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# **AIDS**

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## **Questions & Answers**



**AIDS INFORMATIONAL HANDOUT**

**WHAT IS AIDS?**

AIDS stands for Acquired Immune Deficiency Syndrome. It is a life threatening disease that damages the ability of the blood in healthy people to wipe out invading germs, viruses, or other infections.



**WHO HAS AIDS?**

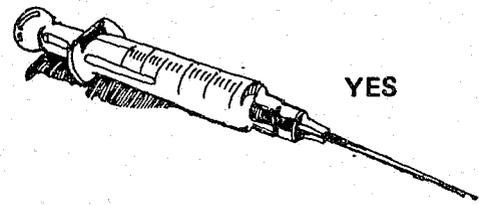
Most of the people who have AIDS fall into two categories:

- Homosexual and Bisexual Men
- Intravenous (Mainlining or Skin Popping) Drug Users

A small percentage are:

- Hemophiliacs (bleeders)
- Women who have sex with men who are at risk for AIDS
- Children born to women who are at risk for AIDS
- People who have received many blood transfusions
- Others?

**HOW IS AIDS SPREAD?**



- Through intimate sexual contact.
- Through the use of shared or used needles for injection of drugs.
- From mother to infant during pregnancy and birth.

**AIDS IS NOT SPREAD THROUGH:**

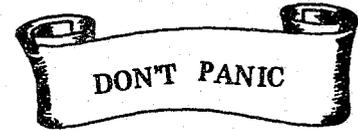
- Sneezing, coughing or spitting
- Handshakes or other nonsexual physical contact.
- Toilet seats, bathtubs or showers
- Utensils, dishes or linens used by a person
- Food prepared or served by an affected person
- articles handled or worn by an affected person
- Being around an affected person, even on a daily basis over a long period of time



**WHAT ARE THE SIGNS AND SYMPTOMS OF AIDS?**

- Unexplained, increasing and persistent fatigue
- Fever of 101 to 102° and night sweats for several weeks
- Continued bouts of diarrhea
- Unexplained weight loss of more than 10 lbs, within two (2) months
- Creamy-white patches on the tongue and/or mouth (thrush)
- Pink or purple, flat or raised skin blotches that do not go away and do not turn pale when pressed
- Unexplained swollen glands in the neck, armpits, and groin
- Persistent dry cough associated with shortness of breath

**WHAT SHOULD YOU DO IF YOU HAVE THESE SYMPTOMS?**



Each of the symptoms listed can appear in illnesses that are not associated with AIDS. For example, everyone occasionally experiences tiredness, headaches, fevers and diarrhea, however, if you have one or more of the listed symptoms for a period of time and cannot identify another cause for the problem, contact a doctor or health clinic and mention the concern about AIDS.

# AIDS RISK

a reference guide

## What the general public should know

Everyone of every sex and race must now be concerned about AIDS. However, many people are unnecessarily fearful for their safety. To have a realistic understanding of this disease, let's examine the facts:

AIDS is contracted through intimate sexual contact, contaminated blood or shared needles. Infants may contract the disease from infected mothers. However, three-quarters of AIDS patients are men who have had male sex partners.

Friends, co-workers and relatives of AIDS patients have not contracted the disease through their usual, everyday contact. Also not at risk are the health care workers who treat or work with persons with AIDS.

# HERO

we want you to know more.

## What is AIDS?

AIDS (Acquired Immune Deficiency Syndrome) is caused by a virus known as HTLV-III which damages the body's natural immune system. Thus, the person's ability to fight disease becomes severely weakened. AIDS patients frequently develop rare and unusual diseases. Most common among these ailments are Kaposi's Sarcoma (a form of cancer) and pneumonia caused by *Pneumocystis carinii*, a parasite that does not usually cause disease in human beings. There is a long list of other, unusual diseases that may also gain a foothold because of the immune system damage.

## Who can contract AIDS?

Simply put, it is possible for anyone to contract this disease. Many sexually active homosexual or bisexual males have been exposed to the virus, as well as many intravenous drug users and hemophiliacs. These individuals, and their sex partners—both male and female—account for most of the present cases.

## There is no evidence to suggest AIDS is spread through these activities:

■ Being around someone with AIDS on a daily basis or over a long period of time.

■ Touching utensils, dishes or linens used by a person with AIDS.

■ Donating blood.

■ Sneezing, coughing or spitting.

■ Handshaking, or other non-sexual physical contact.

■ Toilet seats, bathtubs, showers or doorknobs.

## The HTLV-III Virus is sensitive to an appropriate use of many disinfectants including:

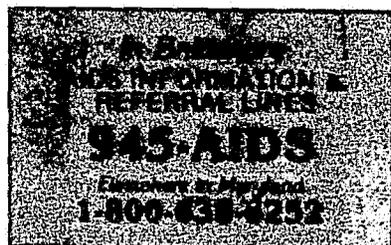
■ Rubbing alcohol

■ Lysol® disinfectant

■ Boiling water

■ Diluted household bleach, 1-part bleach: 10 parts water.

## Where to call



# HERO

The Health Education Resource Organization (HERO) is a non-profit community AIDS project working in cooperation with the State Department of Health & Mental Hygiene and the Baltimore City Health Department.

Publication design: Steve McLerran.

*Counseling Materials*

**INFORMATION FOR THE HIGH RISK PERSON WHO HAS  
HAD A POSITIVE HTLV-III ANTIBODY TEST**

What Does a Positive Test Mean?

If one of the following descriptions applies to you, your positive test result probably means that you have been infected with the HTLV-III virus, which is believed to cause AIDS:

1. Male who has had sexual contact with another man since 1979
2. User of intravenous drugs
3. Hemophiliac
4. Haitian immigrant
5. Sexual partner of a person with AIDS or a person with increased risk of exposure to AIDS (i.e., one of the above)

Nevertheless, your positive test result could mean any one of four things:

1. The test is falsely positive. If this is the case, you have never been infected with the virus, and you do not truly have antibody against it. The result could be positive because the test cross-reacted with something else in your blood or because of a technical problem. If your blood has not been tested twice, a repeat test should be done.
2. You have been previously infected with the virus, but are now immune and no longer infectious to others.
3. You are not ill with AIDS and may never develop AIDS, but have been infected with HTLV-III virus and may be capable of exposing others to the virus through sexual contact, sharing needles, or donating blood or plasma.
4. You have AIDS or are developing AIDS.

Scientists believe that AIDS occurs in only a small proportion of people infected with the virus. Current information suggests that most individuals with a positive antibody test do not have AIDS.

### What is AIDS?

AIDS (acquired immunodeficiency syndrome) is a serious illness resulting from failure of an important part of a person's immune system. This failure is thought to be caused by infection with the human T-lymphotropic virus III, also known as HTLV-III.

Persons with AIDS may develop life-threatening infections and/or a rare form of cancer called Kaposi's sarcoma. It is now thought that many persons infected with HTLV-III may develop only mild illness, and some may develop no illness at all. Much is still unknown about the long-term results of HTLV-III infection.

If illness does occur, symptoms may include significant unexplained weight loss, unexplained fever lasting for several weeks, unexplained diarrhea lasting for weeks, recurrent yeast infections in the mouth, and recurring episodes of unexplained sweating during the night.

### How is the Virus Spread?

The virus is spread from an infected person to others by sexual contact, by blood or blood products, or by sharing needles used for injecting drugs.

A woman infected with the virus can transmit it to her unborn or newborn child. It is not known whether spread from mother to child occurs before the child is born, at the time of birth, or during the first few days or weeks after birth. It is possible that spread could occur at all these times.

It may be possible that an infected person can expose others via saliva during oral-genital contact or deep kissing. This route of transmission has not been well documented.

### What Should You Do Because of Your Positive Antibody Test?

1. You should ask to make sure that your blood specimen was tested twice. If it was not, you should request that your antibody test be repeated to help evaluate the meaning of your positive test.
2. You should see a doctor for an examination. Be sure to choose a doctor with whom you can form a comfortable relationship for follow-up examinations. If you do not have a regular doctor, ask the person who gave you this form to suggest a list of names from which you can choose.
3. If your doctor finds no evidence of AIDS-related illness by examination, you should plan to visit him or her for re-evaluation at least twice a year. If significant, unexplained weight loss, unexplained fever, unexplained diarrhea, yeast infections in your mouth, or severe sweating during the night occur between your routine doctor visits, you should seek medical care right away.

4. If your doctor does find evidence of AIDS-related illness by examination, you should follow his or her advice for further evaluation.
5. You should understand that if you have been infected with the virus, you will probably remain infected. This means that you may spread infection to others, even if you remain well. To avoid exposing others you should:
  - a. Refrain from donating blood or plasma, sperm for artificial insemination, and body organs or tissues for transplantation.
  - b. Avoid exposing others through sexual contact. You can do this by abstinence from sexual contact or by using safe sexual practices. Ask your counselor for more information.
  - c. Avoid exposing others to your saliva by oral-genital contact or deep kissing.
  - d. Avoid sharing of needles for injecting drugs.
  - e. Avoid sharing toothbrushes, razors, or other implements that could become contaminated with blood.
  - f. If you bleed from a cut or other wound, you should clean up any clothes, furniture, or other surfaces with a mixture of household bleach and water (1 part bleach mixed with 10 parts water).
  - g. You should inform any person providing you with medical or dental care of your positive antibody test. This will enable your health care providers to take appropriate precautions to avoid exposure of others.
  - h. If your work involves significant potential for exposing others to your blood or other body fluids, you should discuss with your doctor those precautions you should take to prevent such exposures.
6. You should inform your sexual partners of your test result with encouragement to see a doctor for evaluation.
7. You should inform your needle-sharing partners of your test result with encouragement to see a doctor for evaluation.
8. If you are a woman, and you have any children who were born since 1979, you should take them to a doctor for evaluation.
9. If you are pregnant, or if your sexual partner is pregnant, you should seek medical advice. Remember that a woman with HTLV-III infection may transmit AIDS to her unborn child or newborn child.

10. If you plan to become pregnant or your sexual partner plans to become pregnant, you should postpone pregnancy until more is known about your risk of transmission.

What Changes in Your Daily Activities Do You Not Need to Make?

You do not need to change your lifestyle beyond the suggestions listed above. Specifically:

1. You can continue your usual social contact with family and friends. Hugging and kissing on the cheek do not spread the virus.
2. You can continue your usual contact with people in the community without special precautions or restrictions.
3. Unless your job involves significant potential for exposing others to your blood or other body fluids, you can continue your usual work without special precautions.

What Should You Do if You Have Further Questions or Need More Help in Coping With the Fact That You Have a Positive HTLV-III Antibody Test?

You should contact your doctor or county health department for help and for referral to additional sources for help.

## INFORMATION FOR THE HIGH RISK PERSON WHO HAS A NEGATIVE HTLV-III ANTIBODY TEST

### What is AIDS?

AIDS (acquired immunodeficiency syndrome) is a serious illness resulting from failure of an important part of a person's immune system. This failure is thought to be caused by infection with the human T-lymphotropic virus III, also known as HTLV-III.

Persons with AIDS may develop life-threatening infections and/or a rare form of cancer called Kaposi's sarcoma. It is now thought that many persons infected with HTLV-III may develop only mild illness, and some may develop no illness at all. Much is still unknown about the long-term results of HTLV-III infection.

If illness does occur, symptoms may include significant unexplained weight loss, unexplained fever lasting for several weeks, unexplained diarrhea lasting for weeks, recurrent yeast infections in the mouth, and recurring episodes of unexplained sweating during the night.

### How is the Virus Spread?

The virus is spread from an infected person to others by sexual contact, by blood or blood products, or by sharing needles used for injecting drugs.

A woman infected with the virus can transmit it to her unborn or newborn child. It is not known whether spread from mother to child occurs before the child is born, at the time of birth, or during the first few days or weeks after birth. It is possible that spread could occur at all these times.

It may be possible that an infected person can expose others via saliva during oral-genital contact or deep kissing. This route of transmission has not been well documented.

### What Does a Negative Test Mean?

If one of the following descriptions applies to you, your negative test may not necessarily mean that you have not been exposed to the virus thought to cause AIDS. This is because it is not yet known how frequently persons who are well, yet infected with the virus, may have a "false negative" test. A "false negative" test means that the test does not detect antibody against the HTLV-III virus, even though the person has been infected. This can happen because of technical problems in the laboratory, or because a person's immune system may not develop antibody against the virus until some time after infection.

The risk group descriptions are:

1. Male who has sexual contact with another man since 1979
2. User of intravenous drugs

3. Hemophiliac
4. Haitian immigrant
5. Sexual partner of a person with AIDS or a person with increased risk of exposure to AIDS (i.e., one of the above)

Additionally, if you continue to have one of the above risk factors, a negative antibody test does not mean that you have no risk of exposure in the future.

Therefore, even though you have had a negative HTLV-III antibody test, you should follow these suggestions:

1. Refrain from donating blood or plasma, sperm for artificial insemination, and body organs or tissues for transplantation.
2. Avoid exposing others through sexual contact by using safe sexual practices. Ask your counselor for more information on these safe practices.
3. Avoid sharing of needles for injecting drugs.
4. Avoid sharing toothbrushes, razors, or other implements that could become contaminated with blood.

## INFORMATION FOR THE LOW RISK PERSON WHO HAS HAD A POSITIVE HTLV-III ANTIBODY TEST

### What Does a Positive Test Mean?

The significance of your positive test result depends entirely on the likelihood that you have been exposed to the virus that is thought to cause AIDS. This likelihood is determined by certain RISK FACTORS:

1. If you are a man and have had sexual contact with another man since 1979, there is a significant chance that you have been exposed to the virus.
2. If you have been treated for hemophilia with factor VIII, there is a significant chance that you have been exposed to the virus.
3. If you have used illicit drugs intravenously, there is a significant chance that you have been exposed to the virus.
4. If you are a Haitian immigrant, there is a significant chance that you have been exposed to the virus.
5. If your sexual partner has AIDS or has one of the above risk factors, there is a significant chance that you have been exposed to the virus.

If you have any one of the above risk factors, your positive test result probably means that you have been infected.

If you are confident that you do not have one of the above risk factors, it is probable, but not certain, that your positive test is a "false positive." If it is a "false positive," you have never been infected with the virus, and you do not truly have antibody against it. The results could be positive because the test cross-reacted with something else in your blood or because of a technical problem. (If your blood has not been tested twice, a repeat test should be done.) A "false positive" test result has no known health significance.

There is not yet any laboratory test available to confirm whether you have been infected with the virus or whether your positive test result is a "false positive." Many research scientists are working to develop such a test.

You should discuss the above risk factors with your doctor or counselor, to help decide how likely it is that you have been infected with the virus. Ultimately, though, only you can determine whether you have one of the above RISK FACTORS.

If you do have one of the RISK FACTORS, you should read and discuss with your doctor or counselor the "Information for the High Risk Person Who Has Had a Positive HTLV-III Antibody Test." You should follow the advice presented there.

Even if you are certain that you do not have one of the risk factors, you should now read and discuss with your doctor or counselor the "Information for the High Risk Person . . . ." You should consider following some of the suggestions presented there. At a minimum, you should do the following until a confirmatory test is available to determine whether you have been infected by the virus or your test is a false positive.

#### What You Should Do Because of Your Positive Test

You should do the following, even if you believe you have none of the above risk factors:

1. You should ask to make sure that your blood specimen was tested twice. If it was not, you should request that your antibody test be repeated. A negative result on such a second test would increase the likelihood that your first test result was a "false positive."
2. You should see a doctor for an examination. If you do not have a regular doctor, ask the person who gave you this form to suggest a list of names from which you can choose.

If your doctor does not find any clinical evidence of AIDS-related illness that, too, increases the likelihood that your first test result was a false positive.

If your doctor does find clinical evidence of AIDS-related illness, you should follow his or her advice for further evaluation. You should also follow the advice for high risk persons.

3. You should consider informing your regular sexual partner(s) of your positive test result with encouragement to see a doctor for an examination and possible HTLV-III antibody test.
4. You should refrain from donating blood or plasma, sperm for artificial insemination and body organs or tissues for transplantation.
5. If you (or your sexual partner) are pregnant or considering pregnancy, you should discuss the implications of your positive antibody test with your physician.
6. You should check with your local health department or doctor every six months to learn if a confirmatory laboratory test has been licensed. When such a test is available, check with the doctor or agency responsible for your original test to arrange for having the new test. It will help to determine whether you have been infected with the virus or whether your initial test was falsely positive.

7. If any of the following symptoms occur, you should see your doctor: significant unexplained weight loss, unexplained fever lasting several weeks, unexplained severe diarrhea lasting for more than a week, yeast infections in your mouth, or recurrent, unexplained severe sweating at night.

You should not change your usual contact with family, friends, and people in the community. You should continue your regular work without special precautions.

## **Counseling Materials**

### **Connecticut Department of Corrections**

#### **GUIDELINES FOR INMATES/PATIENTS FOUND TO HAVE HTLV-III ANTIBODY, OR WHO ARE STRONGLY SUSPECTED OF HARBORING THIS VIRUS**

1. The prognosis for a patient infected with the HTLV-III virus over the long term is not known at this time. However, most data available indicate that most persons will remain infected with the virus for life once it is acquired. That is, once a patient is infected with this virus, he will carry that virus for a prolonged period of time, perhaps "forever." This is true whether or not the patient has full-blown AIDS.
2. If you have been infected with the HTLV-III virus, this does NOT mean that you will definitely acquire AIDS. Only about 1 person in every 10 or 20 who is infected with the virus will develop AIDS. The others may have a few symptoms (such as enlarged lymph nodes, fever on occasion, night sweats, weight loss, etc.), but they may not develop frank AIDS in the future. Only if you acquire one of the "special" kinds of infection that are seen with severe suppression of the immune system, OR if you acquire certain types of rare cancer, will you be classified as having AIDS. We do not know the long-term consequences of having this HTLV-III infection in those who do not develop AIDS in the first 5 years of infection.
3. Though you may not have symptoms with an HTLV-III infection, you might be able to transmit the infection to others. This virus is not spread by casual contact, such as shaking hands, hugging, coughing, sneezing, spitting, or the usual social contact with other people. It is not spread by toilet seats, showers, bathtubs, dishes, or linen. However, it can be spread by the following activities:
  - sexual activity, including sexual intercourse, rectal intercourse, fisting, etc. It is not known if very intimate kissing (French kissing, prolonged oral contact, etc.) is capable of transmitting the virus.
  - sharing toothbrushes, razors, or other implements that could become contaminated by blood.
  - sharing devices that puncture the skin, such as hypodermic needles or acupuncture needles. This includes tattooing needles. All such devices should be legally sterilized when multiple use is planned.The efficacy of condoms in preventing infection with HTLV-III is unproven, though they may be helpful.
4. You should not donate blood, plasma, body organs, other tissue, or sperm . . . due to the risk of infecting others.
5. If there is an accident with bleeding, contaminated surfaces should be cleaned with household bleach freshly diluted 1:10 in water. This will kill the virus.
6. It would be best not to share towels or other very intimate items.
7. Those people with whom you have had intimate contact in those at-risk activities listed above (e.g., sexual partners, persons with whom needles have been shared, infants born to infected mothers, etc.) should be notified of the possible risk of acquiring this virus. They may wish to have testing with their personal physician.
8. Any pregnancy in which you are the biologic parent and in which you carried the HTLV-III virus does have a risk of transmitting the HTLV-III virus to offspring.

Should you have any questions regarding this virus, risk of transmission, prognosis, etc., please write out your question and send it to my office. I will personally answer any such request.

*Pre/Post Test of AIDS Knowledge*

WASHINGTON STATE DEPARTMENT OF CORRECTIONS

Acquired Immune Deficiency Syndrome

Pre/Post Test

1. A positive AIDS anti-body test means that: (circle all correct responses).
  - a. A high likelihood exists that the individual will develop AIDS.
  - b. the individual has developed antibodies to the AIDS virus
  - c. the individual needs to restrict his or her normal day to day contacts
  - d. the individual has AIDS
  - e. the individual may need to modify his or her sexual practices
  - f. the individual has been exposed to the AIDS virus
  
2. What evidence is required to make a diagnosis of a case of AIDS?
  
3. The AIDS virus is easily killed by soap and water.    T    F
  
4. In its later stages, AIDS can be spread by casual contact with the patient, e.g., by shaking hands or touching objects handled by the patient.    T    F
  
5. To August 30, 1985, approximately how many AIDS cases in the United States have been reported to the Center for Disease Control? \_\_\_\_\_
  
6. You can contract AIDS by doing Frisk Pat Down Searches, and searching personal effects.    T    F
  
7. AIDS is transmitted through the following mode(s): (circle all correct responses)
  - a. shared eating utensils
  - b. contaminate clotting factor used by hemophiliacs.
  - c. contaminated blood transfusions.
  - d. mother to fetus.
  - e. exchange of bodily fluids, e.g. blood, semen.

AIDS is transmitted...

- f. shared toothbrushes
- g. sharing of needles among IV drug users
- h. other - specify: \_\_\_\_\_

8. Of AIDS victims, approximately what percentages belong to each of the following groups?

CHOICES: 73%; 17%; 4%; 4%; 1%; 1%; 1%

- Transfusion recipients \_\_\_\_\_
- Intravenous drug users \_\_\_\_\_
- Haitians (recent immigrants) \_\_\_\_\_
- Homosexually contacts \_\_\_\_\_
- Hemophiliacs \_\_\_\_\_
- "Other", unspecified \_\_\_\_\_

9. AIDS victims have been shown to carry a high concentration of the organism in their saliva and tears. T F

10. ARC is an abbreviation for: \_\_\_\_\_

11. ARC may be defined as:

- a. conditions seen with increased frequency in high risk populations for AIDS, but which don't meet the criteria for AIDS.
- b. conditions signalling the onset of AIDS.
- c. a cluster of symptoms which appear in the later states of AIDS.
- d. none of the above.

12. There are no documented cases of AIDS contracted by giving CPR. T F

13. What precautions should you take when giving CPR or First Aids.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

14. There is no proven care for AIDS? T F

## **APPENDIX E**

### **CDC Guidelines for Health-Care Workers and Guidelines for Preventing Transmission of HTLV-III Infection in the Workplace**

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From "Reports on AIDS," Published in the  
Morbidity and Mortality Weekly Report,  
June 1981 through September 1985

Department of Health and Human Services  
Public Health Service  
Centers for Disease Control  
Atlanta, Georgia

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1982 Nov 5;31:577-80

**Acquired Immune Deficiency Syndrome (AIDS):  
Precautions for Clinical and Laboratory Staffs**

The etiology of the underlying immune deficiencies seen in AIDS cases is unknown. One hypothesis consistent with current observations is that a transmissible agent may be involved. If so, transmission of the agent would appear most commonly to require intimate, direct contact involving mucosal surfaces, such as sexual contact among homosexual males, or through parenteral spread, such as occurs among intravenous drug abusers and possibly hemophilia patients using Factor VIII products. Airborne spread and interpersonal spread through casual contact do not seem likely. These patterns resemble the distribution of disease and modes of spread of hepatitis B virus, and hepatitis B virus infections occur very frequently among AIDS cases.

There is presently no evidence of AIDS transmission to hospital personnel from contact with affected patients or clinical specimens. Because of concern about a possible transmissible agent, however, interim suggestions are appropriate to guide patient-care and laboratory personnel, including those whose work involves experimental animals. At present, it appears

prudent for hospital personnel to use the same precautions when caring for patients with AIDS as those used for patients with hepatitis B virus infection, in which blood and body fluids likely to have been contaminated with blood are considered infective. Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin and mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS. The following precautions do not specifically address out-patient care, dental care, surgery, necropsy, or hemodialysis of AIDS patients. In general, procedures appropriate for patients known to be infected with hepatitis B virus are advised, and blood and organs of AIDS patients should not be donated.

The precautions that follow are advised for persons and specimens from persons with: opportunistic infections that are not associated with underlying immunosuppressive disease or therapy; Kaposi's sarcoma (patients under 60 years of age); chronic generalized lymphadenopathy, unexplained weight loss and/or prolonged unexplained fever in persons who belong to groups with apparently increased risks of AIDS (homosexual males, intravenous drug abusers, Haitian entrants, hemophiliacs); and possible AIDS (hospitalized for evaluation). Hospitals and laboratories should adapt the following suggested precautions to their individual circumstances; these recommendations are not meant to restrict hospitals from implementing additional precautions.

- A. The following precautions are advised in providing care to AIDS patients:
1. Extraordinary care must be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material and to avoid contact of open skin lesions with material from AIDS patients.
  2. Gloves should be worn when handling blood specimens, blood-soiled items, body fluids, excretions, and secretions, as well as surfaces, materials, and objects exposed to them.
  3. Gowns should be worn when clothing may be soiled with body fluids, blood, secretions, or excretions.
  4. Hands should be washed after removing gowns and gloves and before leaving the rooms of known or suspected AIDS patients. Hands should also be washed thoroughly and immediately if they become contaminated with blood.
  5. Blood and other specimens should be labeled prominently with a special warning, such as "Blood Precautions" or "AIDS Precautions." If the outside of the specimen container is visibly contaminated with blood, it should be cleaned with a disinfectant (such as a 1:10 dilution of 5.25% sodium hypochlorite [household bleach] with water). All blood specimens should be placed in a second container, such as an impervious bag, for transport. The container or bag should be examined carefully for leaks or cracks.
  6. Blood spills should be cleaned up promptly with a disinfectant solution, such as sodium hypochlorite (see above).
  7. Articles soiled with blood should be placed in an impervious bag prominently labeled "AIDS Precautions" or "Blood Precautions" before being sent for reprocessing or disposal. Alternatively, such contaminated items may be placed in plastic bags of a particular color designated solely for disposal of infectious wastes by the hospital. Disposable items should be incinerated or disposed of in accord with the hospital's policies for disposal of infectious wastes. Reusable items should be reprocessed in accord with hospital policies for hepatitis B virus-contaminated items. Lensed instruments should be sterilized after use on AIDS patients.
  8. Needles should not be bent after use, but should be promptly placed in a puncture-resistant container used solely for such disposal. Needles should not be reinserted into their original sheaths before being discarded into the container, since this is a common cause of needle injury.
  9. Disposable syringes and needles are preferred. Only needle-locking syringes or one-piece needle-syringe units should be used to aspirate fluids from patients, so that collected fluid can be safely discharged through the needle, if desired. If reusable syringes are employed, they should be decontaminated before reprocessing.
  10. A private room is indicated for patients who are too ill to use good hygiene, such as those with profuse diarrhea, fecal incontinence, or altered behavior secondary to central nervous system infections.

Precautions appropriate for particular infections that concurrently occur in AIDS patients should be added to the above, if needed.

- B. The following precautions are advised for persons performing laboratory tests or studies on clinical specimens or other potentially infectious materials (such as inoculated tissue

cultures, embryonated eggs, animal tissues, etc.) from known or suspected AIDS cases:

1. Mechanical pipetting devices should be used for the manipulation of all liquids in the laboratory. Mouth pipetting should not be allowed.
2. Needles and syringes should be handled as stipulated in Section A (above).
3. Laboratory coats, gowns, or uniforms should be worn while working with potentially infectious materials and should be discarded appropriately before leaving the laboratory.
4. Gloves should be worn to avoid skin contact with blood, specimens containing blood, blood-soiled items, body fluids, excretions, and secretions, as well as surfaces, materials, and objects exposed to them.
5. All procedures and manipulations of potentially infectious material should be performed carefully to minimize the creation of droplets and aerosols.
6. Biological safety cabinets (Class I or II) and other primary containment devices (e.g., centrifuge safety cups) are advised whenever procedures are conducted that have a high potential for creating aerosols or infectious droplets. These include centrifuging, blending, sonicating, vigorous mixing, and harvesting infected tissues from animals or embryonated eggs. Fluorescent activated cell sorters generate droplets that could potentially result in infectious aerosols. Translucent plastic shielding between the droplet-collecting area and the equipment operator should be used to reduce the presently uncertain magnitude of this risk. Primary containment devices are also used in handling materials that might contain concentrated infectious agents or organisms in greater quantities than expected in clinical specimens.
7. Laboratory work surfaces should be decontaminated with a disinfectant, such as sodium hypochlorite solution (see A5 above), following any spill of potentially infectious material and at the completion of work activities.
8. All potentially contaminated materials used in laboratory tests should be decontaminated, preferably by autoclaving, before disposal or reprocessing.
9. All personnel should wash their hands following completion of laboratory activities, removal of protective clothing, and before leaving the laboratory.

C. The following additional precautions are advised for studies involving experimental animals inoculated with tissues or other potentially infectious materials from individuals with known or suspected AIDS.

1. Laboratory coats, gowns, or uniforms should be worn by personnel entering rooms housing inoculated animals. Certain nonhuman primates, such as chimpanzees, are prone to throw excreta and to spit at attendants; personnel attending inoculated animals should wear molded surgical masks and goggles or other equipment sufficient to prevent potentially infective droplets from reaching the mucosal surfaces of their mouths, nares, and eyes. In addition, when handled, other animals may disturb excreta in their bedding. Therefore, the above precautions should be taken when handling them.
2. Personnel should wear gloves for all activities involving direct contact with experimental animals and their bedding and cages. Such manipulations should be performed carefully to minimize the creation of aerosols and droplets.
3. Necropsy of experimental animals should be conducted by personnel wearing gowns and gloves. If procedures generating aerosols are performed, masks and goggles should be worn.
4. Extraordinary care must be taken to avoid accidental sticks or cuts with sharp instruments contaminated with body fluids or tissues of experimental animals inoculated with material from AIDS patients.
5. Animal cages should be decontaminated, preferably by autoclaving, before they are cleaned and washed.
6. Only needle-locking syringes or one-piece needle-syringe units should be used to inject potentially infectious fluids into experimental animals.

The above precautions are intended to apply to both clinical and research laboratories. Biological safety cabinets and other safety equipment may not be generally available in clinical laboratories. Assistance should be sought from a microbiology laboratory, as needed, to assure containment facilities are adequate to permit laboratory tests to be conducted safely.

*Reported by Hospital Infections Program, Div of Viral Diseases, Div of Host Factors, Div of Hepatitis and Viral Enteritis, AIDS Activity, Center for Infectious Diseases, Office of Biosafety, CDC; Div of Safety, National Institutes of Health.*

# M M W R

MORBIDITY AND MORTALITY WEEKLY REPORT

- 681 Summary: Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace
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## Current Trends

### **Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace**

The information and recommendations contained in this document have been developed with particular emphasis on health-care workers and others in related occupations in which exposure might occur to blood from persons infected with HTLV-III/LAV, the "AIDS virus." Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and those preparing and serving food and beverages, this document also addresses personal-service and food-service workers. Finally, it addresses "other workers"—persons in settings, such as offices, schools, factories, and construction sites, where there is no known risk of AIDS virus transmission.

Because AIDS is a bloodborne, sexually transmitted disease that is not spread by casual contact, this document does *not* recommend routine HTLV-III/LAV antibody screening for the groups addressed. Because AIDS is not transmitted through preparation or serving of food and beverages, these recommendations state that food-service workers known to be infected with AIDS should not be restricted from work unless they have another infection or illness for which such restriction would be warranted.

This document contains detailed recommendations for precautions appropriate to prevent transmission of all bloodborne infectious diseases to people exposed—in the course of their duties—to blood from persons who may be infected with HTLV-III/LAV. They emphasize that health-care workers should take all possible precautions to prevent needlestick injury. The recommendations are based on the well-documented modes of HTLV-III/LAV transmission and incorporate a "worst case" scenario, the hepatitis B model of transmission. Because the hepatitis B virus is also bloodborne and is both harder and more infectious than HTLV-III/LAV, recommendations that would prevent transmission of hepatitis B will also prevent transmission of AIDS.

Formulation of specific recommendations for health-care workers who perform invasive procedures is in progress.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES / PUBLIC HEALTH SERVICE

### Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace

Persons at increased risk of acquiring infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS), include homosexual and bisexual men, intravenous (IV) drug abusers, persons transfused with contaminated blood or blood products, heterosexual contacts of persons with HTLV-III/LAV infection, and children born to infected mothers. HTLV-III/LAV is transmitted through sexual contact, parenteral exposure to infected blood or blood components, and perinatal transmission from mother to neonate. HTLV-III/LAV has been isolated from blood, semen, saliva, tears, breast milk, and urine and is likely to be isolated from some other body fluids, secretions, and excretions, but epidemiologic evidence has implicated only blood and semen in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III/LAV.

As in the development of any such recommendations, the paramount consideration is the protection of the public's health. The following recommendations have been developed for all workers, particularly workers in occupations in which exposure might occur to blood from individuals infected with HTLV-III/LAV. These recommendations reinforce and supplement the specific recommendations that were published earlier for clinical and laboratory staffs (1) and for dental-care personnel and persons performing necropsies and morticians' services (2). Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and by food and beverages, these recommendations contain information and recommendations for personal-service and food-service workers. Finally, these recommendations address workplaces in general where there is no known risk of transmission of HTLV-III/LAV (e.g., offices, schools, factories, construction sites). Formulation of specific recommendations for health-care workers (HCWs) who perform invasive procedures (e.g., surgeons, dentists) is in progress. Separate recommendations are also being developed to prevent HTLV-III/LAV transmission in prisons, other correctional facilities, and institutions housing individuals who may exhibit uncontrollable behavior (e.g., custodial institutions) and in the perinatal setting. In addition, separate recommendations have already been developed for children in schools and day-care centers (3).

HTLV-III/LAV-infected individuals include those with AIDS (4); those diagnosed by their physician(s) as having other illnesses due to infection with HTLV-III/LAV; and those who have virologic or serologic evidence of infection with HTLV-III/LAV but who are not ill.

These recommendations are based on the well-documented modes of HTLV-III/LAV transmission identified in epidemiologic studies and on comparison with the hepatitis B experience. Other recommendations are based on the hepatitis B model of transmission.

#### COMPARISON WITH THE HEPATITIS B VIRUS EXPERIENCE

The epidemiology of HTLV-III/LAV infection is similar to that of hepatitis B virus (HBV) infection, and much that has been learned over the last 15 years related to the risk of acquiring hepatitis B in the workplace can be applied to understanding the risk of HTLV-III/LAV transmission in the health-care and other occupational settings. Both viruses are transmitted through

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sexual contact, parenteral exposure to contaminated blood or blood products, and perinatal transmission from infected mothers to their offspring. Thus, some of the same major groups at high risk for HBV infection (e.g., homosexual men, IV drug abusers, persons with hemophilia, infants born to infected mothers) are also the groups at highest risk for HTLV-III/LAV infection. Neither HBV nor HTLV-III/LAV has been shown to be transmitted by casual contact in the workplace, contaminated food or water, or airborne or fecal-oral routes (5).

HBV infection is an occupational risk for HCWs, but this risk is related to degree of contact with blood or contaminated needles. HCWs who do not have contact with blood or needles contaminated with blood are not at risk for acquiring HBV infection in the workplace (6-8).

In the health-care setting, HBV transmission has not been documented between hospitalized patients, except in hemodialysis units, where blood contamination of the environment has been extensive or where HBV-positive blood from one patient has been transferred to another patient through contamination of instruments. Evidence of HBV transmission from HCWs to patients has been rare and limited to situations in which the HCWs exhibited high concentrations of virus in their blood (at least 100,000,000 infectious virus particles per ml of serum), and the HCWs sustained a puncture wound while performing traumatic procedures on patients or had exudative or weeping lesions that allowed virus to contaminate instruments or open wounds of patients (9-11).

Current evidence indicates that, despite epidemiologic similarities of HBV and HTLV-III/LAV infection, the risk for HBV transmission in health-care settings far exceeds that for HTLV-III/LAV transmission. The risk of acquiring HBV infection following a needlestick from an HBV carrier ranges from 6% to 30% (12,13), far in excess of the risk of HTLV-III/LAV infection following a needlestick involving a source patient infected with HTLV-III/LAV, which is less than 1%. In addition, all HCWs who have been shown to transmit HBV infection in health-care settings have belonged to the subset of chronic HBV carriers who, when tested, have exhibited evidence of exceptionally high concentrations of virus (at least 100,000,000 infectious virus particles per ml) in their blood. Chronic carriers who have substantially lower concentrations of virus in their blood have not been implicated in transmission in the health-care setting (9-11,14). The HBV model thus represents a "worst case" condition in regard to transmission in health-care and other related settings. Therefore, recommendations for the control of HBV infection should, if followed, also effectively prevent spread of HTLV-III/LAV. Whether additional measures are indicated for those HCWs who perform invasive procedures will be addressed in the recommendations currently being developed.

Routine screening of all patients or HCWs for evidence of HBV infection has never been recommended. Control of HBV transmission in the health-care setting has emphasized the implementation of recommendations for the appropriate handling of blood, other body fluids, and items soiled with blood or other body fluids.

**TRANSMISSION FROM PATIENTS TO HEALTH-CARE WORKERS**

HCWs include, but are not limited to, nurses, physicians, dentists and other dental workers, optometrists, podiatrists, chiropractors, laboratory and blood bank technologists and technicians, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers, and others whose work involves contact with patients, their blood or other body fluids, or corpses.

Recommendations for HCWs emphasize precautions appropriate for preventing transmission of bloodborne infectious diseases, including HTLV-III/LAV and HBV infections. Thus, these precautions should be enforced routinely, as should other standard infection-control precautions, regardless of whether HCWs or patients are known to be infected with HTLV-III/LAV or HBV. In addition to being informed of these precautions, all HCWs, including students

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and housestaff, should be educated regarding the epidemiology, modes of transmission, and prevention of HTLV-III/LAV infection.

**Risk of HCWs acquiring HTLV-III/LAV in the workplace.** Using the HBV model, the highest risk for transmission of HTLV-III/LAV in the workplace would involve parenteral exposure to a needle or other sharp instrument contaminated with blood of an infected patient. The risk to HCWs of acquiring HTLV-III/LAV infection in the workplace has been evaluated in several studies. In five separate studies, a total of 1,498 HCWs have been tested for antibody to HTLV-III/LAV. In these studies, 666 (44.5%) of the HCWs had direct parenteral (needlestick or cut) or mucous membrane exposure to patients with AIDS or HTLV-III/LAV infection. Most of these exposures were to blood rather than to other body fluids. None of the HCWs whose initial serologic tests were negative developed subsequent evidence of HTLV-III/LAV infection following their exposures. Twenty-six HCWs in these five studies were seropositive when first tested; all but three of these persons belonged to groups recognized to be at increased risk for AIDS (15). Since one was tested anonymously, epidemiologic information was available on only two of these three seropositive HCWs. Although these two HCWs were reported as probable occupationally related HTLV-III/LAV infection (15,16), neither had a preexposure nor an early postexposure serum sample available to help determine the onset of infection. One case reported from England describes a nurse who seroconverted following an accidental parenteral exposure to a needle contaminated with blood from an AIDS patient (17).

In spite of the extremely low risk of transmission of HTLV-III/LAV infection, even when needlestick injuries occur, more emphasis must be given to precautions targeted to prevent needlestick injuries in HCWs caring for any patient, since such injuries continue to occur even during the care of patients who are known to be infected with HTLV-III/LAV.

**Precautions to prevent acquisition of HTLV-III/LAV infection by HCWs in the workplace.** These precautions represent prudent practices that apply to preventing transmission of HTLV-III/LAV and other bloodborne infections and should be used routinely (18).

1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.
2. Disposable syringes and needles, scalpel blades, and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
3. When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.
4. To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.
5. Pregnant HCWs are not known to be at greater risk of contracting HTLV-III/LAV infections than HCWs who are not pregnant; however, if a HCW develops HTLV-III/LAV infection during pregnancy, the infant is at increased risk of infection resulting from

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perinatal transmission. Because of this risk, pregnant HCWs should be especially familiar with precautions for the preventing HTLV-III/LAV transmission (19).

**Precautions for HCWs during home care of persons infected with HTLV-III/LAV.** Persons infected with HTLV-III/LAV can be safely cared for in home environments. Studies of family members of patients infected with HTLV-III/LAV have found no evidence of HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to children who were not at risk for perinatal transmission (3). HCWs providing home care face the same risk of transmission of infection as HCWs in hospitals and other health-care settings, especially if there are needlesticks or other parenteral or mucous membrane exposures to blood or other body fluids.

When providing health-care service in the home to persons infected with HTLV-III/LAV, measures similar to those used in hospitals are appropriate. As in the hospital, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand. Needles and other sharp items should be placed into puncture-resistant containers and disposed of in accordance with local regulations for solid waste. Blood and other body fluids can be flushed down the toilet. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy (not easily penetrated). It should be placed in a second bag before being discarded in a manner consistent with local regulations for solid waste disposal. Spills of blood or other body fluids should be cleaned with soap and water or a household detergent. As in the hospital, individuals cleaning up such spills should wear disposable gloves. A disinfectant solution or a freshly prepared solution of sodium hypochlorite (household bleach, see below) should be used to wipe the area after cleaning.

**Precautions for providers of prehospital emergency health care.** Providers of prehospital emergency health care include the following: paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards, and others whose job might require them to provide first-response medical care. The risk of transmission of infection, including HTLV-III/LAV infection, from infected persons to providers of prehospital emergency health care should be no higher than that for HCWs providing emergency care in the hospital if appropriate precautions are taken to prevent exposure to blood or other body fluids.

Providers of prehospital emergency health care should follow the precautions outlined above for other HCWs. No transmission of HBV infection during mouth-to-mouth resuscitation has been documented. However, because of the theoretical risk of salivary transmission of HTLV-III/LAV during mouth-to-mouth resuscitation, special attention should be given to the use of disposable airway equipment or resuscitation bags and the wearing of gloves when in contact with blood or other body fluids. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use.

**Management of parenteral and mucous membrane exposures of HCWs.** If a HCW has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III/LAV infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III/LAV infection. If the source patient has AIDS or other evidence of HTLV-III/LAV infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV-III/LAV infection as soon as possible after the exposure, and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6, and 12 months following exposure) to determine if

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transmission has occurred. During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed HCWs should receive counseling about the risk of infection and follow U.S. Public Health Service (PHS) recommendations for preventing transmission of AIDS (20,21). If the source patient is seronegative and has no other evidence of HTLV-III/LAV infection, no further follow-up of the HCW is necessary. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected.

**Serologic testing of patients.** Routine serologic testing of all patients for antibody to HTLV-III/LAV is not recommended to prevent transmission of HTLV-III/LAV infection in the workplace. Results of such testing are unlikely to further reduce the risk of transmission, which, even with documented needlesticks, is already extremely low. Furthermore, the risk of needlestick and other parenteral exposures could be reduced by emphasizing and more consistently implementing routinely recommended infection-control precautions (e.g., not recapping needles). Moreover, results of routine serologic testing would not be available for

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emergency cases and patients with short lengths of stay, and additional tests to determine whether a positive test was a true or false positive would be required in populations with a low prevalence of infection. However, this recommendation is based only on considerations of occupational risks and should not be construed as a recommendation against other uses of the serologic test, such as for diagnosis or to facilitate medical management of patients. Since the experience with infected patients varies substantially among hospitals (75% of all AIDS cases have been reported by only 280 of the more than 6,000 acute-care hospitals in the United States), some hospitals in certain geographic areas may deem it appropriate to initiate serologic testing of patients.

**TRANSMISSION FROM HEALTH-CARE WORKERS TO PATIENTS**

**Risk of transmission of HTLV-III/LAV infection from HCWs to patients.** Although there is no evidence that HCWs infected with HTLV-III/LAV have transmitted infection to patients, a risk of transmission of HTLV-III/LAV infection from HCWs to patients would exist in situations where there is both (1) a high degree of trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected HCW to the open tissue of a patient, as could occur if the HCW sustains a needlestick or scalpel injury during an invasive procedure. HCWs known to be infected with HTLV-III/LAV who do not perform invasive procedures need not be restricted from work unless they have evidence of other infection or illness for which any HCW should be restricted. Whether additional restrictions are indicated for HCWs who perform invasive procedures is currently being considered.

**Precautions to prevent transmission of HTLV-III/LAV infection from HCWs to patients.** These precautions apply to all HCWs, regardless of whether they perform invasive procedures: (1) All HCWs should wear gloves for direct contact with mucous membranes or nonintact skin of all patients and (2) HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

**Management of parenteral and mucous membrane exposures of patients.** If a patient has a parenteral or mucous membrane exposure to blood or other body fluids of a HCW, the patient should be informed of the incident and the same procedure outlined above for exposures of HCWs to patients should be followed for both the source HCW and the potentially exposed patient. Management of this type of exposure will be addressed in more detail in the recommendations for HCWs who perform invasive procedures.

**Serologic testing of HCWs.** Routine serologic testing of HCWs who do not perform invasive procedures (including providers of home and prehospital emergency care) is not recommended to prevent transmission of HTLV-III/LAV infection. The risk of transmission is extremely low and can be further minimized when routinely recommended infection-control precautions are followed. However, serologic testing should be available to HCWs who may wish to know their HTLV-III/LAV infection status. Whether indications exist for serologic testing of HCWs who perform invasive procedures is currently being considered.

**Risk of occupational acquisition of other infectious diseases by HCWs infected with HTLV-III/LAV.** HCWs who are known to be infected with HTLV-III/LAV and who have defective immune systems are at increased risk of acquiring or experiencing serious complications of other infectious diseases. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., tuberculosis). HCWs infected with HTLV-III/LAV should be counseled about the potential risk associated with taking care of patients with transmissible infections and should continue to follow existing recommendations for infection control to minimize

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their risk of exposure to other infectious agents (18,19). The HCWs' personal physician(s), in conjunction with their institutions' personnel health services or medical directors, should determine on an individual basis whether the infected HCWs can adequately and safely perform patient-care duties and suggest changes in work assignments, if indicated. In making this determination, recommendations of the Immunization Practices Advisory Committee and institutional policies concerning requirements for vaccinating HCWs with live-virus vaccines should also be considered.

**STERILIZATION, DISINFECTION, HOUSEKEEPING, AND WASTE DISPOSAL TO PREVENT TRANSMISSION OF HTLV-III/LAV**

Sterilization and disinfection procedures currently recommended for use (22,23) in health-care and dental facilities are adequate to sterilize or disinfect instruments, devices, or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III/LAV. Instruments or other nondisposable items that enter normally sterile tissue or the vascular system or through which blood flows should be sterilized before reuse. Surgical instruments used on all patients should be decontaminated after use rather than just rinsed with water. Decontamination can be accomplished by machine or by hand cleaning by trained personnel wearing appropriate protective attire (24) and using appropriate chemical germicides. Instruments or other nondisposable items that touch intact mucous membranes should receive high-level disinfection.

Several liquid chemical germicides commonly used in laboratories and health-care facilities have been shown to kill HTLV-III/LAV at concentrations much lower than are used in practice (25). When decontaminating instruments or medical devices, chemical germicides that are registered with and approved by the U.S. Environmental Protection Agency (EPA) as "sterilants" can be used either for sterilization or for high-level disinfection depending on contact time; germicides that are approved for use as "hospital disinfectants" and are mycobactericidal when used at appropriate dilutions can also be used for high-level disinfection of devices and instruments. Germicides that are mycobactericidal are preferred because mycobacteria represent one of the most resistant groups of microorganisms; therefore, germicides that are effective against mycobacteria are also effective against other bacterial and viral pathogens. When chemical germicides are used, instruments or devices to be sterilized or disinfected should be thoroughly cleaned before exposure to the germicide, and the manufacturer's instructions for use of the germicide should be followed.

Laundry and dishwashing cycles commonly used in hospitals are adequate to decontaminate linens, dishes, glassware, and utensils. When cleaning environmental surfaces, housekeeping procedures commonly used in hospitals are adequate; surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C., 20460.

In addition to hospital disinfectants, a freshly prepared solution of sodium hypochlorite (household bleach) is an inexpensive and very effective germicide (25). Concentrations ranging from 5,000 ppm (a 1:10 dilution of household bleach) to 500 ppm (a 1:100 dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g., blood, mucus, etc.) present on the surface to be cleaned and disinfected.

Sharp items should be considered as potentially infective and should be handled and disposed of with extraordinary care to prevent accidental injuries. Other potentially infective waste should be contained and transported in clearly identified impervious plastic bags. If the

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outside of the bag is contaminated with blood or other body fluids, a second outer bag should be used. Recommended practices for disposal of infective waste (23) are adequate for disposal of waste contaminated by HTLV-III/LAV. Blood and other body fluids may be carefully poured down a drain connected to a sanitary sewer.

**CONSIDERATIONS RELEVANT TO OTHER WORKERS**

**Personal-service workers (PSWs).** PSWs are defined as individuals whose occupations involve close personal contact with clients (e.g., hairdressers, barbers, estheticians, cosmetologists, manicurists, pedicurists, massage therapists). PSWs whose services (tattooing, ear piercing, acupuncture, etc.) require needles or other instruments that penetrate the skin should follow precautions indicated for HCWs. Although there is no evidence of transmission of HTLV-III/LAV from clients to PSWs, from PSWs to clients, or between clients of PSWs, a risk of transmission would exist from PSWs to clients and vice versa in situations where there is both (1) trauma to one of the individuals that would provide a portal of entry for the virus and (2) access of blood or serous fluid from one infected person to the open tissue of the other, as could occur if either sustained a cut. A risk of transmission from client to client exists when instruments contaminated with blood are not sterilized or disinfected between clients. However, HBV transmission has been documented only rarely in acupuncture, ear piercing, and tattoo establishments and never in other personal-service settings, indicating that any risk for HTLV-III/LAV transmission in personal-service settings must be extremely low.

All PSWs should be educated about transmission of bloodborne infections, including HTLV-III/LAV and HBV. Such education should emphasize principles of good hygiene, antiseptics, and disinfection. This education can be accomplished by national or state professional organizations, with assistance from state and local health departments, using lectures at meetings or self-instructional materials. Licensure requirements should include evidence of such education. Instruments that are intended to penetrate the skin (e.g., tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or be thoroughly cleaned and sterilized after each use using procedures recommended for use in health-care institutions. Instruments not intended to penetrate the skin but which may become contaminated with blood (e.g., razors), should be used for only one client and be disposed of or thoroughly cleaned and disinfected after use using procedures recommended for use in health-care institutions. Any PSW with exudative lesions or weeping dermatitis, regardless of HTLV-III/LAV infection status, should refrain from direct contact with clients until the condition resolves. PSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infections or illnesses for which any PSW should also be restricted.

Routine serologic testing of PSWs for antibody to HTLV-III/LAV is not recommended to prevent transmission from PSWs to clients.

**Food-service workers (FSWs).** FSWs are defined as individuals whose occupations involve the preparation or serving of food or beverages (e.g., cooks, caterers, servers, waiters, bartenders, airline attendants). All epidemiologic and laboratory evidence indicates that bloodborne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages, and no instances of HBV or HTLV-III/LAV transmission have been documented in this setting.

All FSWs should follow recommended standards and practices of good personal hygiene and food sanitation (26). All FSWs should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded. FSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infection or illness for which any FSW should also be restricted.

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Routine serologic testing of FSWs for antibody to HTLV-III/LAV is not recommended to prevent disease transmission from FSWs to consumers.

**Other workers sharing the same work environment.** No known risk of transmission to co-workers, clients, or consumers exists from HTLV-III/LAV-infected workers in other settings (e.g., offices, schools, factories, construction sites). This infection is spread by sexual contact with infected persons, injection of contaminated blood or blood products, and by perinatal transmission. Workers known to be infected with HTLV-III/LAV should not be restricted from work solely based on this finding. Moreover, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HTLV-III/LAV infection status, should be cleaned with soap and water or a detergent. A disinfectant solution or a fresh solution of sodium hypochlorite (household bleach, see above) should be used to wipe the area after cleaning.

**OTHER ISSUES IN THE WORKPLACE**

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III/LAV infection. The diagnosis of HTLV-III/LAV infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

**DEVELOPMENT OF THESE RECOMMENDATIONS**

The information and recommendations contained in these recommendations were developed and compiled by CDC and other PHS agencies in consultation with individuals representing various organizations. The following organizations were represented: Association of State and Territorial Health Officials, Conference of State and Territorial Epidemiologists, Association of State and Territorial Public Health Laboratory Directors, National Association of County Health Officials, American Hospital Association, United States Conference of Local Health Officers, Association for Practitioners in Infection Control, Society of Hospital Epidemiologists of America, American Dental Association, American Medical Association, American Nurses' Association, American Association of Medical Colleges, American Association of Dental Schools, National Institutes of Health, Food and Drug Administration, Food Research Institute, National Restaurant Association, National Hairdressers and Cosmetologists Association, National Gay Task Force, National Funeral Directors and Morticians Association, American Association of Physicians for Human Rights, and National Association of Emergency Medical Technicians. The consultants also included a labor union representative, an attorney, a corporate medical director, and a pathologist. However, these recommendations may not reflect the views of individual consultants or the organizations they represented.

**References**

1. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. MMWR 1982;31:577-80.
2. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for health-care workers and allied professionals. MMWR 1983;32:450-1.
3. CDC. Education and foster care of children infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1985;34:517-21.
4. CDC. Revision of the case definition of acquired immunodeficiency syndrome for national reporting—United States. MMWR 1985;34:373-5.

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5. CDC. ACIP recommendations for protection against viral hepatitis. *MMWR* 1985;34:313-24, 329-335.
6. Hadler SC, Doto IL, Maynard JE, et al. Occupational risk of hepatitis B infection in hospital workers. *Infect Control* 1985;6:24-31.
7. Dienstag JL, Ryan DM. Occupational exposure to hepatitis B virus in hospital personnel: infection or immunization? *Am J Epidemiol* 1982;115:26-39.
8. Pattison CP, Maynard JE, Berquist KR, et al. Epidemiology of hepatitis B in hospital personnel. *Am J Epidemiol* 1975;101:59-64.
9. Kane MA, Lettau LA. Transmission of HBV from dental personnel to patients. *JADA* 1985;110:634-6.
10. Hadler SC, Sorley DL, Acree KH, et al. An outbreak of hepatitis B in a dental practice. *Ann Intern Med* 1981;95:133-8.
11. Carl M, Blakey DL, Francis DP, Maynard JE. Interruption of hepatitis B transmission by modification of a gynaecologist's surgical technique. *Lancet* 1982;i:731-3.
12. Seeff LB, Wright EC, Zimmerman HJ, et al. Type B hepatitis after needlestick exposure; prevention with hepatitis B immune globulin. *Ann Intern Med* 1978;88:285-93.
13. Grady GF, Lee VA, Prince AM, et al. Hepatitis B immune globulin for accidental exposures among medical personnel: Final report of a multicenter controlled trial. *J Infect Dis* 1978;138:625-38.
14. Shikata T, Karasawa T, Abe K, et al. Hepatitis B e antigen and infectivity of hepatitis B virus. *J Infect Dis* 1977;136:571-6.
15. CDC. Update: evaluation of human T-lymphotropic virus type III/lymphadenopathy-associated virus infection in health-care personnel—United States. *MMWR* 1985;34:575-8.
16. Weiss SH, Saxinger WC, Rechtman D, et al. HTLV-III infection among health care workers: association with needle-stick injuries. *JAMA* 1985;254:2089-93.
17. Anonymous. Needlestick transmission of HTLV-III from a patient infected in Africa. *Lancet* 1984;ii:1376-7.
18. Garner JS, Simmons BP. Guideline for isolation precautions in hospitals. *Infect Control* 1983;4:245-325.
19. Williams WW. Guideline for infection control in hospital personnel. *Infect Control* 1983;4:326-49.
20. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. *MMWR* 1983;32:101-3.
21. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. *MMWR* 1985;34:1-5.
22. Favero MS. Sterilization, disinfection, and antisepsis in the hospital. In: *Manual of Clinical Microbiology*. 4th ed. Washington, D.C.: American Society for Microbiology, 1985;129-37.
23. Garner JS, Favero MS. Guideline for handwashing and hospital environmental control, 1985. Atlanta Georgia: Centers for Disease Control, 1985. Publication no. 99-1117.
24. Kneeder JA, Dodge GH. *Perioperative patient care*. Boston: Blackwell Scientific Publications, 1983: 210-1.
25. Martin LS, McDougal JS, Loskoski SL. Disinfection and inactivation of the human T-lymphotropic virus type III/lymphadenopathy-associated virus. *J Infect Dis* 1985;152:400-3.
26. Food Service Sanitation Manual 1976. DHEW publication no. (FDA) 78-2081. First printing June 1978.

**APPENDIX F**

**Maryland's Expanded History-Taking  
Questionnaire**

AIDS Related Syndrome Questionnaire

Inmate Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_ Interviewer \_\_\_\_\_

**DIRECTIONS:** This form is to be filled out on each new admitted inmate to the Division of Correction. This form is also to be used at sick call when the health care provider suspects the possibility of AIDS.

ASK ALL QUESTIONS VERBATIM

In the last month, have you had any of the following problems or symptoms?

A. How about (EACH)? Did you have that at any time in the past month?

FOR EACH "YES", ASK B AND C:

B. When did it begin?

C. Do you still have that?

PROBLEM OR SYMPTOM	A. HAD IN LAST MONTH		B. WHEN BEGAN Month Year	C. HAVE NOW	
	NO	YES		NO	YES
(1) Persistent shortness of breath for at least 2 weeks.....1		2	____ 19__	1	2
(2) A new or unusual kind of dry cough that lasted 2 weeks or longer.....1		2	____ 19__	1	2
(3) Thrush, Candida or white patches in your mouth or throat for at least two weeks.....1		2	____ 19__	1	2
(4) An unintentional weight loss of at least 10 pounds (unrelated to dieting).....1		2	____ 19__	1	2
(5) Diarrhea for at least two weeks.....1		2	____ 19__	1	2
(6) Persistent or recurring fever higher than 100° for at least two weeks.....1		2	____ 19__	1	2
(7) Tender or enlarged glands or lymph nodes (not counting your groin) for at least two weeks.....1		2	____ 19__	1	2
(8) Sweating at night for at least two weeks.....1		2	____ 19__	1	2

## **APPENDIX G**

**Wisconsin Department of Health and  
Social Services Draft Guidelines  
for Preventing Transmission  
of Infection with HTLV-III  
in Prisons**

Wisconsin Department Of Health And Social Services  
Guidelines For Preventing Transmission Of  
Infection With HTLV-III In Prisons

Purpose

The information and guidelines contained in this document have been developed for correctional staff to assist in the management of inmates infected with human T-cell lymphotropic virus type III (HTLV-III), the virus that causes acquired immunodeficiency syndrome (AIDS). The document is intended to provide overall guidance on preventing the transmission of HTLV-III within the correctional system, as well as protecting the confidentiality of infected inmates and reducing the anxiety and misunderstanding about the disease within the correctional system. In addition, the guidelines address general infection control precautions. Adherence to these policies will also reduce the risk of transmission of other viral and bacterial infections in the correctional setting.

Applicability

The guidelines provided in this document are applicable to all adult and juvenile correctional institutions in Wisconsin under the jurisdiction of the Division of Corrections and all institution staff (correctional and health service unit staff) should become thoroughly familiar with the guidelines. The guidelines address issues specific for the correctional institutions and may not be directly applicable to all situations encountered in community correction programs.

### Background Information On HTLV-III Infections

Acquired immunodeficiency syndrome (AIDS) is a serious communicable disease caused by the human T-cell lymphotropic virus type III (HTLV-III), a virus that alters the body's immune system. As a result of the damage to their immune system caused by HTLV-III, persons with AIDS are susceptible to serious infections ("opportunistic infections") and specific cancers which would not normally be a threat to individuals whose immune system is functioning normally. For the purposes of surveillance, the Centers for Disease Control (CDC) has defined a case of AIDS as an illness moderately indicative of a cellular immune deficiency in a person who has no known reason for having a deficient immune system (i.e., they do not have cancer or are not on immunosuppressive drugs). About 85 percent of the AIDS patients studied have had one or both of two diseases: Pneumocystis carinii pneumonia, a parasitic opportunistic infection of the lungs; and a type of cancer known as Kaposi's sarcoma which usually initially appears as a reddish or blue-violet spot on the surface of the skin or in the mouth. The complete CDC case definition of AIDS is included in Appendix A.

Not all individuals infected with HTLV-III develop AIDS. In fact, most individuals (60 percent) infected with the virus have no symptoms and generally feel well. Approximately 25 percent of infected persons develop persistent symptoms which may include fatigue, fever, loss of appetite and weight, chronic or recurrent diarrhea, night sweats, non-productive cough, shortness of breath, and swollen lymph nodes (lymph glands)--usually in the neck, armpits or groin. In addition, individuals infected with HTLV-III may have altered immune function that may be detected on blood tests (e.g., T-cell

lymphocyte studies). Persons who develop two or more clinical signs or symptoms and two or more laboratory abnormalities related to an HTLV-III infection are classified as having AIDS-Related Complex or ARC (a case definition for ARC is included in Appendix B). Thus, HTLV-III infections represent a spectrum of severity of illness; individuals may be totally symptom-free, have mild signs or symptoms, ARC or the nearly always fatal AIDS. All of these individuals should be considered to be infected with HTLV-III and to be infectious. Progression to AIDS does not always occur. Initial studies have shown that 7-19 percent of persons with HTLV-III infections have developed AIDS; however, because the incubation period (the time of exposure to development of disease) is long (6 months to 5 years and possibly longer) and our experience with this virus is short (the first U.S. cases were diagnosed in 1981), we cannot accurately project the long term consequences and complications of an infection with HTLV-III.

HTLV-III has been isolated from the blood, semen, saliva, tears, urine and breast milk. However, only intimate exposure to blood and semen appear to be associated with transmission of the virus. The evidence to date indicates that casual contact with saliva and tears rarely, if ever, results in transmission of infection. AIDS, ARC and HTLV-III infections are transmitted primarily by sexual contact (homosexual or heterosexual) and by the sharing of blood contaminated needles. Transmission may occur less commonly through transfusions of blood or blood products and from mothers to their babies during pregnancy or during birth. Thus, persons at increased risk of acquiring an HTLV-III infection are sexually active homosexual and bisexual men typically with multiple partners (73 percent of the cases of AIDS), present and past users of intravenous drugs (17 percent), persons with

hemophilia (1 percent), persons who have transfusions with blood or blood products (2 percent), and heterosexual contacts of someone with AIDS or at risk for HTLV-III infections (1 percent). Six percent of AIDS cases could not be placed in one of the identified risk groups. These cases included recent Haitian immigrants and immigrants of other developing countries where AIDS is known to exist, persons who could not be or refused to be interviewed and men who gave histories of sexual contact with female prostitutes.

Casual contact with individuals infected with HTLV-III or persons who are at increased risk for acquiring an HTLV-III infection does not place others at risk for getting the infection. Even in the households of over 15,000 AIDS patients, spread of HTLV-III infection to household contacts has not been detected when the contacts have not been sex partners or have not been infants of infected mothers. Six studies of family members of patients with HTLV-III infection have failed to demonstrate HTLV-III transmission to adults who are not sexual contacts of the infected patients or to older children who are not likely to have been infected during pregnancy or delivery [1-6]. Even non-sexual household contacts of persons with hemophilia who actively and regularly assist in blood product infusions have not developed evidence of HTLV-III infections [7].

Exposure to inmates that are bleeding or who have bitten a staff member should be considered more than casual contact. The highest risk for transmission of HTLV-III to a staff member would involve staff receiving a cut or stick exposure to a needle, knife, or other sharp instrument contaminated with blood from an infected person. However, even among the thousands of health care workers who have cared for the over 15,000 individuals with AIDS, no reported

cases of AIDS have occurred that can be linked to a specific occupational exposure. National studies of 666 health care workers who have inadvertently been exposed to blood or body fluids of AIDS patients (e.g., by accidental needle sticks) have identified only two persons who potentially may have developed an HTLV-III infection through occupational exposure [8]. Both of these cases involved direct inoculation of infected blood via a needle stick injury. Finally, there has not been a single case in which a policeman, paramedic, security officer or prison guard has developed an HTLV-III infection as a result of assisting an AIDS patient or in providing cardiopulmonary resuscitation (CPR). These results suggest that the risk of transmitting infection from an infected person by needle stick injury is probably less than 1 percent, and reveal no evidence of any other mode of spread from cases to attendants despite far more frequent contact with secretions and excretions of infected persons than would generally be expected for correctional staff.

#### HTLV-III And Hepatitis B Infections In Correctional Facilities

The need for institutional control programs to prevent HTLV-III infections depends on two main factors:

1. The likely frequency of sharing of equipment of IV drug abuse and frequency of male homosexual activity among inmates.
2. The prevalence of HTLV-III infections among prisoners.

Transmission requires both the presence of the virus in the prison population and opportunities for spread. The risk of transmission of HTLV-III increases as the frequencies of both factors increase.

Nationally, AIDS cases have been reported from correctional facilities in 12 states. Among the 175 cases reported by November 25, 1985, the largest numbers were reported from New York State (122) and New Jersey (31). These numbers are underestimates, since many inmate cases are not reported as being associated with a correctional facility. The duration of incarceration before onset of AIDS is not known for these cases. In a study reported in 1983 of seven AIDS cases among male inmates of a correctional facility in New York State [9], all cases occurred in persons who were IV drug abusers before incarceration and onsets of AIDS occurred 5-38 months after incarceration. These results suggest, but do not prove, that infections were acquired before incarceration, since these time periods are within the latent periods observed between single known exposures to HTLV-III and onset of AIDS.

Little is known about the prevalence of HTLV-III infections or their transmission in correctional facilities. However, since intravenous drug abuse is an important factor predisposing to both incarceration and HTLV-III infection, a higher proportion of prisoners will be infected with this virus than in the population at large. The prevalence of HTLV-III infections among unincarcerated heterosexual intravenous drug abusers in the U.S. has varied from 2 percent to 59 percent [10, 11]. The prevalence of HTLV-III infections among IV drug abusers in Wisconsin is likely to be low.

A 1979 stratified random sample of 12,000 state prison inmates in the U.S. demonstrated that 30 percent of inmates had ever used heroin and 12 percent had used heroin in the month prior to the crime they had committed [12]. In Wisconsin, two studies estimated that 27 percent of inmates had ever used illicit IV drugs and 9 percent had used heroin in the six months prior to incarceration [13-15]. No definitive data on IV drug use within prisons is available; however, urine drug screenings conducted by the Wisconsin Division of Corrections suggest that IV drug use in the institutions occurs very rarely. The sharing of unsterilized needles used for tattooing may potentially result in the transmission of HTLV-III. Data on the practice of tattooing within the institutions is not available.

Though it is generally recognized that male homosexual activity may occur in association with incarceration, reliable estimates of the frequency of such activity are not available. Homosexual activity in the prisons may be engaged in through consent or coercion, with non-consenting sexual interactions resulting from sexual extortion (the inmate is pressured into paying his indebtedness to another inmate by relinquishing sex) or sexual assault (the inmate is overpowered or threatened with physical injury unless he submits sexually). The few studies that have been completed on homosexual activity in the prison conservatively estimate that 0.5 to 3 percent of inmates incarcerated are subjected to sexual assault, between 9 and 20 percent have been sexually victimized and overall 30 to 40 percent of inmates have had a homosexual experience while incarcerated [16-20]. The percentage of inmates having had a homosexual experience prior to incarceration is not markedly different from that of adult males in the general population. Data specific to the Wisconsin correctional system are not available. [Division of Corrections officials will provide some background information on this issue at the January 9 meeting.]

The epidemiology of HTLV-III infection is similar to that of hepatitis B virus (HBV) infection, and much that has been learned about the risk of acquiring hepatitis B can be applied to understanding the risk of HTLV-III transmission in correctional facilities. Both viruses are transmitted through sexual contact, parenteral (needle stick or cut) exposure to contaminated blood or blood products, and perinatally from infected mothers to their offspring. Thus, some of the same major groups at high risk for HBV infection (e.g., homosexual men, IV drug abusers, persons with hemophilia, infants born to infected mothers) are also the groups at highest risk for HTLV-III infection. Neither HBV nor HTLV-III has been shown to be transmitted by casual contact in the work place, contaminated food or water, or airborne or fecal-oral routes [21].

The prevalence of serologic evidence of HBV infections among male prisoners is high, ranging from 19 to 47 percent in recent studies [13, 22, 23]. The antibody profiles of nearly all of these men indicated that they were immune to HBV, and the prevalence of carriers of the virus was only about 1 percent. A 1983 study of adult male prisoners entering the Wisconsin state prison system identified 1.1 percent of the study participants as carriers of HBV (HBsAg positive) and 19 percent as ever having been infected with HBV (any marker positive) [13]. Transmission of HBV within correctional facilities may be underestimated by the frequency of HBV infections, because inmates at highest risk of exposure to HBV are highly likely to be already immune when incarcerated [23]. Only one outbreak of hepatitis B has been reported from a prison setting [24]. That outbreak was related to plasmaphoresis and drug abuse. Annual seroconversion rates to HBV among prisoners incarcerated for one year have ranged from 0.8 percent [23] to 1.32 percent [25]. All but one

of the five seroconverters observed in these two studies admitted to intravenous drug abuse prior to incarceration.

### Identification And Evaluation

The diagnosis of AIDS and ARC may be established based on a medical history, clinical evaluation and the results of laboratory studies. The development and implementation of protocols for the clinical management and assessment of symptomatic inmates is primarily the responsibility of the Bureau of Correctional Health Services; these protocols are not included in this document. Cases of AIDS and ARC only represent the most severe form of HTLV-III infections; approximately 60 percent of individuals infected with HTLV-III remain asymptomatic. Currently, the only method to identify individuals that have been infected with HTLV-III is through an HTLV-III antibody test. Antibody to HTLV-III in blood specimens may be detected by one of several federally licensed enzyme-linked immunoassay (ELISA) tests. The ELISA test will successfully identify between 93-98 percent of individuals that have had an HTLV-III infection, thus false negative tests will occur. False positive tests may also occur, the magnitude of which depends upon the population group being tested. However, the accuracy of positive test results is greatly improved (false positives almost totally eliminated) by repeating an initially reactive ELISA test several times and by using a different antibody testing method (Western blot) to verify the ELISA test results.

It is important to understand that not all individuals with a positive HTLV-III antibody test result will develop AIDS or ARC. Current scientific data based on studies of individuals at high risk for HTLV-III infections

suggest that 7-19 percent of individuals with a positive HTLV-III antibody will develop AIDS within 2 to 5 years; 25 percent will develop ARC or related conditions and approximately 60 percent will remain asymptomatic. However, the vast majority of individuals with a positive HTLV-III antibody test result remain infected with HTLV-III. The semen and blood and possibly other body fluids of these individuals should be considered to be infective.

Testing of all inmates for antibody to HTLV-III upon admittance or during incarceration is not considered likely to be an important means to prevent spread from prisoners to correctional staff, since the usual, nonsexual contacts between prisoners and correctional staff will not spread infection. However, testing may be useful in preventing transmission of HTLV-III among prisoners by alteration of behavior of tested persons after being counseled on ways to prevent transmission or acquisition of infection. Ideally, all inmates belonging to risk groups for HTLV-III should be able to voluntarily, safely and confidentially seek serologic testing and counseling, and subsequently behave responsibly in accord with the test results. In addition to potentially changing personal sexual behavior, the test results might influence important personal decisions in the life of an inmate, and could assist medical staff of the prison in medically managing the inmate. Knowledge of HTLV-III infection would assist in more rapid, accurate diagnosis and treatment of intercurrent illness, assist in determining the need for prophylaxis following exposure to certain infections such as tuberculosis, serve as a relative contraindication for use of immunosuppressive agents, and contraindicate the donation of blood or organs. Unfortunately these ideals cannot always be achieved in a prison environment. Serologic test information also has more general uses, such as permitting sexual contacts of infected

persons to be identified, tested and counseled. Routine systematic testing of persons at the beginning of custody and perhaps periodically thereafter could be used for surveillance of trends in the incidence of HTLV-III infection and for evaluating the effectiveness of educational and control programs within correctional facilities. Information from testing would also facilitate incident management, since the probable infection status of the person in custody could be established at the time of the incident. However, knowledge that a person in custody was previously uninfected would not obviate the need to ascertain infection status at the time of an incident, and a delay of several days in determining that the person to whom one was exposed was infected would not importantly influence the ability to document seroconversions in exposed persons. Finally, knowledge of infection status at the time of incarceration would permit the assignment of appropriate housing for infected persons likely to engage in behavior that might pose a risk of transmission to others.

There are potentially serious complications deriving from the serologic testing of prisoners, regardless of the purposes for which testing was performed. If individually identifiable results of such tests could not be kept confidential in correctional settings, and if the lives of infected prisoners would be endangered by violent acts of other prisoners, total separation of infected from uninfected prisoners would be needed. Such total separation of prisoners from each other (totally separate cells, dining halls, and indoor and outdoor recreational facilities), though imposed for safety purposes, could nonetheless prevent transmission without requiring behavior changes of prisoners. If infected prisoners were not completely separated from uninfected prisoners, tests would need to be repeated periodically on

those who were uninfected. Knowledge that a person in custody was infected might also lead some correctional staff to the unwarranted neglect of activities affecting the welfare of the person in custody, and, even if the correctional facility could segregate, it might be difficult to identify correctional staff who would be willing to work with infected prisoners.

Even if routine serologic screening is not performed, the proportion of prisoners who are aware of their HTLV-III infection status, or with medical records reflecting such a status, at the time they are incarcerated is likely to increase greatly over the next several years as serologic testing becomes more widely used in public health prevention programs.

Thus, if confidentiality of test results cannot be maintained in prison environments, routine testing on admission should only be performed if the safety of infected inmates can be guaranteed, which may require separate facilities for infected inmates.

#### Support Services

Providing optimal care for persons diagnosed as having AIDS, ARC or an HTLV-III infection or persons who are at risk for an HTLV-III infection requires having appropriate referral and social/psychological support services available. Persons with these diagnoses are generally anxious and may have special psychological as well as medical needs. Being able to offer services directed at fulfilling these special needs is an important aspect in the comprehensive treatment and care of infected persons.

Members of groups at highest risk for HTLV-III/LAV infections are common in prison populations and, if tests are not performed while incarcerated, testing should be offered to high risk persons at the time of release into society. This would permit infected persons to be counseled regarding precautions and responsibilities to prevent spread to others, and uninfected risk group members to be counseled about how to remain uninfected. Such programs should be jointly developed by public health officials and correctional authorities.

#### Education Of Staff And Inmates

A comprehensive educational effort directed at the correctional staff and inmates is an important aspect of preventing transmission of infections and in reducing the anxiety and misunderstanding about the potential for transmission of infectious agents within the institution. Although educational initiatives need to address communicable diseases in general, specific emphasis should be directed at AIDS and HTLV-III infections. The goal of such an education plan is to combat fear that is based on misinformation or lack of information and to minimize the risk of transmission of HTLV-III by promoting good health practices, including routine use of infection control precautions and eliminating high risk behaviors. Thus, staff and inmates need to be provided with information regarding the signs and symptoms of HTLV-III infections, the methods of transmission of the virus and preventive measures.

#### Legal Issues

Policies regarding the management of inmates infected with HTLV-III must consider current Wisconsin statutes pertaining to the confidentiality of HTLV-III antibody test results (Wis. Stat. 146.025) and the Department of

Health and Social Service's (DH&SS) responsibility for the administration of the prison system and its duty to provide health services to inmates (Wis. Stats. 46.03 (1) and 53.385). Within the prison context, there are three major issues of concern:

1. Providing blood tests for HTLV-III antibody.
2. Access to medical records; specifically, access to HTLV-III antibody test results.
3. Housing of inmates infected with HTLV-III.

A discussion of each issue follows:

Providing blood tests for HTLV-III antibody. Wisconsin statute 146.025 describes the conditions under which an individual may be tested for antibody to HTLV-III and to whom the test results may be disclosed. This statute would apply to any inmate in the correctional system and any proposed HTLV-III antibody testing protocol.

Specifically, "no health care provider...may subject a person to a test for the presence of antibody to HTLV-III unless the subject of the test first provides informed consent for testing...The results of a test for the presence of antibody to HTLV-III may be disclosed only to the following persons or under the following circumstances [only those circumstances related to the prison setting are listed here]...

1. To the subject of the test.
2. To the test subject's health care provider, including those instances in which a health care provider provides emergency care to the subject.
3. To an agent or employee of the test subject's health care provider who provides patient care or handles or processes specimens of body fluids or tissues...
6. To the state epidemiologist...
8. To health care facility staff committees or accreditation or health care services review organizations for the purposes of conducting program monitoring and evaluation and health care services reviews.
9. Under a lawful order of a court of record."

The statute also requires the mandatory reporting of positive test results for antibody to HTLV-III to the state epidemiologist. Finally the statute provides for significant civil and criminal penalties for negligent or intentional violation of provisions of the statute. Any person violating the specified testing and disclosure provisions "is liable to the subject of the test for actual damages and costs, plus exemplary damages of up to \$1,000 for a negligent violation and up to \$5,000 for an intentional violation. Whoever intentionally discloses the results of a blood test in violation...[of the

statute provisions] and thereby causes bodily harm or psychological harm to the test subject may be fined not more than \$10,000 or imprisoned not more than 9 months or both."

The discussion above specifically relates to disclosure of HTLV-III antibody test results. Restrictions pertaining to the disclosure of the fact that an individual is diagnosed as having AIDS or ARC would be governed by statutes that generally protect the confidentiality of medical records (Wis. Stats. 146.81-146.82). Disclosure of medical information in general is discussed below.

Access to medical records and HTLV-III antibody test results. The basic statutes concerning disclosure of medical records are set forth in Wisconsin statutes 146.81-146.82 in which a "health care provider" is prohibited from making disclosures from health care records except under certain circumstances. Wisconsin statute 146.025 as noted above also prohibits the "health care provider" from disclosure of the HTLV-III antibody test results except under certain circumstances [Wis. Stat. 146.025 (5a)]. In both cases, the term "health care provider" is defined by reference to Wisconsin statute 146.81 which is phrased in terms of the applicable licensed medical professional, such as a physician or nurse. However, other statutes clearly assign responsibility for operation of the prisons to the Department of Health and Social Services as a whole. It is the responsibility of the Department of Health and Social Services as a whole for ensuring that inmates receive proper medical care [Wis. Stats. 46.03 (1), 46.03 (6), 46.115, 46.16 and 53.385], and those statutes must be honored. Additionally, the superintendents of the State's prisons also have a duty to provide a healthy and safe environment for

all inmates [Wis. Stats. 53.04, 53.07 and 53.08, and HSS 306.03 and 306.04]. Moreover, the Department of Health and Social Services employs and supervises the superintendents and the medical staff. Thus, the Department must be considered as the legal "health care provider" in a prison context and can determine which of its health or corrections staff will have record access. In order for the superintendents and other corrections staff to fulfill the prison system's statutory obligations, there must be sufficient access to medical information which is necessary to protect the health and safety of staff and inmates. This does not mean that all correctional staff should have access to all types of medical information. Rather, these statutes as interpreted above indicate that there is no legal obstacle for correctional staff, who have a legitimate need to know, from having access to inmate HTLV-III antibody test information or to inmate medical information covered by Wisconsin statute 146.82, if the Department approves that access. Recommendations on who needs to have access to HTLV-III antibody results in the correctional setting are included in the section on "Confidentiality."

Finally, it should be noted that the Employee's Right to Know Law [Wis. Stats. 101.58-101.599] does not require disclosure of HTLV-III test results in the correctional setting. This law only applies to an infectious agent that is "introduced" by an employer to be "used, studied or produced" in the work place. An inmate infected with HTLV-III would not qualify under this statutory description.

Legal issues regarding the housing of inmates infected with HTLV-III. Inmate housing decisions are for the most part, based on security and medical (recommendations of the health services unit staff) concerns with the

superintendent of the institution ultimately having the legal authority for the placement of inmates. In general, legal authorities, when considering issues of inmate housing (e.g., constitutional concerns regarding prisoner liberty which might be violated as a result of segregation based on medical grounds) have established that the court is not a proper body to measure the propriety of medical standards and precautions. Accordingly, the courts will generally defer to the judgement of medical authorities where such authorities' determinations appear to be reasonable in light of the present available medical information. Therefore, as long as prison authorities' decisions to house inmates infected with HTLV-III are based on clinically substantiated indications and health concerns, and where present available information provides no contraindications, courts are likely to support the official's decisions on housing.

Specific Guidelines For The Identification  
And Evaluation Of HTLV-III Infections

1. All newly-admitted inmates will routinely be screened to identify individuals with symptomatic or clinically apparent HTLV-III infections. This screening procedure will include:
  - a. History--A standardized questionnaire will be utilized to identify specific symptoms and risk activities associated with HTLV-III infections. The questionnaire will be included in the Bureau of Correctional Health Services protocol and will be administered by the Bureau's health care staff. An assessment of risk activities will include any information available from pre-sentence reports or other routine entrance interviews conducted by correctional staff.
  - b. Physical examination--The routine entrance physical examination will include a careful evaluation of the skin, mouth and pharynx, lymph nodes and rectum for pathology and infectious processes related to HTLV-III infections. A standardized physical examination form will be included in the Bureau of Correctional Health Services protocol.
  - c. Laboratory--As part of a routine entrance evaluation all inmates will have performed a complete blood cell count (CBC) with a differential, a serologic test for syphilis, a urinalysis and a Mantoux tuberculin skin test (PPD).

2. Inmates already within the system who have symptomatic HTLV-III infections will most likely come to the attention of the health service unit staff through either staff or inmate initiated clinic visits. Any inmate complaining of a symptom suggestive of an HTLV-III infection should be evaluated by the health service unit staff through careful history taking (including standardized HTLV-III related questionnaire), physical examination and medically appropriate laboratory tests and diagnostic procedures.

3. HTLV-III antibody testing.

- a. Inmates will not routinely be tested for antibody to HTLV-III upon entrance into the correctional system or during their incarceration.
- b. Inmates who have a history of high risk activities for an HTLV-III infection, or who have a physical examination or laboratory studies suggestive of a HTLV-III infection should be counseled by the Bureau of Correctional Health Services staff regarding the need for further medical evaluation and should be informed of the availability of the HTLV-III antibody test.
- c. Inmates who independently request an HTLV-III antibody test should be medically evaluated and counseled by the health service unit staff prior to the HTLV-III antibody test being performed. No more than two inmate requested and not medically indicated (as determined by the health services unit) HTLV-III antibody tests will be provided to an inmate per year.

- d. The HTLV-III antibody test will be performed after an inmate has been medically evaluated, has signed an informed consent form and has received counseling from the health service unit staff regarding the test. Inmates who have had a test performed will receive additional counseling by the health service unit staff upon receiving the test results. Any necessary referral services will be coordinated through the health service unit staff.
- e. The only exception to point d above is that informed consent is not required prior testing of inmates in which the superintendent and supervisor of the health service unit both have determine mandatory testing is necessary per the requirements established in point 5 in the section on "Specific infection control guidelines for HTLV-III infections." [Testing without informed consent as noted in this recommendation would only occur if existing statutory language is modified.]

#### Specific Guidelines Regarding Confidentiality

1. Information regarding who has been tested and/or who is being evaluated for an HTLV-III infection will be limited to the medical record and the medical staff.
2. Individually identifiable information regarding inmates diagnosed with an HTLV-III infection (AIDS, ARC or persons with a validated positive HTLV-III antibody test) will be limited:

- 765
- a. On a routine basis to the Superintendent of the appropriate institution and his/her legal designees ("chain of command"), the institution program review committee, the institution health unit staff, the Director of the Bureau of Correctional Health Services and designated bureau staff and the State Epidemiologist and his/her designated staff.
  - b. In special circumstances as deemed necessary by the institution superintendent (e.g., an infected inmate involved in a sexual assault, an employee with a significant exposure to the body fluids of an infected inmate, a security disruption related to an infected inmate), the Director of the Bureau of Correctional Health Services or the State Epidemiologist to the Secretary of the Department of Health and Social Services, the Administrators of the Divisions of Health and Corrections and their respective designated staff.
3. Exemptions to the above disclosure guidelines include circumstances where:
- a. The inmate has provided a written informed consent for disclosure to other specified persons or disclosures specifically permitted under Wisconsin statute 146.025.
  - b. It has been determined by the Superintendent of the institution in consultation with the health services unit staff that for non-medical reasons the inmate requires special handling (as discussed in the section on "Specific Infection Control Guidelines," point 3). In

those situations, only staff who have a need to know will be informed of the need for special handling precautions. In most cases, this information should be restricted to the specifics of handling precautions and does not require the disclosure of the specific diagnosis.

c. An inmate or correctional staff member has had a parenteral or mucous membrane exposure to blood or other body fluid of an infected individual that is determined by the health service unit to be significant.

4. It is the responsibility of the institution superintendent to inform staff of the consequences of violations of confidentiality.

#### General Infection Control Guidelines

1. With the assistance of the health service unit staff, each superintendent will review aspects of institution operations including security, laundry, work areas, food services, visiting, barber services, recreation, transportation and maintenance to assess areas where improvements can be made to reduce the risk of transmission of infectious diseases. Particular attention should be given to circumstances where the potential exists for someone to come in contact with the body fluids or another. To facilitate this process, the Division of Corrections and Bureau of Correctional Health Services should establish a committee to review infection control policies utilized in the institutions.

2. Institutions should evaluate and improve, if indicated, programs to control illegal drug use, non-authorized tatooing and illicit sexual activity.
3. Institution procedures and operations will discourage the sharing of unsterilized objects which could be contaminated with the body fluids of others. This includes razors (electric or straight edge), toothbrushes, towels, soap, eating and drinking utensils, fingernail clippers, combs, scissors, clothes and linens.
4. Cleaning supplies including brushes, baskets, bleach, rubber gloves, and plastic bags should be available in housing and program areas. Inmates should be supplied with cleaning supplies and encouraged to routinely clean their cell or room.
5. First aid information and supplies, including CPR masks, should be available in housing and program areas.
6. All correctional staff should routinely wear gloves for direct contact with mucous membranes or non-intact skin of all inmates.
7. Routine and standard procedures should be used to clean up after any accident or injury or by any inmates or staff responsible for cleaning areas or handling objects potentially contaminated with body fluids. These precautions would include:

- Wearing of gloves, especially when personnel have open lesions on their hands.
- Blood and body fluid spills should be cleaned up soon after the spill with a disposable towel.
- Following a body fluid spill, the environmental surface should be cleaned up with a freshly prepared bleach in water solution (at least a 1 to 10 dilution of bleach in water) or another disinfectant (see Appendix C).
- Blood (or body fluid) soaked items that are disposable should be placed in a sturdy plastic bag, sealed and marked "Blood and body fluid precautions." Persons disposing of the plastic bag should wear gloves.
- Persons cleaning up spills or handling contaminated items should wash their hands after such activities, even if they had been wearing gloves.
- Clothes and linens contaminated with body fluids should be placed in a water soluble bag and then in a plastic bag and laundered separately. Persons handling contaminated clothing should wear gloves.
- Persons whose clothes have been contaminated with body fluids or another person should be provided with a change of clothes and an opportunity to wash as soon as possible.

- Any person that has had a significant exposure (splashing of a body fluid into the eye, mouth or an open lesion, puncture with an item contaminated with a body fluid or a bite) should consult with the health service unit staff regarding the exposure and potential follow-up recommendations.

#### Specific Infection Control Guidelines For HTLV-III Infections

1. Inmates under medical evaluation for a suspected HTLV-III infection or having been diagnosed with an HTLV-III infection will not be managed differently than other inmates unless medically indicated on the basis of signs symptoms or co-existing infections.
  - Housing--Inmates with HTLV-III infections should be housed with the general population, although they will not be placed in multi-person cells or rooms.
  - Activities--Inmates with HTLV-III infections will be allowed standard access to recreational activities, work assignments, visitation privileges, showers and bathroom facilities, food services and other program activities.
  - Laundry--The laundry of inmates with HTLV-III infections will be handled using the general guidelines listed above and washed with that of the general population unless grossly soiled with bodily fluids.

- Transportation--When transporting inmates with HTLV-III infections, standard security precautions shall be utilized. No special infection control precautions need to be instituted.
  - Security--Routine security procedures should be utilized when handling infected inmates or responding to security situations. No special infection control precautions need to be instituted.
  - Classification and transfer--Routine classification and transfer policies will be observed for infected inmates.
2. When an inmate with an HTLV-III infection requires special handling or infection control precautions based on his/her health status (e.g., symptoms, co-existing infections, or immune suppression) the health service unit staff will recommend special handling orders based on standard medical practice. These recommendations should be made to the superintendent.
3. The only exceptions to guidelines #1 and #2 listed above relate to circumstances where the infected inmate poses a significant risk of transmitting HTLV-III to other inmates and staff because of non-medical characteristics or behaviors. [A list of these situations will be distributed and discussed at the January 9 meeting.] In these situations the program review committee can dictate special handling orders after consulting with the health service unit staff. This decision should be based on an evaluation of the inmate's behavior pattern and the risks the

infected inmate poses of exposing other persons to his body fluids. Special handling orders may consist of limitations and restrictions on housing, program activities or work assignments.

4. The superintendent, the health service unit supervisor or physician, and the program review committee should review available information on an infected inmate's health status and behavior record at the time the inmate enters the institution and periodically during the course of the stay. Any recommendations regarding precautions to be taken in addition to standard infection control and security procedures should be carefully documented by this group. Documentation regarding the management and treatment of all HTLV-III infected inmates (excluding identifying information) should be submitted monthly by this group to the Administrator of the Division of Corrections and the Director of the Bureau of Correctional Health Services.
  
5. The above measures should reduce risks of transmission of infection, but accidents resulting in exposure will still occur and some persons in custody may exhibit violent, aberrant or uncontrolled behavior, including rape, resulting in exposure of others to their blood or other body fluids. Serological testing plays a useful role in managing such incidents.

If a parenteral (e.g., cut or needle stick) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids of another person occurs, the health service unit should be consulted concerning the likelihood of HTLV-III infection in the source person. If the health service unit judges that infection may exist and the exposure was significant, then the source person in custody should be serologically

tested for evidence of HTLV-III infection. [Currently this would be done on an informed consent basis.] If the source person has AIDS, other evidence of HTLV-III infection, or a positive test for HTLV-III, the exposed person should be evaluated clinically and serologically for evidence of HTLV-III infection as soon as possible after the exposure, and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 5 and 12 months) to determine if transmission has occurred. During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed persons should receive counseling about the risk of infection and follow U.S. Public Health Service recommendations for preventing transmission of AIDS [26, 27]. If the source person is seronegative, remains seronegative in follow-up testing, and has no other evidence of HTLV-III infection, no further follow-up of the exposed person is necessary.

#### Specific Guidelines For Providing Support Services

1. The health services unit staff is responsible for providing the inmate with counseling prior to testing for HTLV-III antibody, for informing the inmate of the test result and for counseling the inmate regarding the meaning of the test result and prevention implications.
2. Consultation with a psychologist or psychiatrist should be offered to every inmate with an HTLV-III infection and the psychologist/psychiatrist in coordination with the health services unit staff should make an assessment of the need for medical or social/psychological referral services. Such an assessment should be made initially and repeated as needed.

3. Prior to release from prison or release on furloughs, infected inmates should receive counseling regarding precautions and prevention recommendations to be utilized when living back in the community. Community medical and psychological service referrals should also be made for inmates that desire such follow-up upon their release. Inmates in groups at highest risk for HTLV-III infections who were not tested during their incarceration should be offered HTLV-III antibody testing prior to their time of release into society. Testing at the time of release is a joint concern of the Divisions of Health and Corrections, and should be pursued collaboratively.

#### Specific Guidelines For The Education Of Staff And Inmates

1. The Divisions of Corrections and Health will jointly be responsible for coordinating an educational program for the correctional system directed at both staff and inmates. The Divisions will also be responsible for the development of appropriate educational materials for use by the institutions. This education program should include information on communicable diseases and infection control precautions in general as well as specific emphasis on HTLV-III infections.

Educational materials and opportunities should be provided as part of an orientation package for staff beginning employment or an inmate entering the system. Inmates and employers should also be provided with periodic information updates as well as continued access to written materials or other information sources.

2. Each institution, in cooperation with the appropriate Division training director and health service unit staff will develop and implement an education program that specifically addresses the needs and concerns of their staff and inmates regarding infection control precautions and HTLV-III infections.
  
3. The Bureau of Correctional Health Services is responsible for providing its staff with an education program specifically addressing infection control precautions and HTLV-III infections. Bureau staff at the institutions should assist the superintendent in implementing educational programs.
  
4. It is important that several persons at each institution develop an expertise regarding HTLV-III so that they may be available to staff and inmates for responding to questions. These persons should include at least one member of the health services unit and one correctional staff member that is not in the health service unit.

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## References

1. Jason JM, Mc Dougal JS, Dixon G, Lawrence DN, Kennedy MS, Hilgartner M, Evatt BL. Lymphadenopathy-associated virus (LAV) antibody and immune status of household contacts and sexual partners of persons with hemophilia. Submitted for publication.
2. Kaplan JE, Oleske JM, Getchell JP, et al. Evidence against transmission of HTLV-III/LAV in families of children with AIDS. Lancet, in press.
3. Lewin EB, Zack R, Ayodele A. Communicability of AIDS in a foster care setting. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, GA, April 1985.
4. Thomas PA, Lubin K, Enlow RW, Getchell J. Comparison of HTLV-3 serology, T cell levels, and general health status of children whose mothers have AIDS with children of healthy inner city mothers in New York. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, GA, April 1985.
5. Fischl MA, Dickinson G, Scott G, Klimas N, Fletcher M, Parks W. Evaluation of household contacts of adult patients with the acquired immunodeficiency syndrome. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, GA, April 1985.
6. Friedland GH, Saltzman BR, Rogers MF, et al. Lack of household transmission of HTLV-III infection. EIS Conference, Atlanta, GA, April 1985.

7. Lawrence DN, Jason JM, Boushasin JD, et al. HTLV-III/LAV antibody status of spouses and household contacts assisting in home infusion of hemophilia patients. Blood 1985; 66:703-5.
8. CDC. Update: evaluation of human T-lymphotropic virus type III/lymphadenopathy-associated virus infection in health-care personnel--United States. MMWR 1985; 34:575-8.
9. Wormser GP, Krupp LB, Hanrahan JP, et al. Acquired immunodeficiency syndrome in male prisoners. Annals Int Med 1988; 98:297-03.
10. Spira TJ, Des Jarlais DC, Bocos D, et al. HTLV-III/LAV Antibodies in intravenous drug abusers: comparison of low and high risk areas for AIDS. Presented at the International Conference on Acquired Immunodeficiency Syndrome, April 17, 1985, Atlanta, GA.
11. Weiss SH, Ginzburg HM, Goedert JJ, et al. Risk for HTLV-III exposure and AIDS among parenteral drug abusers in New Jersey. Presented at the International Conference on Acquired Immunodeficiency Syndrome, April 17, 1985, Atlanta, GA.
12. U.S. Department of Justice. Prisoners and drugs. Bureau of Justice Statistics Bulletin. March 1983.
13. Anda RF, Perlman SB, D'Alessio, et al. Hepatitis B in Wisconsin Male Prisoners: Considerations for Serologic Screening and Vaccination. Am J Pub Health 1985; 75:1182-5.

14. Wisconsin Division of Corrections. 1983 study of drug use among inmates prior to incarceration.
15. Wisconsin Division of Corrections. 1976 study of drug use among inmates prior to incarceration.
16. Davis AJ. Sexual assaults in the Philadelphia prison system and sheriff's vans. Transaction. December 1968:8-16.
17. Scacco A. Rape in prison. Springfield, IL. C. C. Thomas, 1975.
18. Moss CS, Hosford RE, Anderson W. Sexual assault in a prison. Psych Reports (Missoula, MT) 1979; 44:823-8.
19. Lockwood D. Prison sexual violence. New York Elsevier 1980.
20. Nacci PL, Kane TR. Sex and sexual aggression in federal prisons. Bureau of Prison Policy Progress Reports 1982; 1(1).
21. CDC. ACIP recommendations for protection against viral hepatitis. MMWR 1985; 34:313-24, 329-35.
22. Decker MD, Vaughn WK, Brodie JS, et al. Seroepidemiology of hepatitis B in Tennessee prisoners. J Infect Dis 1984; 150:450-9.
23. Hull HF, Lyons LH, Mann JM, et al. Incidence of hepatitis B in the penitentiary of New Mexico. Am J Pub Health 1985; 75:1213-4.

24. Koplan JP, Walker JA, Bryan JA. Prevalence of hepatitis B surface antigen and antibody at a state prison in Kansas. J Infect Dis 1978; 137:505.
25. Decker MD, Vaughn WK, Brodie JS, et al. The incidence of hepatitis B in Tennessee prisoners. J Infect Dis 1985; 152:213-7.
26. CDC. Prevention of acquired immune deficiency syndrome (AIDS): report of inter-agency recommendations. MMWR 1983; 32:101-3.
27. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985; 34:1-5.