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U.S. Department of Justice
Office of Justice Programs

Bureau of Justice Statistics
810 Seventh Street, N.W.
Washington, DC 20531



Monday, November 01, 1999 1:28:54 PM

To: THE WHITE HOUSE
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From: Bureau of Justice Statistics
Phone Number: Stu Smith, 202-307-0784
Fax Number: 202-307-5846
Name/address/fax number change: Fax to 202-307-5846, Attention: D. Oliphant

Subject: Following is a 2-page press release and 8 pages of the 12-page report:
HIV in Prisons 1997, embargoed for release until **Wednesday, November 3, 1999, at 4:30 p.m. EST.**

If you do not receive all 10 pages of this fax, you can receive them by calling the BJS fax-on-demand number, **301-519-5550**, follow the prompts and use fax order number--

174 for HIV in Prisons 1997 (12 pages)
175 for the press release (2 pages).

Upon release, both the 12-page report and the 2-page press release will be available on the BJS web site at--

HIV in Prisons 1997 NCJ 178284
<http://www.ojp.usdoj.gov/bjs/abstract/hivp97.htm>

The full report may be ordered as follows:

- Call **1-800-732-3277** and order using order # NCJ 178284.
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Total pages including cover page: 11



Department of Justice

ADVANCE FOR RELEASE AT 4:30 P.M. EST
WEDNESDAY, NOVEMBER 3, 1999

BJS
202/307-0784

RATES OF HIV INFECTION AND AIDS-RELATED DEATHS DROP AMONG THE NATION'S PRISONERS

WASHINGTON, D.C. – The rate of human immunodeficiency virus (HIV) infection among state and federal prisoners dropped from 2.3 percent in 1996 to 2.1 percent in 1997, according to a new bulletin released today by the Justice Department's Bureau of Justice Statistics (BJS). There were 23,548 HIV-infected inmates at the end of 1997, down from 23,881 in 1996. In 1997, 22,518 state prisoners and 1,030 federal prisoners were known to be HIV positive.

The number of deaths due to AIDS dropped from 907 in 1996 to 538 in 1997. The rate of death due to AIDS dropped sharply from 100 deaths per 100,000 state inmates in 1995 (the highest rate recorded) to 48 deaths per 100,000 inmates in 1997. Between 1991 (the first year of data collection) and 1996 about one in three state prisoner deaths were attributable to AIDS. During 1997 it was about one in five.

Of inmates known to be HIV positive, 6,184 had confirmed AIDS, while 16,503 either showed symptoms of HIV infection or were asymptomatic. Between 1991 and 1997 the number of inmates with confirmed AIDS increased by more than 4,500 -- an increase of over 24 percent per year. At year end 1997 the rate of confirmed AIDS in prison (55 per 10,000 inmates) was at least 5 times the rate in the U.S. general population (10 per 10,000 U.S. residents age 13 or older).

These HIV-positive inmates were concentrated in a small number of states. New York state prisons, with 7,500 HIV-positive inmates, and Florida state prisons, with 2,325, held more than 40 percent of all HIV-infected inmates.

Nearly half of the state prisoners known to be HIV positive were held in the Northeast, where 6.4 percent of the inmates were HIV positive, followed by 2 percent in the South, 0.9 percent in the Midwest and 0.8 percent in the West. New York had the highest percentage (10.8 percent), followed by Connecticut (5.1 percent), Massachusetts (3.7 percent), Florida (3.6 percent) and Maryland (3.5 percent).

(MORE)

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In most states, female inmates had higher HIV infection rates than male inmates. Overall, 2.2 percent of male inmates and 3.5 percent of female inmates were HIV positive. In two states at least 10 percent of the female inmates were infected -- New York (20.7 percent) and Connecticut (13.1).

The BJS report indicated a strong link between prior drug use and HIV infection. Based on personal interviews with state prisoners, 2.7 percent of those who had used drugs in the month before their current offense said they were HIV positive, as did 4.6 percent of those who had used a needle to inject drugs and 7.7 percent of those who had shared a needle.

The rate of HIV infection was higher among black (2.8 percent) and Hispanic (2.5 percent) state prison inmates than white inmates (1.4 percent). State inmates age 35 to 44 had the highest rates of infection (3.1 percent), while those age 24 or younger had the lowest (0.5 percent).

The bulletin, "HIV in Prisons 1997" (NCJ-178284), was written by BJS statistician Laura M. Maruschak. Single copies may be obtained from the BJS fax-on-demand system by dialing 301/519-5550, listening to the complete menu and selecting document number 174. Or call the BJS clearinghouse number: 1-800-732-3277. Fax orders for mail delivery to 410/792-4358. The BJS Internet site is:

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After hours contact: Stu Smith at 301/983-9354



Bureau of Justice Statistics Bulletin

November 1999, NCJ 178284

HIV in Prisons 1997

By Laura M. Maruschak
BJS Statistician

At yearend 1997, 2.1% of all State and Federal prison inmates were known to be infected with the human immunodeficiency virus (HIV). The infection rate was down from 2.3% in 1996. In 1997 a total of 23,548 prison inmates were HIV positive (1,030 Federal and 22,518 State). HIV-positive inmates made up 1.0% of Federal prison inmates and 2.2% of State prison inmates. Of those known to be HIV positive in all U.S. prisons, 6,184 were confirmed AIDS cases, while the remaining 16,503 either showed symptoms of HIV infection or were asymptomatic.

In 1997 there were 538 AIDS-related deaths in State prisons, down from 907 in 1996. For every 100,000 State prison inmates in 1997, 48 died of AIDS-related causes. Between 1991 and 1996, about 1 in 3 State prison inmate deaths were attributed to AIDS-related causes; in 1997 about 1 in 5.

Data based on personal interviews from the 1997 Survey of Inmates in State Correctional Facilities show that 75% of State inmates were ever tested for HIV. Of those who were ever tested and reported results, 2.2% were HIV positive — 2.2% of males and 3.4% of females. As level of prior involvement in drug use increased, so did the percentage of HIV-positive inmates: 2.3% of those who said they had ever used drugs, 2.7% of those who used drugs in the month before the current offense, 4.6% of those who injected drugs, and 7.7% of those who ever shared a needle were HIV positive.

Highlights

Year	HIV-positive State and Federal prison inmates	
	Number	Percent of custody population
1991	17,551	2.2%
1992	20,651	2.5
1993	21,475	2.4
1994	22,717	2.4
1995	24,256	2.3
1996	23,881	2.3
1997	23,548	2.1

• Between 1991 and 1997 the number of HIV-positive prisoners grew at a slower rate (34%) than the overall prison population (49%).

• At yearend 1997, 3.5% of all female State prison inmates were HIV positive, compared to 2.2% of male State prisoners.

Jurisdiction	HIV-positive prison inmates	
	Number	Percent of custody population
New York	7,500	10.8%
Florida	2,325	3.6
Texas	2,126	1.5
California	1,328	.9
Federal system	1,030	1.0
New Jersey	867	3.4
Georgia	861	2.4
Connecticut	798	5.1
Maryland	768	3.5

Based on jurisdictions with more than 700 HIV-positive inmates.

• New York held about a third of all inmates (7,500 inmates) known to be HIV positive at yearend 1997.

• Of all HIV-positive prison inmates, 26% were confirmed AIDS cases. In State prisons 26% of HIV-positive inmates had AIDS; in Federal prisons, 36%.

• The overall rate of confirmed AIDS among the Nation's prison population (0.55%) was more than 5 times the rate in the U.S. population (0.10%).

• The number of AIDS-related deaths among prison inmates decreased from 907 in 1996 to 538 in 1997.

• Of all State prison inmates, 2.8% of black inmates and 2.5% of Hispanic inmates, compared to 1.4% of white inmates reported to survey interviewers that they were HIV positive.

	Tested inmates who reported results	
	Number	Percent HIV positive
All inmates	790,128	2.2%
Male	734,327	2.2
Female	55,800	3.4
White	257,919	1.4%
Black	384,870	2.8
Hispanic	123,725	2.5
Age 24 or younger	154,181	.5%
25-34	310,161	2.3
35-44	232,835	3.1
45 or older	92,168	2.7
Ever used drugs	665,977	2.3%
Used in month before offense	460,685	2.7

From the 1997 Survey of Inmates in State Correctional Facilities.

Table 1. Inmates in custody of State or Federal prison authorities and known to be positive for the human immunodeficiency virus, 1995-97

Jurisdiction	Total known to be HIV positive			HIV/AIDS cases as a percent of total custody population ^a		
	1995	1996	1997	1995	1996	1997
U.S. total^b	24,256	23,881	23,548	2.3%	2.2%	2.1%
Federal	822	947	1,030	0.9	1.0	1.0
State	23,434	22,934	22,518	2.4	2.3	2.2
Northeast	12,262	11,090	10,394	7.8%	6.9%	6.4%
Connecticut	755	690	798	5.1	4.6	5.1
Maine	4	4	--	0.3	0.3	--
Massachusetts	409	393	402	3.9	3.6	3.7
New Hampshire	31	18	17	1.5	0.9	0.8
New Jersey	847	705	867	3.7	3.0	3.4
New York	9,500	8,500	7,500	13.9	12.2	10.8
Pennsylvania	590	652	697	1.8	1.9	2.0
Rhode Island	126	125	107	4.4	3.9	3.2
Vermont	0	3	6	0	0.3	0.5
Midwest	1,667	1,874	1,849	0.9%	1.0%	0.9%
Illinois	583	634	655	1.5	1.6	1.6
Indiana	--	--	--	--	--	--
Iowa	20	24	34	0.3	0.4	0.5
Kansas	24	16	4	0.3	0.2	0.1
Michigan	379	528	419	0.9	1.2	0.9
Minnesota	46	24	31	1.0	0.5	0.6
Missouri	173	190	227	0.9	0.9	0.9
Nebraska	19	17	22	0.6	0.5	0.7
North Dakota	2	3	7	0.3	0.4	0.9
Ohio	346	343	365	0.8	0.7	0.8
South Dakota	3	4	1	0.2	0.2	0.0
Wisconsin	72	91	84	0.6	0.7	0.6
South	7,870	8,162	8,281	1.8%	1.9%	2.0%
Alabama	222	234	212	1.1	1.1	1.0
Arkansas	83	77	86	1.0	0.9	1.0
Delaware	122	--	--	2.5	--	--
District of Columbia	--	--	75	--	--	1.1
Florida	2,193	2,152	2,325	3.4	3.4	3.6
Georgia	658	814	861	2.5	2.3	2.4
Kentucky	41	55	55	0.4	0.5	0.5
Louisiana	314	347	397	1.8	2.0	2.1
Maryland	724	832	766	3.4	3.8	3.5
Mississippi	138	135	189	1.4	1.3	1.8
North Carolina	526	589	519	1.9	2.0	1.7
Oklahoma	115	108	107	0.8	0.7	0.7
South Carolina	380	422	432	2.0	2.1	2.1
Tennessee	120	131	131	0.9	1.0	0.9
Texas	1,890	1,876	2,126	1.5	1.4	1.5
Virginia	134	383	--	0.6	1.5	--
West Virginia	10	7	10	0.4	0.3	0.4
West	1,635	1,808	1,984	0.8%	0.8%	0.8%
Alaska	5	10	10	0.2	0.3	0.3
Arizona	140	205	105	0.7	0.9	0.4
California	1,042	1,136	1,328	0.8	0.8	0.9
Colorado	93	84	110	1.0	0.9	1.0
Hawaii	12	23	16	0.4	0.7	0.4
Idaho	11	17	10	0.4	0.5	0.3
Montana	4	6	8	0.2	0.4	0.4
Nevada	147	133	139	1.9	1.6	1.6
New Mexico	24	11	23	0.6	0.2	0.6
Oregon	29	39	54	0.4	0.5	0.7
Utah	31	31	80	0.8	0.7	1.2
Washington	92	99	119	0.8	0.8	0.9
Wyoming	5	4	2	0.4	0.3	0.1

--Not reported.

^aThe custody population includes only those inmates housed in a jurisdiction's facilities.

^bTotals exclude those inmates in jurisdictions that did not report data on HIV/AIDS.

Counts may differ from previous reports. Percentages for all years are based on yearend custody counts.

Data based on official records and prisoner interviews

Departments of corrections in 50 States and the District of Columbia as well as the Federal Bureau of Prisons provided data on HIV/AIDS among inmates. Since 1991 respondents have reported their HIV-testing policies and the number of HIV-infected inmates in their custody at yearend. Those inmates are reported to be asymptomatic, symptomatic, or with confirmed AIDS. (See questionnaire items in figure 1, page 10.) Respondents have also reported for each year the number of inmate deaths from HIV-related infections and other causes.

Data on HIV/AIDS and demographics for prison inmates were calculated from the 1997 Surveys of Inmates in State and Federal Correctional Facilities. Through personal interviews, inmates held in prisons were questioned about current offenses, prior drug use and treatment, personal characteristics and other aspects of their life. Questions on whether inmates had ever been tested for HIV and the results of the test were included in the interviews.

States report a small decrease in the number of HIV-infected inmates during 1997

At yearend 1997, 23,548 inmates in State and Federal prisons were known to be infected with the human immunodeficiency virus (HIV) (table 1). Although the number of reported HIV-positive inmates was down from the total reported at yearend 1996 (23,881), Virginia and Maine (with 383 and 4 cases, respectively, in 1996) did not report data in 1997. The District of Columbia (with 75 cases in 1997) had not reported data in 1996. Based on comparable reporting jurisdictions in both years, the number of HIV-positive inmates decreased slightly in State prisons (down 104) and increased in Federal prisons (up 83).

From 1991, when BJS began collecting data annually on HIV/AIDS, to 1997, the number of inmates reported to be HIV positive increased at about the same rate as the overall prison population. HIV-positive inmates comprised 2.2% of the State prison population in 1997, down from 2.3% in 1991. Infected inmates were 1.0% of Federal prisoners in 1997, unchanged from 1991.

HIV-infected inmates were concentrated in a small number of States. New York and Florida housed the largest number of HIV-positive inmates (7,500 and 2,325, respectively). In 1997 these two States housed more than 40% of all HIV-infected inmates in State prisons.

Year	Percent of custody population known to be HIV positive	
	State	Federal
1991	2.3%	1.0%
1992	2.6	1.2
1993	2.6	1.2
1994	2.5	1.1
1995	2.4	0.9
1996	2.4	1.0
1997	2.2	1.0

Northeast prisons held the largest number of HIV-infected inmates

Nearly half the State prison inmates known to be HIV positive were in the Northeast. Within the Northeast, 6.4% of the prison population were HIV positive, followed by 2.0% in the South, 0.9% in the Midwest, and 0.8% in the West. New York had the highest percentage of inmates known to be HIV positive (10.8%), followed by Connecticut (5.1%) and Massachusetts (3.7%).

Nine States (Alaska, Idaho, Kansas, Montana, North Dakota, South Dakota, Vermont, West Virginia, and Wyoming) reported 10 or fewer cases of HIV-positive inmates in their prisons. Of the 46 States that reported information in 1997, each reported having at least one HIV-positive inmate. Nine States reported that fewer than 0.5% of their inmate population were HIV positive.

Table 2. Inmates in custody of State and Federal prison authorities, by type of HIV infection or confirmed AIDS, yearend 1997

Jurisdiction	Cases of HIV or confirmed AIDS				Confirmed AIDS cases as a percent of	
	Total ^a	Asymptomatic ^b	Symptomatic ^c	Confirmed AIDS	Total HIV cases	Custody population
U.S. total	23,548	13,532	2,971	6,184	26.3%	0.5%
Federal	1,030	662	0	368	35.7	0.4
State	22,518	12,870	2,971	5,816	25.8	0.6
Northeast	10,394	7,053	1,122	2,219	21.3%	1.4%
Connecticut	798	171	425	202	25.3	1.3
Maine	--	--	--	--	--	--
Massachusetts	402	51	214	137	34.1	1.3
New Hampshire	17	3	7	7	41.2	0.3
New Jersey	867	565	--	302	34.8	1.2
New York	7,500	5,928	273	1,301	17.3	1.9
Pennsylvania	697	323	153	221	31.7	0.6
Rhode Island	107	11	50	46	43.0	1.4
Vermont	6	3	0	3	--	0.2
Midwest	1,849	910	365	574	31.0%	0.3%
Illinois	655	418	36	201	30.7	0.5
Indiana	--	--	--	--	--	--
Iowa	34	26	--	8	23.5	0.1
Kansas	4	3	--	1	--	±
Michigan	419	216	--	203	48.4	0.5
Minnesota	31	26	0	5	16.1	0.1
Missouri	227	--	190	37	16.3	0.2
Nebraska	22	18	1	3	13.6	0.1
North Dakota	7	0	6	1	--	0.1
Ohio	365	155	119	91	24.9	0.2
South Dakota	1	0	0	1	--	±
Wisconsin	84	48	13	23	27.4	0.2
South	8,291	3,669	1,147	2,614	31.5%	0.6%
Alabama	212	58	103	51	24.1	0.2
Arkansas	86	46	26	14	16.3	0.2
Delaware	--	--	--	--	--	--
District of Columbia	75	--	--	75	100.0	1.1
Florida	2,325	1,499	--	826	35.5	1.3
Georgia	861	--	--	--	--	--
Kentucky	55	27	17	11	20.0	0.1
Louisiana	397	--	290	107	27.0	0.6
Maryland	768	272	220	274	35.8	1.3
Mississippi	189	151	--	38	20.1	0.4
North Carolina	519	349	--	170	32.8	0.5
Oklahoma	107	103	--	4	3.7	±
South Carolina	432	64	197	171	39.6	0.8
Tennessee	131	--	89	42	32.1	0.3
Texas	2,126	1,092	205	829	39.0	0.6
Virginia	--	--	--	--	--	--
West Virginia	10	8	0	2	--	0.1
West	1,984	1,238	337	409	20.6%	0.2%
Alaska	10	0	10	0	--	0
Arizona	105	59	--	46	43.8	±
California	1,328	974	197	157	11.8	0.1
Colorado	110	37	42	31	28.2	0.3
Hawaii	16	3	9	4	25.0	0.1
Idaho	10	5	2	3	--	0.1
Montana	8	1	0	7	--	0.4
Nevada	139	67	29	43	30.9	0.5
New Mexico	23	20	0	3	13.0	0.1
Oregon	54	33	14	7	13.0	0.1
Utah	60	10	34	16	26.7	0.3
Washington	119	27	--	92	77.3	0.7
Wyoming	2	2	0	0	--	0

Note: Totals and percentages exclude inmates in jurisdictions that did not report data on type of HIV/AIDS infection. The custody population includes only inmates housed at the end of 1997.

--Not reported.

--Not calculated for 10 or fewer cases.

± Less than .05%.

^aGeorgia reported the total of HIV-positive cases but not the type of HIV infection.

^bIncludes all inmates who had tested positive for the HIV antibody but had no HIV-related symptoms.

^cIncludes inmates with symptoms of HIV infection but without a confirmed AIDS diagnosis.

Between 1996 and 1997, 15 States reported a decreased number of HIV-positive inmates. The largest decrease (1,000 cases) was reported in New York — 7,500 in 1997, down from 8,500 in 1996. Michigan (down 109), Arizona (down 100), North Carolina (down 70), and Maryland (down 66) also reported large decreases. Twenty-eight States reported an increased number of HIV cases. Texas reported the largest increase (up 250) during 1997, followed by California (up 192) and Florida (up 173).

Confirmed AIDS cases in prison more than tripled from 1991 to 1997

At the end of 1997, 6,184 inmates had confirmed AIDS: 5,816 were State inmates and 368 were Federal inmates (table 2). Of the remaining HIV-positive inmates, 2,971 showed symptoms of AIDS (symptomatic), while 13,532 were HIV positive but showed no symptoms of AIDS (asymptomatic).

Confirmed AIDS cases made up 0.5% of all inmates in State and Federal prisons. Of those known to be HIV-positive inmates, over a quarter had confirmed AIDS.

Year	HIV-positive State and Federal inmates	
	Confirmed AIDS cases	Other than confirmed AIDS cases
1991	1,682	15,797
1992	2,644	18,087
1993	3,765	17,773
1994	4,849	17,864
1995	5,099	18,165
1996	5,847	16,656
1997	6,184	16,503

Note: Care should be exercised when comparing the number of reported cases over time. In January 1993 the Centers for Disease Control and Prevention revised the HIV classification system and expanded the surveillance case definition for AIDS to include specific CD4+ T-lymphocyte criteria and three additional clinical conditions — pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer. This expansion resulted in a substantial increase in the number of reported AIDS cases during 1993. See *Methodology*.

During 1997 the number of confirmed AIDS cases increased by 337. Overall, after 1991 the number of confirmed AIDS cases increased 4,502 — an annual average increase of 24.2%. While the number of confirmed AIDS cases increased, the number of inmates with lesser or no symptoms of HIV infection decreased from 18,165 in 1995 to 16,503 in 1997.

The States with the largest number of confirmed AIDS cases were New York (1,301), Texas (829), and Florida (826). Combined, these States made up 51% of all confirmed AIDS cases in State prisons. Seventeen States reported having fewer than 10 confirmed AIDS cases in their prison.

The highest percentage of the State prison population having confirmed AIDS was in New York (1.9%), followed by Rhode Island (1.4%), Connecticut (1.3%), Florida (1.3%), and Maryland (1.3%). In 17 States, confirmed AIDS cases comprised 0.1% or less of State inmates.

The rate of AIDS in prison at least 5 times the rate in the general population

At the end of 1997, the rate of confirmed AIDS in State and Federal prisons was 5½ times higher than in the total U.S. population. About 55 per 10,000 prison inmates had confirmed AIDS, compared to 10 per 10,000 persons in the U.S. population.

Year	Percent of population with confirmed AIDS	
	U.S. general population	Inmates in State and Federal prisons
1991	0.03%	0.21%
1992	0.03	0.33
1993	0.06	0.50
1994	0.07	0.52
1995	0.08	0.51
1996	0.09	0.54
1997	0.10	0.55

Note: The percent of the general population with confirmed AIDS in each year may be overestimated due to delays in death reports. Care should be exercised when comparing percentages over time, because of changes in the case definition for AIDS. See *Methodology*.

In every year since 1991, the rate of confirmed AIDS has been higher among prison inmates than in the general population. In 1992 the rate of AIDS was 10 times higher for prisoners than the general population. In 1993, following a revision of the HIV classification system and an expansion of the case definition for AIDS, the rate of confirmed AIDS increased 1½ times among prisoners and doubled in the general population. After the adoption of these new measures, the incidence of AIDS grew somewhat faster in the general population.

Table 3. State prison inmates known to be positive for the human immunodeficiency virus, by gender, yearend 1997

Jurisdiction	Male HIV cases		Female HIV cases	
	Number	Percent of population	Number	Percent of population
Total	20,153	2.2%	2,185	3.5%
Northeast	9,322	6.0	1,072	12.7
Connecticut	659	4.6	139	13.1
Maine	—	—	—	—
Massachusetts	344	3.4	58	8.2
New Hampshire	15	0.8	2	1.5
New Jersey	796	3.3	71	5.5
New York	6,755	10.3	745	20.7
Pennsylvania	653	1.9	44	3.1
Rhode Island	95	3.1	12	6.1
Vermont	5	0.4	1	1.9
Midwest	1,708	0.9%	141	1.2%
Illinois	591	1.5	64	2.6
Indiana	—	—	—	—
Iowa	27	0.4	7	1.3
Kansas	4	0.1	0	0
Michigan	398	0.9	21	1.0
Minnesota	31	0.6	0	0
Missouri	212	0.9	15	0.9
Nebraska	20	0.6	2	0.9
North Dakota	5	0.7	2	3.0
Ohio	340	0.8	25	0.9
South Dakota	1	0	0	0
Wisconsin	79	0.6	5	0.7
South	7,385	1.9%	831	3.1%
Alabama	197	1.0	15	1.1
Arkansas	81	1.0	5	0.8
Delaware	—	—	—	—
District of Columbia	—	—	—	—
Florida	2,082	3.4	243	7.1
Georgia	765	2.2	96	4.2
Kentucky	50	0.5	5	0.8
Louisiana	372	2.1	25	2.7
Maryland	682	3.3	84	7.6
Mississippi	171	1.8	18	2.0
North Carolina	455	1.6	64	3.6
Oklahoma	97	0.7	10	0.8
South Carolina	409	2.1	23	1.8
Tennessee	127	0.9	4	0.7
Texas	1,887	1.5	239	2.3
Virginia	—	—	—	—
West Virginia	10	0.4	0	0
West	1,738	0.9%	141	0.9%
Alaska	6	0.2	4	1.9
Arizona	—	—	—	—
California	1,248	0.9	80	0.7
Colorado	102	1.0	8	1.0
Hawaii	16	0.4	0	0
Idaho	10	0.3	0	0
Montana	7	0.4	1	1.2
Nevada	108	1.4	31	4.9
New Mexico	22	0.7	1	0.3
Oregon	51	0.7	3	0.7
Utah	57	1.2	3	1.1
Washington	109	0.9	10	1.1
Wyoming	2	0.2	0	0

—Not reported.

A greater percent of females than males reported HIV infection

At yearend 1997, 20,153 male inmates and 2,185 female inmates were known to be HIV positive (table 3). Those known to be HIV positive were 2.2% of male inmates and 3.5% of female inmates. In most States and in all regions except the West, female inmates had a higher HIV-positive infection rate than male inmates.

Year	State prison inmates	
	Number of HIV-positive inmates	Percent HIV-positive in custody population of reporting States
Males		
1991	16,150	2.2%
1992	18,266	2.6
1993	18,218	2.5
1994	19,762	2.4
1995	20,690	2.3
1996	21,799	2.3
1997	20,153	2.2
Annual average change, 1991-97*	3.8%	
Females		
1991	1,159	3.0%
1992	1,598	4.0
1993	1,796	4.2
1994	1,953	3.9
1995	2,182	4.0
1996	2,135	3.5
1997	2,185	3.5
Annual average change, 1991-97*	11.1%	

*In 1991 North Carolina, South Dakota, and the District of Columbia did not report data by gender. In 1997 Maine, Delaware, Indiana, Virginia, Arizona, and the District of Columbia did not report data by gender.

Following a decrease in 1996, the number of HIV-infected females increased during 1997 (from 2,135 to 2,185). The number of infected male inmates decreased 7.6% (from 21,799 in 1996 to 20,153 in 1997). On average, from 1991 to 1997 the number of male inmates in State prison infected with HIV increased 3.8%; the number of female infected inmates increased 11.1%.

States in the Northeast reported the largest number of HIV-positive male and female inmates (9,322 and 1,072, respectively). In seven States, more than 5% of all female inmates were known to be HIV positive. In New

York (20.7%) and Connecticut (13.1%) over 10% of female inmates were known to be HIV-positive. New York (10.3%) was the only State in which more than 10% of all male inmates were HIV-positive.

New York also reported the largest number of male and female HIV-positive inmates (6,755 and 745, respectively). The second largest numbers of HIV-positive male and female inmates were in Florida (2,082 and 243, respectively), followed by Texas (1,887 and 239, respectively). Seven States reported no female HIV-positive inmates. Every State reported at least one male inmate as HIV positive.

AIDS-related deaths in State prisons dropped 41% during 1997

The number of State inmates who died of *Pneumocystis carinii* pneumonia, Kaposi's sarcoma, or other AIDS-related diseases decreased from 907 in 1996 to 538 in 1997 (table 4). These AIDS deaths accounted for 19% of all deaths among State prisoners, down from 29% in 1996. Even with a sharp decline, AIDS-related illnesses were still the second leading cause of death in State prisons behind natural causes other than AIDS.

In 1997 for every 100,000 inmates, 48 died from AIDS-related causes (table 5). Between 1995 and 1997, the number of AIDS-related deaths in State prisons decreased 47%. This decrease may reflect improvement in the effectiveness of HIV/AIDS care, following the introduction of protease inhibitors and combination antiretroviral therapies.

Table 4. Number of inmate deaths in State prisons, by cause, 1995-97

Cause of death	1995		1996		1997	
	Number	Rate of death per 100,000 inmates	Number	Rate of death per 100,000 inmates	Number	Rate of death per 100,000 inmates
Total	3,133	311	3,095	308	2,872	255
Natural causes other than AIDS	1,569	156	1,715	170	1,859	165
AIDS	1,010	100	907	90	538	48
Suicide	160	16	154	15	159	14
Accident	48	5	43	4	37	3
Execution	58	6	45	4	74	7
By another person	86	9	65	6	75	7
Other/unspecified	204	20	166	16	130	12

Note: In 1997 some States did not report complete data on cause of death. To calculate the rate of death, the number of inmates under State jurisdiction on June 30 of each year was used as an approximation of the average population exposed to the risk of death during the year. All States reported data on inmate deaths in 1995 and 1996.

AIDS death rate in State prison at least 3 times the rate in the general population

In 1997 the rate of death because of AIDS was over 3 times higher in the prison population than in the total U.S. population age 15-54. About 1 in every 5 prisoner deaths were attributable to AIDS-related causes. In 1996 about 1 in 10 deaths in the general population were AIDS related.

Year	AIDS-related deaths as a percent of all deaths	
	U.S. general population age 15-54*	State prison inmates
1991	10.4%	28.0%
1992	11.7	35.2
1993	11.9	33.2
1994	12.7	35.1
1995	13.1	34.2
1996	10.1	29.3
1997	5.8	18.7

*See *Methodology* for source of data.

AIDS-related deaths accounted for more than a third of all inmate deaths in Florida (45%), New Jersey (41%), Connecticut (39%), and South Carolina (35%) (table 5). Prison officials in the South reported the most AIDS-related deaths (309); Florida accounted for 108 of those deaths. Nineteen States reported having no AIDS-related deaths, and 7 States reported 1 AIDS-related death.

Table 5. AIDS-related deaths of sentenced prisoners under State jurisdiction, 1997

Jurisdiction	Deaths from all causes in State prisons		AIDS-related deaths		
	Total	Rate per 100,000 inmates ^a	Total	Rate per 100,000 inmates ^a	As a percent of all deaths ^b
Total	2,872	256	538	48	18.7%
Northeast	501	292	136	79	27.1
Connecticut	33	191	13	75	39.4
Maine	1	62	0	0	**
Massachusetts	24	201	2	17	8.3
New Hampshire	5	231	0	0	**
New Jersey	101	356	41	145	40.6
New York	221	320	60	87	27.1
Pennsylvania	109	312	19	54	17.4
Rhode Island	6	178	1	30	**
Vermont	1	79	0	0	**
Midwest	488	223	50	23	10.2%
Illinois	101	248	16	39	15.8
Indiana	45	251	1	6	2.2
Iowa	9	130	0	0	**
Kansas	24	303	1	13	4.2
Michigan	99	221	18	40	18.2
Minnesota	6	113	1	19	**
Missouri	48	200	6	25	12.5
Nebraska	10	294	0	0	**
North Dakota	1	125	0	0	**
Ohio	117	244	6	12	5.1
South Dakota	6	268	0	0	**
Wisconsin	22	135	1	6	4.5
South	1,415	294	309	64	21.8%
Alabama	91	408	14	63	15.4
Arkansas	31	309	0	0	0
Delaware	12	221	0	0	0
District of Columbia	25	267	—	—	—
Florida	242	374	108	167	44.6
Georgia	114	312	41	112	36.0
Kentucky	28	192	0	0	0
Louisiana	80	273	17	58	21.3
Maryland	54	243	12	54	22.2
Mississippi	47	329	4	28	8.5
North Carolina	56	177	8	25	14.3
Oklahoma	68	331	3	15	4.4
South Carolina	55	260	19	90	34.5
Tennessee	70	420	13	78	18.6
Texas	341	243	56	40	16.4
Virginia	92	324	14	49	15.2
West Virginia	9	286	0	0	**
West	468	188	43	17	9.2%
Alaska	4	96	0	0	**
Arizona	61	260	0	0	0
California	268	172	36	23	13.4
Colorado	34	253	0	0	0
Hawaii	8	161	1	20	**
Idaho	10	258	2	51	20.0
Montana	4	159	0	0	**
Nevada	25	277	3	33	12.0
New Mexico	7	149	0	0	**
Oregon	19	238	0	0	0
Utah	3	70	0	0	**
Washington	23	174	1	8	4.3
Wyoming	2	129	0	0	**

—Not reported.

**Not calculated for 10 or fewer deaths.

^aBased on the number of inmates under State jurisdiction on June 30, 1997, with a sentence of more than 1 year.

^bNational and regional totals exclude inmates in jurisdictions that did not report data on cause of death.

Eighteen States tested all inmates for HIV either at admission or while in prison

Prison officials report data on HIV and AIDS in the National Prisoner Statistics series (NPS-1). The quality of the reporting may vary by the nature and extent of testing in each jurisdiction. Testing policies range from testing all inmates to testing only upon inmate request.

In 1997 all States, the District of Columbia, and the Federal Bureau of Prisons tested their inmates for HIV based on certain criteria (table 6). Most jurisdictions (44 out of 52) tested inmates if they had HIV-related symptoms or if the inmates requested a test. Twenty-nine States tested inmates after they were involved in an incident, and 15 States tested inmates who belonged to specific "high-risk groups."

Of the 18 States that tested all entering inmates, 4 States (Alabama, Missouri, Nevada, and Virginia) and the Federal Bureau of Prisons tested inmates at release.

Arkansas, Rhode Island, and Virginia tested all inmates currently in custody. New York was the only State that tested inmates selected at random.

Testing policy	Number of jurisdictions
Upon inmate request	40
Upon clinical indication of need	37
Upon involvement in an incident	29
All incoming inmates	18
High-risk groups	15
All inmates at time of release	5
All inmates currently in custody	3
Random sample	1

Note: Detail adds to more than 52 because a jurisdiction may have more than one testing policy.

Table 6. Prison system testing policies for the antibody to the human immunodeficiency virus, by jurisdiction, 1997

	All inmates		High risk	Upon inmate request	Clinical indication	Involvement in incident	Random sample	Other
	Entering custody	At release	group					
Federal		X		X	X			
Northeast								
Connecticut			X	X	X	X		
Maine				X				
Massachusetts				X				
New Hampshire	X							
New Jersey				X	X			X
New York			X	X	X	X	X	
Pennsylvania				X				
Rhode Island	X	X		X	X	X		
Vermont				X	X	X		
Midwest								
Illinois			X	X	X	X		
Indiana			X	X	X			
Iowa	X							
Kansas				X	X	X		
Michigan	X			X	X	X		
Minnesota			X	X	X	X		
Missouri	X	X	X	X	X	X		
Nebraska	X				X	X		
North Dakota	X							
Ohio			X	X	X	X		X
South Dakota	X							
Wisconsin				X		X		
South								
Alabama	X	X			X			
Arkansas	X	X	X	X	X	X		
Delaware			X		X	X		
District of Columbia				X				
Florida				X	X	X		
Georgia	X			X	X			
Kentucky			X	X	X	X		
Louisiana				X	X	X		
Maryland				X	X	X		
Mississippi	X							
North Carolina				X	X	X		
Oklahoma	X			X	X	X		
South Carolina			X	X	X	X		
Tennessee			X	X	X	X		X
Texas			X	X	X	X		
Virginia	X	X	X	X	X	X		
West Virginia				X	X			
West								
Alaska								X
Arizona			X	X	X	X		
California				X	X	X		
Colorado	X			X	X	X		X
Hawaii				X	X			
Idaho	X							
Montana			X	X	X	X		
Nevada	X	X		X	X	X		
New Mexico				X				X
Oregon				X				
Utah	X							
Washington				X	X			X
Wyoming					X			

MEMORANDUM OF UNDERSTANDING
BETWEEN

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES'
HEALTH RESOURCES AND SERVICES ADMINISTRATION

AND

THE DEPARTMENT OF JUSTICE'S
FEDERAL BUREAU OF PRISONS

This Memorandum sets forth the terms of an agreement between the Health Resources and Services Administration (HRSA) of The Department of Health and Human Services (HHS) and the Federal Bureau of Prisons (BOP) of the Department of Justice (DOJ) for the development of a BOP pre-release planning program to link HIV-infected inmates to community services prior to discharge.

I. BACKGROUND

The Ryan White CARE Act was enacted in 1990 to fill demonstrated gaps in care for low income uninsured and under insured people with HIV/AIDS. These gaps included populations who were inadequately served by the existing system, specific services not sufficiently available, and payers whose eligibility standards could not be met by people with HIV in need of services. While the particular services, populations, and payers have shifted over the last decade, the CARE Act has retained the same purpose of filling the gaps in the continuum of health and support services needed by people living with HIV/AIDS.

Incarcerated and released prisoners have been dramatically affected by the epidemic of HIV/AIDS. Released inmates from the Federal system have experienced numerous barriers to connecting with the health system and in some instances to receiving the continuous and intensive care and medical support, including proper medications, necessary to treat HIV infection appropriately. Both barriers to and the benefits of treatment have intensified in the last several years. Just as much more effective treatments became available, the barriers to their receipt by recently released prisoners were increased by changes in Medicaid and income support eligibility and Federal and State policies that further restrict access for this population. Additionally, many in this population report injection and other drug use. Analysis of CDC HIV incidence data by percent of individuals who reported injection drug use as their main exposure category varies by area of the United States. For example, in some East Coast areas, injection drug use now accounts for the majority of new HIV infections. The AIDS case rate is seven times higher in State and Federal prisons than in the general population. The incidence of

CDC defined AIDS in American prisons parallels the uneven geographic distribution of CDC defined AIDS injection drug users (IDUs). Several East Coast states share more than half of the CDC defined AIDS cases in the U.S. prisoners. In these states' prisons and jails, HIV infection associated with injection drug use is most prevalent (Hammett TM, 1994 update: HIV/AIDS and STD's in correctional facilities. Washington: U.S. Department of Justice, 1995).

Therefore, we would expect to find State and local planning for use of Ryan White CARE funds to be filling the gaps in needed HIV care for recently released federal prisoners. However, there has been some evidence that the HIV care needs of recently released prisoners are not being met.

II. PURPOSE AND SCOPE

The BOP is attempting to develop a program that will assist its HIV infected population to adjust to the community upon their release from a federal prison facility into a community pre-release program. Specifically, this program will be designed to assist the HIV positive inmate(s) to assimilate into the community health care environment as they seek medical treatment. Through the assistance of the HIV/AIDS Bureau's (HAB) Office of Policy and Program Development (OPPD) at HRSA, which will support a consultant contractor, the BOP will develop a "Release Planning Program" that will link HIV infected inmates to community services upon their entry into a pre-release program. The purpose and scope of this Memorandum of Understanding (MOU) is to formalize this effort between BOP and HRSA.

SPECIFIC RESPONSIBILITIES:

A. HRSA'S RESPONSIBILITIES

HRSA will:

- Provide 6 months of support for a consultant contractor whose primary responsibility is to develop a state-of-the-art case management program for the BOP to be used on the local level. The purpose of this case management program is to enable these sites to provide HIV positive inmates in community-based settings, prior to the completion of their sentence, with a fully integrated medical care and social services program which will enable these persons to transition successfully to the HIV care system upon ultimate release. Specifically, the contractor will:
 - Develop a written case management plan and policy for the BOP that details the release planning program of HIV infected inmates to the community;
 - Provide recommendations on possible approaches to training workers in the selected pilot pre-release centers who will implement the case management program; and

- Develop and present a final report.

B. BOP RESPONSIBILITIES

The BOP will take the lead in working with the consultant contractor. The BOP will provide program and policy leadership and guidance and resources which will facilitate the development of a proposed program framework. The BOP will take the lead in working with HRSA to explore policy and procedural issues between the 2 agencies that emerge from the consultant's work for the purpose of resolving any barriers to implementation of the BOP pilot program. In addition, the BOP will:

- Provide the work station in the Health Services Division's area for the consultant contractor to work on this project. This work station will include a computer station, telephone and general office supplies;
- Provide appropriate staff assistance from the Health Services Division to assist the consultant contractor. Staff assistance will include providing the consultant contractor with applicable BOP policies and institution contacts; and
- Review all work products generated by the consultant contractor for approval by the BOP's Medical Director.

IV. TERM OF AGREEMENT

The performance period for this MOU is 6 months from date of signatures or until such time the work product is complete.

XII. ANTI-DEFICIENCY ACT

Nothing contained herein shall be construed to obligate the BOP to any expenditure or obligation of funds in excess or in advance of appropriations in violation of the Anti-Deficiency Act, 31 U.S.C., §1341, as amended.

VI. MODIFICATIONS

This Agreement, or any of its specific provisions, may be revised or modified by signatory occurrence of the undersigned parties, or their respective official successors or delagees. Each party shall promptly notify the other when successors or delagees are appointed.

VII. TERMINATION

This Agreement may be terminated by either party upon sixty (60) days written notice to the other party .

VIII. FUNDING

The services to be performed by HRSA, described herein, are being provided to the BOP at no cost; therefore, obligation of funds is not required.

IX. AGENCY INTERFACE

HAB/HRSA

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Director, Office of Policy and Program Development
HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 7-20
Rockville, MD 20857
Phone: (301) 443-4274

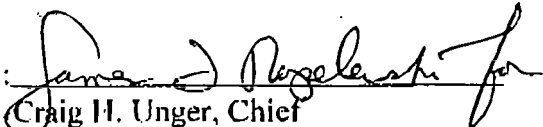
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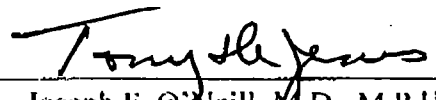
Signature Page

ACCEPTED
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

By: 
Craig H. Unger, Chief
Procurement and Property Branch

Date: 9/22/99

ACCEPTED
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

By: 
Joseph F. O'Neill, M.D., M.P.H.
Associate Administrator
HIV/AIDS Bureau

Date: 9-30-99



MISSOURI DEPARTMENT OF
HEALTH

Mel Carnahan
Governor

Maureen E. Dempsey, M.D.
Director

Northwestern District • Cameron Area Office
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816/632-2107
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May 27, 1998

**Todd Summers, Deputy Director
Office of National AIDS Policy
736 Jackson Place, N. W.
Washington, D.C. 20503**

Dear Mr. Summers:

Your luncheon presentation at the Kansas City Chicken Soup Conference May 1, 1998, was enlightening and I was delighted to have had the opportunity to spend a couple of minutes with you after the talk. Your enthusiasm, encouragement, and cautious optimism were very refreshing and energizing; thank you. Per our conversation I promised to send you a brief history and description of Missouri's pilot discharge program linking HIV+ inmates to the service coordination network prior to release. This information is attached.

The Missouri Department of Health, Bureau of HIV/AIDS Care and Prevention Services is currently in the process of locating funding sources to assist us with this program. I will be eager to hear of any opportunities that we might pursue.

Again, thank you for your assistance in this matter.

Sincerely,

**Susan Moore, Service Coordinator
Bureau of HIV/AIDS Care and Prevention Services**

SM/jd

Attachment

c **Pamela Rice Walker, M.P.A.-Director
Mary Menges, Bureau Chief**

ATTACHMENT:

PRISON LINKAGE PROJECT:

GOAL: TO LINK EVERY HIV+ INMATE TO THE SERVICE COORDINATION NETWORK PRIOR TO RELEASE.

History

I have been involved in the AIDS pandemic for 13 years, the last eight as a case manager. I became increasingly concerned when formerly incarcerated HIV+ individuals were delaying accessing our service coordination network, for up to one year. This meant that they were not receiving vital services. Some of them have since reported that they simply returned to an environment they knew, Correctional Centers, to continue their care. With the support of the Bureau of HIV/AIDS Care and Prevention Services, I began to identify the barriers to accessing the life sustaining services that are offered through Ryan White Title II and prevention funding.

After interviewing the inmates, I determined that their discharge plan did not include a referral for Ryan White case management services or medical care and that they had no idea where to start locating the services. In fact, I was told by the medical staff in all five sites that they knew nothing about the services that were offered through the Missouri Department of Health, Local Health Departments, Community Based Organizations, or where to send the HIV+ inmates for medical care. I know from years of experience that finding a physician to treat HIV in the rural areas is not an easy task. In some cases, it was reported that medical pamphlets on HIV were avoided because they had never learned to read. Some reported that they did not take their medication while incarcerated for fear that their peers would "figure it out" and were afraid of the repercussions. Pursuing treatment on the "outside" was not high on their list of priorities for those who avoided care while incarcerated. Some reported that they just wanted to forget their pain and felt that talking about it was just a reminder that they were going to die. None of the former inmates reported knowing much about risk reduction or how to access free condoms. It became clear that time and energy was needed to educate the Correctional Medical Services Staff about the services available through service coordination (case management) and that personal contact with the soon to be released inmates was vital to the success of the linkage.

With the support of my bureau, I partnered with a Disease Intervention Specialist with the Missouri Department of Health STD/HIV Prevention Bureau who introduced me to the Medical Facilities Administrator at Western Missouri Correctional Center in Cameron, Missouri. The Department of Corrections contracts their Medical Services through

Correctional Medical Services, Inc. I explained our service delivery system and asked if the infectious disease nurse would be willing to contact me with the discharge date of all HIV+ inmates prior to their release. I asked permission to meet with the inmates to explain the benefits of our program, give them a choice of agencies, and have them call that agency and speak with a case manager to schedule an appointment prior to their release. The connection that the inmate makes that day is key to the success of this program as they start to build a relationship with a very concerned, caring, non-judgmental and encouraging case manager. This connection makes it is less intimidating to walk into a strange facility and keep their scheduled appointment. The administrator was very optimistic after hearing that there is community based assistance with medications, housing, food, transportation, risk reduction methods, and free condoms. She agreed to take the request to her superiors. Shortly after that meeting the administrator called to report that I had been cleared to meet with the HIV+ prisoners in her Center, but warned me that the notification of discharge is often very close to the discharge date. It was later that I learned that average length of discharge notification time from parole is only 5 days. Because I have a full case load of HIV+ symptomatic individuals, I knew that this short notification time would be a barrier to reaching all of the inmates, but I made a commitment to that administrator, that whenever possible, I would work within that time frame.

That first contact was made in August of 1995. Since then, four Correctional Centers located in this 19 county area of Northwest Missouri have been added. These include: Crossroads maximum security, Chillicothe Correctional Center for women; Western Regional Diagnostic and Treatment Center for substance abusers, and Maryville Treatment Center, also for substance abusers. It is now clear that in order to meet our objective of taking this project statewide we will need additional staff. There are 26 Correctional Centers, representing 9.5% of the HIV morbidity reported in the last year, and 136 jails in the State of Missouri. I am gathering data on the numbers of Juvenile Detention Centers, Residential Treatment Centers, Halfway Houses, Honor Centers, and facilities housing forensics patients.

This discharge program is effective at reducing the time from release to accessing case management services. I contact the agencies located in the community in which they will reside (frequently in St. Louis and Kansas City) and verify that the appointment was kept or rescheduled. Because I meet weekly with the Case Managers from all of the agencies in Kansas City area, I receive feedback about their visits. The inmates are very grateful to find that there is a mechanism to obtain medications, housing, transportation, and mental health services. I watch as their faces soften; some become so overwhelmed with emotion that their eyes fill with tears.

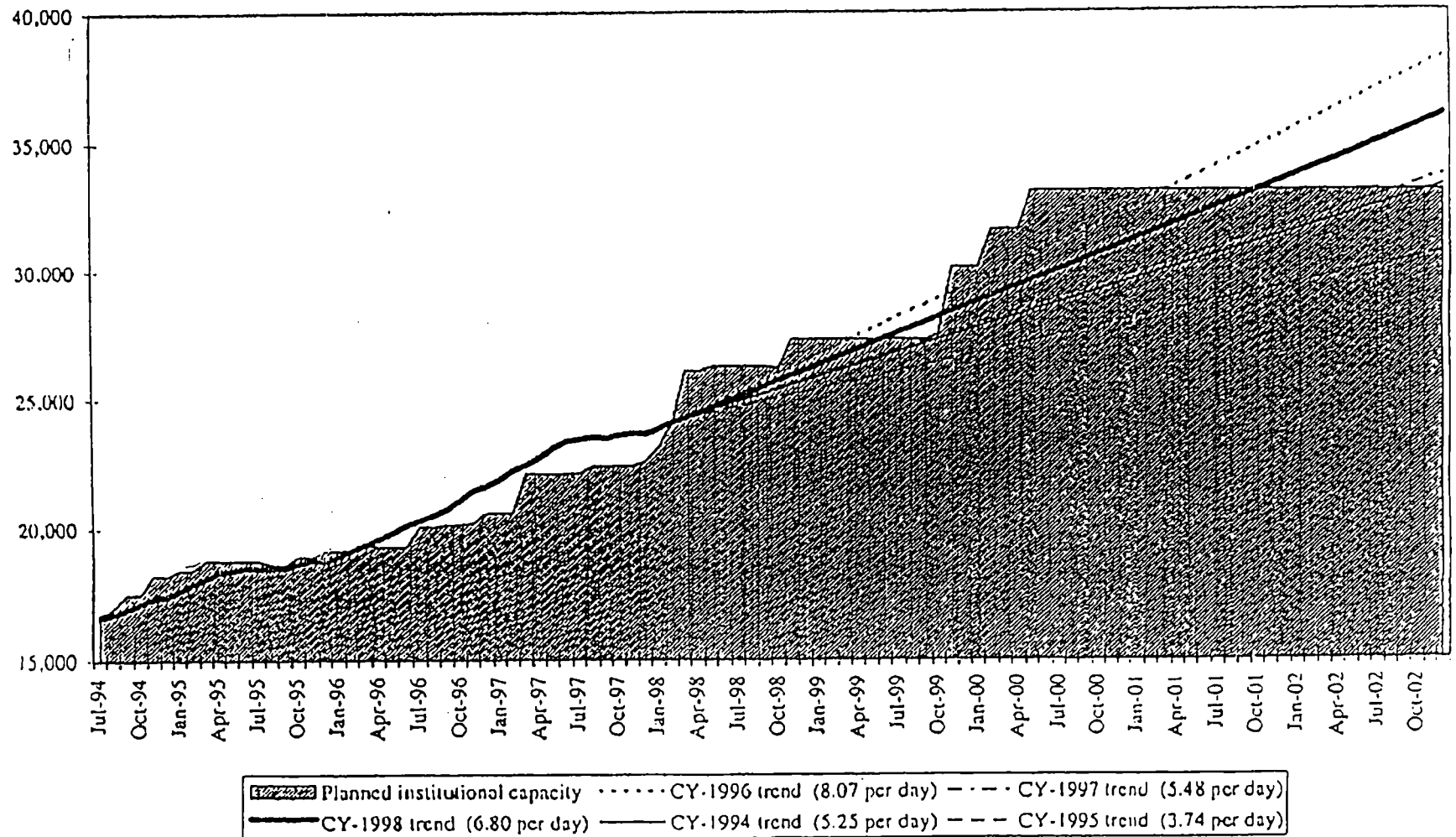
This project was just recently presented to the Governor's Council on AIDS who were all very supportive of pursuing funding in order to increase the number of sites. They are also making a recommendation that the parole officer notify medical services at least 30 days prior to release.

Two additional barriers have been identified. There is significant turnover of medical services staff that the referral process was not being passed on to the new employee. However, this will be alleviated with additional staff having designated dates to meet with medical services on a routine schedule. The Department of Health will work with the Department of Corrections to create standardized training for the Medical Services Staff on this outreach and transitional case management program. Although Missouri requires an HIV antibody test on all inmates upon entrance and exit, there can be up to a three month delay in notifying medical services of a positive test result. Inmates who seroconvert while incarcerated are released without knowing their test results as the HIV antibodies are drawn the week of their release. Surveillance is eventually notified and the former inmate will be contacted, however; without post test counseling, the potential of unprotected sexual activity is of great concern. This was presented as a barrier and the Department of Corrections will be discussing this concern during their strategic planning meetings. We have also been advised that new staff has been hired at the lab and there will no longer be such a delay in entering the HIV test results in the computer. I am concerned that three out of the last four inmates with whom I spoke reported that they seroconverted while they were incarcerated. These were inmates who requested a HIV antibody test. The ID Nurses confirmed that inmates are being infected while they are incarcerated and share our concern.

I have enclosed the growth projections from the Department of Corrections. They anticipate a 30% increase or 8,000 additional inmates, by April 2000. There is a strong focus on treatment, so we can expect an increase of injecting drug users and their sex partners.

Missouri is spread out over a large geographic area, and we project a minimum of four to six outreach workers routinely visiting the sites, meeting with the inmates to provide education, assess their needs, assist with their discharge and link with a case manager. In the future, we hope to facilitate support groups and offer HIV Antibody testing at sites where it is not currently available. In addition, there is a need for at least two transitional case managers who will function as their primary transitional case manager. Based on the average number of releases each month, two transitional case managers could have up to 36 clients in a 6-8 month time frame with releases from just the major Correctional Centers.

Institutional Population and Capacity Projection to December 2002 **April 7, 1998**



Summary of Reported HIV and AIDS Cases, Missouri, 1982-1997*

Geographic Area	HIV Cases**				AIDS Cases***				Total HIV/AIDS Cases	
	Reported 1997*		Cumulative*		Reported 1997*		Cumulative*		Cumulative*	
	Case	%	Case	%	Case	%	Case	%	Case	%
Location										
St. Louis City ^I	137	(29.1%)	 1,062	(28.7%)	 120	(25.0%)	 1,980	(26.6%)	 3,042	(27.3%)
St. Louis County ^I	77	(16.4%)	 526	(14.2%)	 92	(19.2%)	 1,197	(16.1%)	 1,723	(15.5%)
Kansas City ^I	101	(21.5%)	 965	(26.1%)	 113	(23.5%)	 2,153	(29.0%)	 3,118	(28.0%)
Outstate ^I	112	(23.8%)	 913	(24.7%)	 129	(26.9%)	 1,934	(26.0%)	 2,847	(25.6%)
Missouri Correctional Facilities ^{II}	43	(9.1%)	 234	(6.3%)	 26	(5.4%)	 170	(2.3%)	 404	(3.6%)
Missouri Total	470	100.0%	 3,700	(100.0%)	 480	(100.0%)	 7,434	(100.0%)	 11,134	(100.0%)

AIDS Policy & Law

The Biweekly Newsletter on Legislation, Regulation and Litigation Concerning AIDS

Route to:

Volume 13, Number 3

February 20, 1998

Prisons

Two Major Prison Cases Poised for Court Review

The question of whether prison inmates with disabilities are entitled to the same programs and services as nondisabled inmates will receive a good deal of attention this spring.

The U.S. Supreme Court will decide whether federal disability-rights statutes apply to state prisoners, and a federal appeals court will rehear a decade-long legal battle over Alabama's policy of barring HIV-positive inmates from most prison programs.

The high court will consider the case of a Pennsylvania inmate who claims that the prison violated the Americans with Disabilities Act by refusing to let him participate in a boot camp program because of his hypertension.

The case, *Pennsylvania Department of Corrections v. Yeskey*, could have enormous significance to inmates with HIV, most notably those in Alabama who have been in court for a decade trying to gain access to prison programs and services.

Late last year, the Alabama case seemed headed for a retrial on the merits of the inmates' allegations in *Onishea*

MORE INSIDE

- Prisons must adhere to evolving standard of HIV care. See page 6.
- Prisoner advocacy group closes for lack of funds. See page 7
- Judge rejects claim that prisons gave substandard care. See page 9.

(See PRISONS on page 8)

Texas To Switch From Codes To Names To Track HIV Cases

The Texas Department of Health is moving to scrap its system of tracking HIV cases by unique identifier and instead begin using individuals' names.

The announcement was expected. State health officials have been unhappy for some time about too many HIV cases slipping through the cracks of their HIV surveillance program.

Texas officials say each year, health-care providers send them thousands of reports with partial code numbers, making it difficult or impossible to eliminate duplicate reports, describe trends in the epidemic or follow up with treatment services.

"The system has some fundamental flaws that we never could fix," said **Dr. Sharon K. Melville**, director of the department's **HIV/STD Epidemiology Division**. "There also were problems that we thought we could fix, but we found they were more difficult to correct than we thought."

Texas is one of only two states — Maryland is the other — that tracks adult HIV cases using coded numbers. Both states use 12-digit numbers containing four elements: the last four digits of the

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Prisons

Prisons Must Adhere to Evolving Standard of HIV Care

As prison populations continue to rise, so does the number of inmates infected with HIV. At the same time, treatment for the disease is increasingly more expensive and time-consuming to administer. Corrections officials must brace themselves for the changes now, or face costly litigation later.

A study released last August by the federal **Bureau of Justice Statistics** shows that the number of federal and state inmates known to have HIV rose to 24,226 in 1995 from 21,475 in 1993, a 13 percent increase.

The challenge facing prison administrators is to provide the latest therapies, which cost between \$600 and \$900 monthly per inmate, to a population that is growing rapidly.

Prison officials may have little choice in the matter. Guidelines from the **U.S. Public Health Service** establish triple combination therapy as the standard of care. Prisons are obligated by law to provide medical care that meets accepted standards.

"The most important message (for administrators) is this is something they are going to have to do and, yes, it costs more money — up to \$12,000 per year — but it saves lives," said **Robert Greifinger**, a correctional health care consultant and former chief medical officer for the **New York State Department of Correctional Services**.

To adequately treat the HIV-positive population, administrators need to keep up with the latest treatment developments and create proper strategies for delivering them.

Experts Offer Information, Advice

Greifinger and other AIDS treatment experts gathered recently for a roundtable discussion on the implications the new medical advances have for prisons. Their recommendations were published in a 14-page monograph, "Management of the HIV-Positive Prisoner," that is being distributed by the **National Commission on Correctional Health Care** and was published by **World Health CME**.

Greifinger said the best approach for corrections agencies is to take responsibility for providing the new treatment right away.

"There are some who are saying it is experimental. They will be in big trouble. There will be a big lawsuit somewhere," he said.

The experts who took part in the roundtable discussion made several recommendations:

■ **Understand the latest treatment.** There are 11 **Food and Drug Administration**-approved antiretroviral drugs, which must be used in combination for the greatest effect. The current guidelines, issued last fall in final form, call for three drugs to be used. Quadruple-drug therapies are in the clinical trial stage.

"If it is out there, the inmates will want it," said **Robert Smith**, medical director for **EMSA Correctional Health Care**, which provides services for prisons in several states.

Frederick Altice, director of the HIV in Prison Program at **Yale University School of Medicine**, said administrators need to be sure inmates already on medications at intake continue to receive the drugs without interruption. They also must ensure that when inmates are released, they can get care in a timely manner.

"If we don't, we will promote resistance and the medications won't work (inside and outside the prison)," Altice said.

Prisons must be prepared routinely to monitor the effectiveness of the medications using viral load tests, which can cost between \$150 and \$200. If medicines aren't working, they must be changed to minimize the level of viral activity.

■ **Obtain experienced physicians.** HIV specialists increasingly recommend that patients, including inmates, be treated by a physician who has experience with the disease.

"It doesn't necessarily mean facilities should hire an infectious disease specialist," Greifinger said.

But many say corrections facilities can't regard HIV disease as a general medical issue either. One reason for this recommendation is the therapies are now so complicated and are changing so rapidly that experts are needed to keep up with the changes.

Smith said EMSA is in the process of creating a protocol document for its prison physicians that describes which drugs should be prescribed under certain situations. For example, an HIV-positive inmate who previously took the drug AZT alone should not take it again in conjunction with a multidrug therapy because the inmate can develop resistant strains.

Physicians also should see HIV-positive inmates on a regular basis, said **Robert Cohen**, a corrections health-care monitor and an **American Public Health Association** representative to the **NCCHC**.

■ **Be sensitive to privacy.** Prison officials shouldn't create disincentives for inmates to seek treatment or learn their HIV status.

This can happen when prisons segregate HIV-positive inmates, deliver multiple doses of medication (the minimum number of pills in triple therapies is 10) to an inmate's cell or force HIV-positive inmates to stand in line to obtain drugs at a window. Other disincentives include the loss of a correctional job or participation in certain programs.

Many feel this can be avoided.

(continued on next page)

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"There is no reason to isolate an HIV-positive inmate unless they have another disease. An inmate on triple-drug therapies may not look any different from someone who doesn't have the virus," said Smith.

Strategies administrators should consider include providing additional education, ensuring inmates are offered HIV testing and offering HIV testing on demand. If testing is coupled with aggressive treatment, inmates will be more motivated to take care of their health, the panel said.

■ **Remove barriers.** Corrections officials are more to blame for adherence problems than inmates, said **Anne DeGroot**, assistant professor in **Brown University's** TB/HIV lab.

"In my experience as an HIV provider, barriers to adherence are 95 percent correctional," DeGroot said.

These include lockdowns, when medicine lines are canceled, and the prison's refusal to furnish medicine when inmates leave the facility for court visits.

Greifinger said managers should give inmates the flexibility they need to take medicines and accommodate them when their medications should be taken before or after meals. That strategy alleviates missed doses, which decrease effectiveness and increase the risk of developing drug resistance.

■ **Team approach to HIV management.** The panel recommends that each facility develop a multidisciplinary team to deal with HIV management, which includes the warden, security staff and physicians. This effort can improve communication and coordination of treatment, such as delivering medication to inmates. It will also help physicians address concerns such as which inmates should be allowed to walk away from a window with medication in hand and which should not.

Smith said a multidisciplinary team can also assist with discharge planning to ensure an inmate on combination drug therapy will continue to receive treatment after release.

Costs Should Not Drive Decisions To Treat

Corrections agencies should not approach HIV treatment by working within a current budget, according to treatment specialists.

The costs are not insignificant. In Illinois, for example, the cost of providing drugs jumped from \$30,000 a month to \$300,000 a month since combination therapy arrived on the scene in late 1995.

Panel members said that the expense associated with new HIV treatments should be added to a budget, otherwise no prison can provide proper treatment to all who need it.

"They don't want to increase their costs, but if they don't ask for an additional half million or a million dol-

lars, they are not asking for enough to treat (inmates)," Cohen said.

DeGroot said the cost of not treating these inmates is one that all taxpayers will pay in future years.

"With treatment we get people who are healthier, have fewer admissions and decrease AIDS-related hospitalizations," she said. "It's going to save them money even though they have to increase pharmacy budgets now."

Cohen said fears that inmates won't adhere to regimens should also not deter prisons from offering the drugs. According to Smith, inmates receiving services from EMSA are all given the new therapies if they want them, despite a history of noncompliance with drug regimens. He said some facilities have a hard time providing these expensive medications to inmates who won't take them on time. "The costs and risks are too great to have someone not take it," Smith said.

But Cohen said prisons have a greater ability to monitor and should take advantage of that.

"It's far more common for (inmates) to not get their medications than it is for them to not take them," he said.

Based on a report in *The Corrections Professional*, published by LRP Publications.

CONTACTS: The monograph, "Management of the HIV-Positive Prisoner," is available through World Health CME, 41 Madison Ave., New York, NY 10010-2202.

Prison Advocacy Group Closes for Lack of Funds

An agency that has become a leading advocate of the rights of prisoners with HIV is shutting down for lack of money.

The **HIV/AIDS in Prison Project of Catholic Charities for the East Bay**, based in Oakland, Calif., is scheduled to close by Feb. 13.

Director **Judy Greenspan** said the project lost its source of foundation funding and was unable to secure new grants. The closure comes at a time when the Prison Project was hoping to expand.

Catholic Charities provided a base and an imprimatur for the project, but did not provide funding.

Greenspan, an advocate for the rights of HIV-positive prisoners for 10 years, plans to continue her work on a part-time basis under the wing of a 2-year-old organization, the **California Prison Focus**, as head of the group's HIV in Prison Committee. The group is financed entirely by donations.

Greenspan can be reached by writing the California Prison Focus at 2489 Mission St., Suite 28, San Francisco, CA 94110.

PRISONS (continued from page 1)

v. Hopper (see *AIDS Policy & Law*, Nov. 26, 1997, page 1). Then, on Jan. 23, the 11th U.S. Circuit Court of Appeals vacated an appellate panel's opinion in favor of the inmates and granted the state's request for a rehearing by the full court.

It's possible that the 11th Circuit will put *Onishea* on hold until it sees what the Supreme Court does in *Yeskey*, according to **Ayesha Khan**, staff counsel with the **American Civil Liberties Union's** National Prison Project in Washington, which represents the Alabama inmates.

However, the 11th Circuit has other issues confronting it in *Onishea*, including whether Alabama has presented valid penological reasons for denying HIV-positive inmates equal access to prison programs and services.

Split Among Circuit Courts

The Supreme Court probably agreed to take up *Yeskey* because federal circuit courts of appeal are divided on the question of whether federal disability-rights laws apply to state prisons, according to **Marjorie Rifkin**, also a staff counsel with the ACLU's National Prison Project.

Until lately, many courts took it for granted that the ADA and the Rehabilitation Act, which covers public entities receiving federal funds, apply to state prisoners, Rifkin said. Increasingly, though, states are beginning to question those assumptions.

The 3rd, 7th, 9th and 11th circuits have upheld prisoners' rights under the disabilities statutes. But the 4th Circuit rejects that view, saying Congress was not clear on whether the ADA applied to prisons. The 10th Circuit also has addressed the question. Its opinion is ambiguous, but has been read as holding that the ADA is inapplicable in a penal setting.

Donald Specter, director of the **Prison Law Office**, a public-interest law firm based in San Rafael, Calif., will argue *Yeskey's* case. Specter said he was disappointed that the Supreme Court decided to review the case because most circuit courts already have held that the law applies to prisons.

"It can only get worse from here," he said.

Twenty-six states and the District of Columbia supported Pennsylvania's appeal. An attorney for the Commonwealth of Pennsylvania could not be reached for comment.

Second ADA Case Before Court

In the *Yeskey* case, the 3rd U.S. Circuit Court of Appeals ruled last July that the law applies to prison inmates and that the boot camp program fell under the definitions of the ADA.

The inmate, **Ronald R. Yeskey**, was denied admission to the **Pennsylvania Department of Correction's** Motivational Boot Camp program because of a history of hypertension, even though the sentencing judge recommended that he be placed there. Inmates may be

assigned by the DOC to serve six months of their sentences at the boot camp. It provides rigorous physical activity, intensive regimentation and discipline, work on public projects and other treatment. The statute creating the camp stated that admission to the camp would be discretionary and that it was not an inmate's right to participate.

Nevertheless, *Yeskey* filed a lawsuit against prison officials claiming that his rights under the ADA had been violated. A district court dismissed *Yeskey's* ADA complaint, but the circuit court reversed the decision.

The Supreme Court is expected to hear arguments in the case by the end of April. That's roughly a month after the court hears its first ADA case, *Bragdon v. Abbott*, which involves a dentist who refused to treat an HIV-positive patient in his office.

The court's timetable for *Yeskey* calls for the Pennsylvania DOC and its supporters to file briefs by March 4. Briefs by *Yeskey* and his allies are due March 30.

En Banc Hearing Is Unusual

In the meantime, the plaintiffs in *Onishea* continue to wait. Their case, originally filed in 1987 as *Harris v. Thigpen*, led to a landmark 1991 circuit court opinion holding that mandatory HIV testing and segregation is permissible because it serves the correctional system's interest in protecting the safety of uninfected inmates. It sent the case back for trial on the question of whether HIV-positive inmates could receive the benefit of prison services and programs without posing a significant risk to the health of others.

Following a bench trial in 1995, a federal district court judge ruled that Alabama was justified in excluding HIV-positive inmates from 79 programs ranging from worship services to work details because of the potential — and sometimes speculative — risk that they might transmit the virus.

Last November, a divided three-judge appeals panel overturned the opinion, ordered a new trial and took the unusual step of removing from the case the original judge.

The 11th Circuit's decision to vacate the panel's ruling and rehear the case *en banc* is unusual.

"It's rare. It's like hen's teeth. Last year, the court had only two *en banc* hearings," said the state's attorney, **David Byrne of Robeson & Belser** in Birmingham, Ala.

No date has been scheduled for oral argument.

(*Pennsylvania Department of Corrections v. Yeskey*; U.S., No. 97-634. Petition for certiorari granted Jan. 23, 1998.)

(*Onishea v. Hopper*; 11th Cir., No. 96-6213. State's petition for rehearing *en banc* granted Jan. 23, 1998.) □

CONTACTS: *Onishea* is represented by the American Civil Liberties Union's National Prison Project in Washington, D.C., (202) 234-4830. *Hopper* is represented by David Byrne of Robeson & Belser in Montgomery, Ala., (334) 834-7000.

Prisons

Judge Rejects Claim That Prisons Gave Poor Medical Care

A federal judge in New York dismissed a complaint filed by six-HIV positive inmates who alleged that three state prisons provided inadequate medical treatment and unsanitary living conditions.

In granting a defense motion for summary judgment, U.S. District Judge **John S. Martin Jr.** said the inmates lacked enough evidence to support their claims that prison officials were deliberately indifferent to their medical needs.

After examining each of the factual allegations, Martin concluded that while the care did not satisfy the inmates, prison health-care personnel did address the medical complaints they raised, and no urgent need went unattended.

The law is clear, the judge said, that differences of opinion between an inmate and a prison about the appropriateness of medical care cannot form the basis for a finding of deliberate indifference.

The suit was brought by six women incarcerated at the **Bedford Hills**, **Albion** and **Taconic** correctional facilities, all operated by the state. The inmates sued on their own, but two of them, including lead plaintiff **Louise K. Nolley**, were represented by legal counsel in the defense petition for summary judgment.

The inmates raised a number of allegations, including substandard medical care, refusal to prescribe requested

drugs and failure to treat HIV-related symptoms aggressively. The care was provided during 1994 and 1995, before combination drug therapy became the accepted standard of care for HIV disease.

In one instance, Nolley alleged that she suffered irreparable harm because her AZT treatment was interrupted three times, twice because of transfers to other prisons and once because a doctor decided to stop it. The longest gap lasted eight days. Her AZT treatment ended four months later when another doctor concluded the medicine was providing no benefit.

Martin noted that Nolley herself "failed to follow up on prescribed medical care" on several occasions since then.

As Martin saw it, the most serious allegation raised by the inmates was that one prison, Taconic, was infested with insects and cats, placing HIV-positive inmates at elevated risk for contracting diseases carried by ticks and cockroaches, and toxoplasmosis from cat feces.

The officials could not be held deliberately indifferent to the problem, the judge said, because the evidence showed that prison officials had made an effort to control the infestation.

(*Nolley v. Lord*; S.D. N.Y., No. 96 CIV 1621. Decided Nov. 10, 1998.) □



Mandatory Testing

New York Judge Lacked Power To Order HIV Test of Defendant

A New York appeals court has ruled that a trial judge lacked the authority to order an HIV test of a defendant who pleaded guilty to attempted sexual abuse.

The defendant, identified in court opinion as **Donald P.**, was indicted on charges of first-degree rape and first-degree sexual abuse.

He initially said the sexual intercourse he had with the complainant was consensual.

The charges were later reduced, and the defendant pleaded guilty to first-degree attempted criminal abuse based on his admission that he tried to force sex on the complainant.

In March 1996, Nassau County Court Judge **Daniel P. Palmieri** included in the sentence a requirement that the defendant submit to an HIV test. The defendant appealed, saying Palmieri lacked the authority to do so.

A four-judge panel of the state Supreme Court's Appellate Division said the defendant was correct.

Under New York law, a trial court has the authority to order a defendant to undergo HIV testing if he or she is convicted of an act that could transmit the virus. The acts include sexual intercourse and deviate sexual intercourse.

The appeals panel said it was common sense that the Legislature did not intend to mandate HIV testing of a defendant convicted of acts of sexual contact that carry no risk of transmission.

Moreover, the law includes a requirement that sexual intercourse or deviate sexual intercourse form the basis for the defendant's conviction. An indictment isn't adequate grounds to compel testing.

"The statute does not make any provision for circumstances such as these, where the charges are reduced pursuant to a plea," the appeals court said.

(*Donald P. v. Palmieri*; N.Y. App. Div., 2nd Dept., No. 96-02915. Decided Jan. 20, 1998.) □

The Latino Commission on AIDS
Report on Sex in Prison Survey:
Former Prisoners Speak Out on the Distribution
of Condoms and Latex Barriers
in New York State Prisons
1999

The Latino Commission on AIDS, along with many other groups and individuals, firmly believes that the unavailability of condoms and latex barriers to prisoners poses a public health risk. To better determine the need for distribution of condoms and latex barriers within prisons in New York State, the Latino Commission on AIDS conducted a survey of former inmates to obtain information to support this argument.

METHODOLOGY:

This anonymous survey was conducted in part to document the extent of sexual activity in New York State prisons. We asked former prisoners about their personal sexual experiences and their observations of sexual activities in prison. There were a total of sixteen questions. We elicited opinions and comments on the most effective methods and locations for the distribution of condoms and latex barriers. The survey was distributed among community-based organizations and drug treatment programs throughout the five boroughs, in both English and Spanish language. The one hundred and eight participants of the survey contributed informative and helpful responses. The survey included questions ranging from observations of sex in prisons, participation in sexual activity, opinions about providing latex barriers and the impact that protection would have on sex in prisons.

SURVEY PARTICIPANTS:

Respondents of the survey self-identified as 74% heterosexual and 16% bisexual, homosexual or transgender, and 10% non-respondents. The racial composite was 46% Latino, 40% African-American, 9% Caucasian and 5% unknown. Of those surveyed, 14% served less than one year in prison, 49% had been incarcerated for one to five years, 15% for six to ten years and 9% for eleven or more years. 13% of the participants did not respond to this question.

SURVEY RESULTS:

The one hundred and eight participants of the survey contributed informative and helpful responses. The survey included questions ranging from observations of sex in prisons, participation in sexual activity, opinions about providing latex barriers and the impact that protection would have on sex in prisons.

OBSERVATIONS:

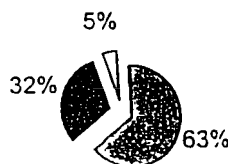
The amount of prisoners that observed sex while in prison was surpassingly high. 63% of those surveyed had witnessed other prisoners having sex.

63% - Observed prisoners having sex

32%- Never

5%- No Answer

Observed Inmates Having Sex



Of those that had observed other prisoners, 33% had seen prisoners having sex on sixteen or more occasions. 17% had witnessed sex four to fifteen times and 15% had witnessed one to three times. Some described the situation of sex within prisons as, "Out of control" "Sex in prison is a fact, and protection should be provided" "Although sex is not permitted in the prisons (just like using intravenous drugs) providing ways to avoid the spread of HIV within the prisons should be considered because sex will always occur whether or not it's permissible" and " Sex is something that has been and always will be inside of the prisons" In the cases in which inmates had witnessed or participated in, there was no one common area of activity. Cells, bathrooms, showers, yard, office closets and gyms were all cited as places of high sexual activity. The most common form of sex in prison was consensual, mutual consent between the persons involved. Other forms of sex reported were for barter, protection and coercion by bribery. There were five reported cases of involuntary sex.

There was an interesting comparison between the men and the women surveyed. 85% of the twenty-six women polled had personally witnessed sexual activity while 57% of the eighty-two men had personal observations

ENGAGEMENT IN SEX:

Of all of the participants of the survey, 17% had engaged in sex while incarcerated. 2% had one to three oral sex encounters, 10% had four to fifteen and 3%

had sixteen or more encounters. 6% of those surveyed had engaged in anal sex one to three times, 4% four to fifteen times and 1% sixteen or more times. 34% of those responding to the survey felt that twenty-five to fifty percent of prisoners are sexually active within correctional facilities. 28% felt that less than ten percent were having sex, 13% said fifty to seventy-five percent were sexually active, 9% felt it was less than 1% and 16% did not answer the question.

AVAILABILITY OF CONDOMS AND LATEX BARRIERS:

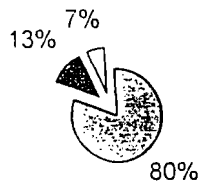
Eighty percent of all of the participants agreed that condoms should be made available within the prison.

80% - Yes

13% - No

7% - No Ans.

Should Condoms Be Distributed in
Correctional Facilities?



75% also felt that latex barriers should be accessible to incarcerated women. 40% of those surveyed said that they would use the protection if provided. The respondents who were not sexually active in prison expressed that they would have no use for the condoms and therefore answered no or gave no response to the question. The participants were also asked what kind of impact the distribution of condoms would

have on sexual activity within correctional facilities. 43% felt that sexual activity would remain the same in these facilities, while 38% felt activity would increase. Much like the previous question, those not sexually active gave no response and indicated lack of knowledge on the subject.

When asked where should condoms and latex barriers should be distributed, the respondents suggested housing units, the commissary, same ways as other supplies are distributed, school areas, the yard, in orientation (upon entry into the system) the gym, sick call, infirmary, common areas, through the package room, placed within a box in the housing areas or in the bathrooms. Many felt that they should be issued in a manner where persons will not be identified, possibly through some prisoner run organization, and 24 hours a day from a trustee prisoner in each dormitory, tier or gallery.

The need for disbursement of condoms and latex barriers in correctional facilities is obvious. 31% of the participants reported knowing someone who had contracted HIV in prison due to unprotected sex. This number provides us with an idea of how much preventive measures need to be taken in prisons to help stop the spread of HIV and other sexually transmitted diseases. The situation of correctional officers engaging in sex with prisoners is an issue. 45% of those surveyed responded they were aware of correctional officers having sex with prisoners . This statistic shows an obvious problem that has a tremendous impact on the need for distribution of condoms as well as the review of officers' behavior. One final note, many survey respondents highlighted the need for education and information together with the distribution of condoms and latex barriers to prisoners.

CONCLUSION:

The responses to this survey confirms that unprotected sex is prevalent in prisons. More recently, the Department of Correctional Services admits that sex occurs within their facilities. However, DOCS maintains that sex among prisoners is a violation of rules and regulations and that condoms are considered contraband. DOCS officials insist that allowing condoms would "send the wrong message" that it would promote and condone sexual activities, which is contrary to their policies.

The Latino Commission on AIDS, along with a state wide coalition of groups and individuals, considers that the lack of condoms in prison constitutes a public health emergency. Our political leaders must be better informed on this issue and urged to take appropriate and responsible actions.

The Department of Correctional Services needs to change its current policies that prohibit condoms. These current policies pre-exist the AIDS/HIV epidemic. These are policies that do not adequately address the needs of prisoners to protect themselves against sexually transmitted diseases.

We must address this public health crisis within our State prisons and advocate for legislative actions that will change existing DOCS policies. Condoms and latex barriers should be made available to prisoners while in the custody of the New York State Department of Correctional Services.

THE LATINO COMMISSION ON AIDS

Report of Sex in Prison Survey

1999

HIGHLIGHTS

- 108 Former New York State Prisoners responded to the survey.
- The survey included questions ranging from observations of sex in prisons, participation in sexual activity and opinions about providing condoms/latex barriers.
- Respondents self-identified as 74% heterosexual, 16% gay, lesbian, bisexual, or transgender.
- 46% Latino. 40% African American. 9% Caucasian.
- 80% of respondents agreed that condoms should be made available.
- 63% observed prisoners having sex.
- 31% of respondents reported knowing someone in prison who had contracted HIV due to unprotected sex.
- 45% of respondents said they were aware of correctional officers having sex with prisoners.
- 33% had seen prisoners having sex on sixteen or more occasions. 17% had witnessed sex four to fifteen times and 15% witnessed sex one to three times.
- 86% of the twenty-six women surveyed witnessed sexual activity. 57% of the eighty-two men had personal observations.
- 40% surveyed said they would use protective barriers if available.
- 43% of respondents felt that sexual activity would remain the same if protective barriers were distributed. 38% said that sexually activity would increase.
- Suggested areas of distribution: housing units, the commissary, school areas, the yard, upon entry into the system (orientation), bathrooms, package rooms, gym, sick call, infirmary,

The New York Times

NEW YORK, THURSDAY, FEBRUARY 18, 1999

Two Reports Criticize Prisons on H.I.V. Policy

By LYNDIA RICHARDSON

Despite a decade of scathing reports and government audits, the New York State Department of Correctional Services has failed to provide adequate H.I.V. prevention and health services, including condoms to all inmates, according to two new reports.

The state's AIDS Advisory Council, in one report, has concluded that prison health services, particularly for inmates with H.I.V., are so seriously deficient that authority for inmate health care should be transferred from the correction agency to the state's Department of Health. The panel report cited uneven, uncoordinated health services in many prisons; major shortages of health care staff and inadequate training.

And in a news conference yesterday, advocates for prisoners and people with AIDS intensified their call for condoms to be made available to all inmates. The advocates, led by the Latino Commission on AIDS, said a survey of 108 former inmates indicated that high levels of unsafe sex in prison posed a public health risk. More than 60 percent of the respondents said they had witnessed inmates having sex.

Of the 70,000 inmates in the state's 73 prisons, about 8,000 are estimated to be infected with H.I.V., the virus that causes AIDS. The state prison system has the highest rate of H.I.V.

infection of any system in the country, about 1 percent of all H.I.V.-infected Americans.

A spokesman for the New York Department of Correctional Services, James B. Flateau, said yesterday that a sharp drop in AIDS-related deaths in the prisons over the last four years attested to the quality of care received by inmates. Mr. Flateau said the AIDS care budget in state prisons had increased by 66 percent since 1995, when Gov. George E. Pataki took office, contributing to an 85 percent decline in AIDS deaths during that time.

New York State prisons do not make condoms available except for conjugal visits. Advocates said yesterday that New York City and several other cities and states, including Washington, San Francisco, Vermont and Mississippi, had rules that ban sex in prisons, yet allow the distribution of condoms to inmates. The authorities at Rikers Island in New York City distributed 200,000 condoms last year, advocates said.

"They've been willing to accept the paradox that they can distribute condoms at the same time as keeping sexual activity illegal," said Steven Nesselroth, the director of the AIDS in Prison program for the Osborne Association, a group that focuses on criminal justice issues.

But Mr. Flateau said he did not anticipate a change in the condom prohibition. "We're not going to do

that," he said, adding that condoms are a security threat because inmates and visitors can hide drugs and other contraband inside the condoms and in their body cavities.

He said the agency did acknowledge that some inmates have sex in prison. "We've never said they weren't, and those inmates risk giving themselves a death sentence and we have told them that," Mr. Flateau said.

Over the years, prison health services have been found inadequate by various groups and government agencies, including the New York City Bar Association, the Correctional Association of New York and the State Health Department, which twice has audited the corrections department.

The 17-member State AIDS Advisory Council first addressed the issue in 1989. The latest report was unanimously endorsed earlier this month by the council, which consists of appointees of the Governor and the Legislature. The panel includes doctors, lawyers, advocates and community service providers.

A spokeswoman for the State Health Department, Frances Tarlton, said yesterday that the correction agency had made strides in improving its health care services.

"We don't see any need for the health department to take over medical care in the state prisons," Ms. Tarlton said.

The Latino Commission on AIDS

Prison Project

FACT SHEET
[as of January 1999]

- New York State has the highest numbers of prisoners living with HIV and AIDS than any other prison system.
- There are over 105,000 people incarcerated throughout the State of New York.
- The New York State Department of Correctional Services houses more than 72,000 prisoners in 70 correctional facilities.
- Latinos are disproportionately affected by the AIDS epidemic; while they comprise about 34% of the prison population, they comprise approximately 52% of prisoners with HIV. Latinos have the highest numbers of AIDS -related deaths in State prisons.
- There are over 3,700 women in State prison. About 18% of the women coming into the NYS prison system are HIV seropositive.
- There are approximately 10,000 Spanish language dominant State prisoners who must rely on bilingual prisoners to translate their needs, due to a severe shortage of Spanish language speaking health care providers.
- More than 2,100 prisoners have died of AIDS -related illnesses while in the custody of NYS Department of Correctional Services.
- There are approximately 2,700 prisoners receiving HIV anti-retroviral therapies within the State prison system.
- Despite legal and statutory mandates and a number of critical reports and audits over the past ten years, no statewide quality assurance mechanisms for prison health services have been established in NYS prisons.
- Condoms and latex barriers are not available to prisoners to help stop the spread of HIV and other sexually transmitted diseases.

FROM THE DESK OF
TONIO BURGOS

TADD

FOR YOUR
INFORMATION