TESTIMONY
PRESENTED TO THE BAR ASSOCIATION OF NEW YORK CITY

AIDS IN NEW YORK STATE'S PRISON SYSTEM

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My name is Cathy Potler. I am the director of the Correctional Association's Prison Conditions Project. Founded in 1844 by concerned citizens, The Correctional Association is the only non-profit, private organization in New York State to have statutory authority to visit prisons and to report to the legislature its findings and recommendations for improvement.

Human Immunodeficiency virus (HIV) is one of the most serious and complex problems facing our policymakers today. No state agency in New York remains unscathed by this devastating disease. Since November 1981 when the first diagnosis of AIDS was made inside the prisons and each year thereafter as the numbers of cases increase, the Department of Correctional Services (DOCS) has been confronted with this difficult situation and all of its various ramifications.

We believe that DOCS cannot be expected to tackle the complexities of the AIDS problem alone. It needs all the assistance it can get from experts in the fields of health,

infectious disease, education and substance abuse along with the support and resources from the Governor and state legislature.

Our first encounter with prisoners with AIDS/ARC was in 1984 while visiting prisons in the preparation of our State of the Prisons report. It was during our visits to the prison infirmaries while reviewing aspects of the medical care delivery system that the need to address this issue became apparent. On one trip we came upon a prisoner with AIDS in the infirmary at Clinton Correctional Facility, a maximum-security prison near Plattsburgh. He was sitting on a chair alone in a locked room watching television. When asked what he does all day, he answered "watch t.v." We learned that before he was given the television, several weeks before our visit, he just sat in his room all day and night. The warm, blue sky May day prompted us to ask him if he ever goes outside. He told us: "No, but I know that if I could only get outdoors and smell that fresh air, I am sure that I would feel better." We asked if he had any visitors. He told us that his elderly mother from New York City occasionally made the long, strenous trip up to visit him but that he did not want to tell her about his diagnosis because then she would feel compelled to visit him more frequently. Then he added that he really didn't believe that he had AIDS. He felt too well to be dying. This encounter raised serious questions regarding many aspects of the AIDS situation in the prison system.

For the last 15 months we have been preparing a report on the situation of AIDS/ARC in the New York State prison system. We have visited 10 prisons, some two and three times, and have met with representatives of all sectors of each institution. Our report focuses on five major areas regarding the situation of AIDS/ARC in the New York State prison system. These include: AIDS education and training for staff and prisoners; segregation of prisoners with AIDS/ARC; psychological aspects of AIDS/ARC; medical care and treatment for prisoners with AIDS/ARC; and early release. In addition to identifying and describing these areas, we are also developing specific recommendations for ways of improving the situation. We will make our report available to all committee members upon publication in December.

BACKGROUND

Until recently, AIDS was most often considered a disease that affected primarily white, middle-class gay men. The reality is, however, that the Human Immunodeficiency virus (HIV) has had grave consequences particularly for the low income Black and Latino communities. The major difference in transmission of the HIV infection between whites and minorities is the small percentage of AIDS cases attributed to IV drug users among whites (4 percent) as compared to Blacks (34 percent) and Latinos (36 percent). The high rate of infection among addicts in New York City -- exceeding 50 percent of the city's 200,000 drug users -- is startling.

The seriousness of HIV infection in the New York State corrections system cannot be over emphasized. The prisons have been primarily filled with young, poor, unemployed, uneducated Black and Latinos from New York City. Of the 40,000 prisoners housed in the state's 52 prisons, Blacks and Latinos comprise about 80 percent of the population. And the Department of Correctional Services (DOCS) officials have estimated that around 60 to 70 percent of all state inmates (some 24,000 to 28,000) have a history of IV drug use.

A survey conducted by the New York State Commission of Corrections in 1986 involving 177 cases (88 percent or 156 of these were from the state system) reveals that the typical AIDS inmate mortality was a Black or Latino heterosexual male, 34 years of age, from New York City, with a history of IV drug use prior to entering the system. He was likely to have been convicted of "money-seeking" crimes related to drug abuse such as robbery, burglary or drug-related offenses.

The State Commission on Correction's September 1987 Update on the Demographic Profile of New York State Inmate AIDS Mortalities shows the profile of a typical female inmate with AIDS as a Black or Latina woman, 31 years of age, unmarried, from New York City, with a history of IV drug abuse prior to her incarceration. Female AIDS decedents had an average of two children each. One particularly striking finding by SCOC regarding the female population was the 80 percent increase in female AIDS inmate mortalities over all previous years

concommitant with the increasing numbers of female drug offenders entering the prison system.

Statistics regarding HIV infection in the state prison system indicate that the situation has become more and more critical each year. Since 1981, 391 persons with AIDS have died while in the custody of DOCS. In 1984, there were 57 deaths attributed to AIDS; in 1985, 98; in 1986, 101; and in the first 7 months of 1987, 102.

EDUCATION

According to experts in the field of public health, the most effective weapon developed thus far for combatting the spread of the HIV infection is education.

Attitudes of Staff and Prisoners

There is an enormous amount of misinformation regarding AIDS among inmates and staff. The persistent fears expressed by both them that the AIDS virus can be spread by casual contact and the general misunderstanding of how the virus is actually transmitted were prevalent at all facilities visited. This general lack of understanding often results in reactions and attitudes ranging from hostile to malicious toward those persons with or suspected of having AIDS/ARC. It should be noted, however, that according to officials in DOCS Central Office, there have been no cases of any prisoners with AIDS/ARC having been assaulted by another inmate because of their AIDS diagnosis. Without effective education and training programs, prison administrators will not

be able to implement sound policy decisions at the facility level regarding the care and treatment of persons with AIDS/ARC.

Over the last three years, prison officials have told us that the hysteria initially expressed by the security staff has subsided considerably. Medical staff said that fewer officers who work in the infirmary are using masks and gloves when escorting prisoners. Nonetheless, prison administrators are still very concerned about the attitudes of staff, particularly those of the uniformed employees. Some superintendents at maximum-security facilities intimated that it was the uniform staff who posed greater obstacles than the prisoners in mainstreaming medically cleared inmates with AIDS/ARC into general population.

Transmission Inside and Outside the Prison Walls

Prison officials, staff and inmates speak quite candidly about the occurrence of IV drug use and homosexual activity inside the prisons. In addition, the number of inmates released each year from the New York State prison system is steadily increasing -- 15,168 were released in 1986. A high proportion of these prisoners are believed to have a history of IV drug use and are therefore at high risk of having the HIV virus. The potential for HIV transmission from IV drug users upon their release from prison to their sexual partners and unborn children is significant. Therefore, it is essential that prisoners be armed with information regarding risk reduction behavior prior to their release from prison. It is far more productive to educate

this "captive" audience while incarcerated than to attempt to undertake such efforts on the streets of New York City.

Education and Training for Prisoners and Staff

Efforts have been made to provide some education and training to uniformed and civilian staff and prisoners; however, much more needs to be done. DOCS takes the position that except for the distribution of some literature on AIDS and any programs that the training lieutenants at each of the facilities set up, AIDS education for staff and prisoners is left up to the AIDS Institute of the state's Department of Health (DOH). Thus, there are no systemwide continuous face-to-face AIDS education and training programs for staff and inmates operated by DOCS. As a result, any DOCS programs that exist at the facility level do so because of initiatives taken by individuals at those prisons. Despite the well meaning efforts made by these staff persons, none of the programs at the facilities visited were conducted on a regular ongoing basis.

With respect to the AIDS Institute, five employees devote part of their working time to the state's prison system by providing some education to prisoners and staff. As initially conceived, the Prison Exit Program (PEP), an ambitious one year project funded by the Center for Disease Control, was to offer AIDS education, HIV pre-test counseling and testing referrals to individual prisoners and groups of prisoners just prior to their release from prison. As one can well imagine, with 15,168 prisoners having been released last year from 52 of the state's

facilities, this task is far beyond the PEP staff's numbers. Thus PEP quickly evolved into a group AIDS education program for staff and some prisoner organization heads. In this one-year program, 44 presentations were made at 22 facilities reaching 1479 correctional staff and administrators and 1246 inmates. The usual PEP format is to provide three live presentations at each facility visited. All presentations are on a voluntary basis; the first is provided to the uniform staff, the second to the civilian staff and the last to a group of inmate organization heads. Each presentation runs for an hour and a half and includes a videotape and a question and anwser period. It is basically a one shot deal entailing basic consciousness raising and education but not training. One to one counseling is offered to inmates after each presenttion, but this rarely occurs. PEP staff can enter a prison only if invited by the superintendent as communicated through DOCS training academy in Albany. In addition, the PEP team has also recently started to provide an hour and a half basic AIDS education session to recruits at the Albany and Harriman training academies.

The regional AIDS Task Forces have occasionally provided educational sessions for prisoners and staff over the past four years. The various Task Forces' ticket into the facilities is based upon each superintendent's willingness to give them access. While some superintendents have taken advantage of the services that the Task Forces are able to provide including basic AIDS education and a buddy program for prisoners with AIDS/ARC, the

majority have not. Even in some of the prisons where they have gained access, Task Force members have described numerous obstacles placed in their way.

No AIDS training programs for the non-uniformed staff is available. For instance, this means that the DOCS chemical abuse counselors who provide group and one to one sessions to prisoners with a history of IV drug use as well as the pre-release counselors who try to reach approximately 15,500 prisoners about to be released each year remain without AIDS specific training.

SEGREGATION OF AIDS INMATES

The question of whether or not to segregate prisoners with AIDS and ARC is one of the most difficult and complex decisions for correctional administrators. For those prisoners who need continuous medical attention or monitoring, the decision is a relatively easy one based purely on medical considerations. However, there is a growing number of prisoners with AIDS/ARC whose illnesses are in remission and need not be segregated for medical concerns. This group poses the most difficult managerial problems to the administrators.

DOCS current directive on AIDS (entitled Policies, Procedures and Guidelines Manual on AIDS, December 23, 1985) contains a brief section on "Cohorting" which provides no guidance to the appropriate facility administrators on housing accomodations and programming of this population. Thus, most facility administrators interpretted this policy to mean that

they could not house medically cleared inmates with AIDS/ARC in general population.

In May 1987, the Assistant Commissioner for Health Services attempted to clarify DOCS policy on cohorting in a memorandum which stated: "The decision to place an AIDS/ARC inmate who does require hospitalization or an infirmary setting is strictly a medical determination." Since June 1987 there has been a greater effort made at the facility level to place medically cleared AIDS/ARC prisoners into general population. According to DOCS, of the 89 reported AIDS cases, 12 are currently in general population. However, at a number of the maximum-security prisons, this policy has been difficult to implement because of the attitudes of some of the administrators, civilian and security staff and prisoners. Without a continuous and comprehensive statewide AIDS educational program for staff and inmates, it may continue to be difficult to overcome resistence, at the facility level, which is based on irrational and unfounded fears about AIDS.

From July 1986 until June 1987, most of the diagnosed prisoners with AIDS and ARC, who did not require acute medical care or intensive monitoring, were segregated from the general population. Except for recreation, most of these prisoners with AIDS/ARC spent their days in the prison infirmary either on a ward with anywhere from two to 11 other patients or alone in a single room. The living accommodations for the AIDS/ARC patients in the prison infirmaries vary from facility to facility.

However, one characteristic common to all of the prisons is that the infirmaries were never designed to accommodate, for long periods of time, ambulatory patients not in need of daily monitoring. Regardless of the best intentions of administrators and staff at the facility level, the serious physical limitations of the infirmaries make it extremely difficult, if not impossible, for them to provide the necessary programs. Adequate program and recreational space and family visiting areas are non-existent. The vast majority of these prisoners are confined to a small area or room of the prison infirmary for much of the day.

Since June, more medically cleared prisoners with AIDS/ARC have been placed in general population. But this is not to say that all have been reintegrated. There have been no reports of any inmate physical assaults against these persons. The ability to be able to move throughout the institution, to participate in programs, to be productive and to have human contact has been an extremely uplifting experience for those persons with AIDS/ARC who have previously been confined to a small area of the prison infirmary.

However, for those inmates with AIDS/ARC who are in need of medical monitoring or are acutely ill, the isolation of the prison infirmary without the necessary support services can have devastating psychological effects, which will be discussed later.

Established in 1983, Sing Sing Correctional Facility is the only prison in the state that has a special needs unit for prisoners with AIDS. This 12 bed ward located in the prison

infirmary contains a small visiting area for families and attorneys, a lounge with a televison and vcr, access to a kitchen for food preparation to supplement prison meals, an outdoor recreation yard with such equipment as volleyball paraphenalia, weights, punching bag, table and benches. A law clerk has regular access to the unit as do volunteers from the Mary Knoll Community. The easy access by train and close proximity of this unit to New York City where the families of all the patients on the unit reside is one of its major assets.

Prison administrators, staff and inmates living on the unit agreed that the space limitations of the unit restrict the movement of the men and the ability to implement more programs. However, it is certainly the best arrangement available in the New York State Prison system.

PSYCHOLOGICAL ASPECTS OF AIDS/ARC

The fatal nature of AIDS, the social stigma associated with contagion and its appearance in certain groups -- gays, bisexuals and IV drug users -- who have long been the object of much discrimination in our society create enormous psychological and social trauma for persons diagnosed with this disease. The ability of persons with AIDS/ARC to tolerate the consequences of the disease depends on their emotional strength and the availability of social support.

The emotional consequences of AIDS/ARC can be catastrophic for those afflicted with the disease. Prisoners are no exception. In fact, their psychological needs are further

exacerated by their incarceration. Since many of the prisons are located far from where the vast majority of the prisoners resided prior to incarceration, physical separation from one's family, lover or close friends only increases the feelings of isolation and loneliness; for those who have lost contact with their family or friends, these feelings are heightened. The often hostile and tense prison environment, the islation inside the prison infirmaries, the ostracism and lack of trust in the medical care delivery system add to the anxiety, anger and depressive symptoms.

Practically all of the civilian staff who have contact the AIDS/ARC patients expressed the need for ongoing counseling on death and dying and psychotherapy for the inmates and their families. However, based upon discussions we had with counselors, clergy, mental health and health care providers at the facilities, it appears that no one in these professions had either the time or expertise to provide such services.

The physical limitations of the prison infirmaries provide the facility administrators with few housing options for the AIDS/ARC patients. The result is that persons with AIDS - regardless of what stage of the illness they are experiencing - are housed together on the same ward or in close proximity in the infirmary for 24 hours a day and seven days per week. While most prisoners with AIDS/ARC prefer not to be alone, they do like to have some privacy. This arrangement takes an enormous psychological toll on many of these prisoners. The most

devastating aspect for most of the AIDS/ARC inmates is having to watch someone with whom you spend 24 hours a day die.

MEDICAL CARE AND TREATMENT

In preparing our report, we hired a team of medical consultants to review the medical care and treatment of prisoners with AIDS/ARC. Unfortunately, our medical team has not completed its assessment to enable us to present its findings at this hearing. Nonetheless, there are a few areas of concern that we would like to mention. These include:

* lack of a written policy on the care of AIDS patients regarding HIV antibody testing and pre- and post-test counseling, of written protocols (medical/nursing), of standardized care for common medical complications of AIDS, and of social support services for AIDS patients and health care staff.
* access to outside hospital care;
* inadequate medical and nursing staffing at the prison infirmaries;
* high rate of medical and nursing staff burnout and turnover;
* lack of skilled nursing care; and
* breach of patient confidentiality.

RELEASE OF ACUTELY ILL PRISONERS

Is prison the appropriate place for inmates with AIDS to spend their last days? We believe that these AIDS patients should be released either to the care of their families or to

outside medical facilities close to their families where they would receive better treatment and have more contact with their families. Some of the high costs of medical care would then be covered by medicaid and/or private funding, thus partially relieving the state of this expense.

Currently, there are two methods for releasing inmates dying of AIDS: parole and executive clemency. The Parole Board can exercise its discretion in releasing an inmate only when he/she has served the minimum imposed by the sentencing judge. While Executive Clemency would enable a chronically ill inmate to appear before the Parole Board at an earlier time than permitted by the sentence, no inmates with AIDS have yet been granted clemency.

CONCLUSION

In the brief time that is available for a public presentation such as this, it is, of course, impossible to adequately cover the complexity of issues involved in this topic. It is also impossible to begin the kind of detailed discussions that must take place regarding solutions to these complex problems. We are very encouraged, however, that the joint Committee of the Bar Association are holding these hearings and will pursue these issues.

I will be happy to answer any questions that you might have regarding the matters that I presented as well as recommendations for improvement.

. AIDS report

DS

I.)
I think need introductory section laying out clear explanation of what AIDS & ARC are; how ~~the~~ virus is transmitted, not trans-mitted; how you determine if you have AIDS; stages in disease; from infection to death; what are common myths.

Who tells us all this ↑? (Not C.A.)

Can't assume, as report does, that everyone knows all about AIDS. What are abbreviations for? What do terms mean?

Can't be patronizing, that we know better.

II.) Tone is too negative, critical, patronizing of DOCS & everyone assoc. w/ them.

Sounds like we're coming from an assumption that DOCS does (every) thing wrong, & inmates are always right, put-upon, etc.

III.) Most of the long quotes shld be dramatically cut, to leave only the most striking couple of sentences. Don't need all the detail that's covered elsewhere

INTRODUCTION

Human immuncdeficiency virus (HIV) is one of the most serious and complex problems facing our policymakers today. No state agency in New York remains unscathed by this devastating disease. Since November 1981 when the first diagnosis of AIDS was made inside the prisons, and each year thereafter as the numbers of cases increase, the Department of Correctional Services (DOCS) has been confronted with this difficult situation and all of its various ramifications. However, DOCS cannot be expected alone to respond to these problems.

Since the 1970's, when a change in the state's sentencing practices resulted in more people being sent to prison for longer periods of time, DOCS' first focus has been primarily consumed in the constant search for more cell space, at the expense of serious conditions problems and program and service needs of the prisoners and staff. Since 1973, the state's prisoner population has more than tripled, going from about 12,500 to just over 40,000 today. Approximately percent of the $ billion DOCS budget goes to prison construction. Over the last five years, alone, DOCS has opened new facilities or additions to existing ones, equaling a grand total of prisons today, And more additions are planned over the next years. [it has barely been able to deal with the basic medical needs of the prisoner population, let alone a complex and debilitating disease such as AIDS.] DOCS alone cannot tackle the complexities of the AIDS problem, it needs all the assistance it can get from experts in the fields of health, infectious disease, education and substance abuse, along with the support and resources from the Governor and state legislature.

THE CORRECTIONAL ASSOCIATION - Past and Present
[take from State of the Prisons report but cut]

THE REPORT

C.A. staff's first encounter with prisoners with AIDS/ARC was in 1984, during visiting to prisons while the preparation of our State of the Prisons report. At that time, there were no plans we never planned to include a section on AIDS/ARC. However, It was during our visits to the prison infirmaries, while reviewing aspects of the medical care delivery system, that the need to address this issue became apparent. On one trip, we came upon a prisoner with AIDS in the infirmary at Clinton Correctional Facility, a maximum-security prison near Plattsburgh. He was sitting on a chair alone in a locked room watching television. When asked what he does all day, he answered "watch t.v." Staff learned that, before receiving he was given the television several weeks earlier, before our visit, the inmate he just sat in his room all day and night. The warm, blue sky May day prompted us to ask him if he ever goes outside. He told us: "No, but I know that if I could only get outdoors and smell that fresh air, I am sure that I would feel better." We asked if he had any visitors.

He told us that his elderly mother from New York City occasionally made the long, strenuous trip up to visit him but that he didn't want to tell her about his diagnosis because then she would feel compelled to visit him more frequently. Then he added that he really didn't believe that he had AIDS. He felt too well to be dying. 9/ We also learned from the medical staff that the nearby outside hospital would no longer provide medical care to prisoners except in "life-threatening" conditions; therefore, prisoners were being transported to outside hospitals throughout the state, the closest being 46 miles and farthest some 300 miles from the prison.

These encounters such as those described above raised serious questions regarding many aspects of the AIDS situation in the prison system. Additionally, the potential for a crisis situation became apparent to us when the Commissioner of DOCS repeatedly stated that all the prisoners with AIDS would be moved out of the prison system. [maybe we should use a direct quote] where, no one was really sure. Hence, we decided to focus on this critical issue.

In light of the C.A.'s legislative mandate to provide useful information to policymakers in the executive and legislative branches, this report focuses on five major areas regarding the situation of AIDS/ARC in the New York State prison system. These include: AIDS education and training for staff and prisoners; segregation of prisoners with AIDS/ARC; psychological aspects of AIDS/ARC; medical care and treatment for prisoners with AIDS/ARC; and early Release. In addition to identifying and describing these areas, we also have made specific recommendations for ways of improving the situation

In preparing this report, we visited 10 prisons, some two or three times, over a fifteen-month period, from July 1986 through October 1987. The prisons visited include: Attica, Auburn, Clinton, Downstate, Green Haven, Sing Sing and Sullivan, all of which are men's maximum-security prisons, and Bedford Hills, Facilities; Fishkill and Wyoming, men's medium-security prisons; and Bedford Hills, the State's only maximum-security institution for women.

During prison visits, we met with prisoners diagnosed with AIDS/ARC, as well as representatives of the Inmate Liaison Committees (ILC) and the Inmate Grievance Resolution Committees (IGRC), and inmate pre-release counselors; Superintendents and Deputy Superintendents; captains, lieutenants, sargeants and correction officers; civilian staff, including health care providers, clergy, counselors and volunteers; and staff from the Office of Mental Health (OMH). We also held discussions with officials from Central Office in the Department of Correctional Services (DOCS), the State Commission of Correction (SCOC), the Department of Health, AIDS Institute (DOH), the Office of Mental Health (OMH), the Department of Substance Abuse Services (DSAS), and the Narcotics ( ), as well as with state legislators, experts in infectious disease, AIDS counseling and education, prisoners' families, ex-offenders with AIDS,

prisoners' attorneys...

[do we need to mention our medical consultants here or just in acknowledgments and beginning of that section]

problems w DOCS → ?

BACKGROUND

The New York prison system houses more inmates with AIDS than any other state. This fact should come as no surprise to those familiar with the statistics on AIDS and ~~iv~~ drug use in New York City, and the New York State prison population.

AIDS is most often associated as a disease of white, middle-class ~~gay~~ men. The reality is that human immunodeficiency virus (HIV) has had grave consequences, particularly for the low-income Black and Latino communities. While Blacks and Latinos represent 11 and 8 percent of the nation's population, respectively, 25 percent of all AIDS patients are Black and 14 percent are Latino. In both New York State and New York City, over 50 percent of AIDS cases are Black and Latino; of women with AIDS, 81 percent; ~~are Black and Latino;~~ and of children with AIDS, 94 percent. ~~are Black and Latino.~~[1]

The most common means of transmission of the HIV infection in all racial or ethnic groups is through homosexual contact between men. However, the major difference in transmission between whites and minorities is the small percentage of AIDS cases attributed to iv drug users among whites (only 4 percent) as compared to Blacks (34 percent) and Latinos (36 percent). Seventy-five percent of iv drug users with AIDS come from New York City.[2] 34 percent of AIDS cases in New York City are associated with iv drug use. The high rate of infection among addicts in New York City - exceeding 50 percent of the city's 200,000 drug users - is startling. It has been reported that the rate of seropositivity in banked serum samples of New York City iv drug users went from 12 percent in 1978 to 60 percent in 1984.[3]

The seriousness of HIV infection in the New York State corrections system cannot be over emphasized. The prisons have been primarily filled with young, poor, unemployed, uneducated Black and Latinos from New York City. Of the 40,000 prisoners housed in the state's 53 prisons, Blacks and Latinos comprise about 80 percent of the population. DOCS officials have estimated that around 60 to 70 percent of all state inmates (some 24,000 to 28,000) have a history of iv drug use. In addition, 78 percent of state inmates are from New York City, where one-third of the nation's AIDS population reside.

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[1] West, Hillary H., AIDS and Minorites, Legislative Commission on Science and Technology, State of New York. June 30, 1987.

[2] Ibid.

[3] Drucker, Ernest, "AIDS and Addiction in New York City." American Journal of Drug and Alcohol Abuse, 1986. [get better cite]

A survey conducted by the New York State Commission of Corrections in 1986 involving 177 cases (88 percent, or 156, of these were from the state system) reveals that the typical AIDS inmate mortality was a Black or Latino heterosexual male, 34 years of age, from New York City, with a history of IV drug use prior to entering the system. He was likely to have been convicted of "money-seeking" crimes related to drug abuse, such as robbery, burglary or drug-related offenses.[4] This study focused primarily on male prisoners because of their overwhelming numbers in comparison to the female population; nevertheless, the much neglected issue of women with AIDS was addressed in the SCOC's September 1987 update on the demographic profile of New York State inmate AIDS mortalities. The typical female inmate with AIDS ~~profile~~ is a Black or Latina woman, 31 years of age, unmarried, from New York City, with a history of IV drug abuse prior to her incarceration. Female AIDS decedents had an average of two children each. One particularly striking finding by SCOC regarding the female population was the 80 percent increase in female AIDS inmate mortalities over all previous years, concommitant with the increasing numbers of female drug offenders entering the prison system.[5] This information raises serious concern about the percentage of female high risk IV drug users in the prison population.

Statistics regarding HIV infection in the state prison system indicate that the situation has become more and more critical each year. Since 1981, 391 persons with AIDS have died while in the custody of DOCS. In 1984, there were 57 deaths attributed to AIDS; in 1985, 98; in 1986, 101; and in the first 7 months of 1987, 102. According to SCOC statistics, on September 1, 1987 prisoners were diagnosed with AIDS. [put in projections]
It for this reason that one cannot step foot inside a prison without hearing health care providers, clergy, or prison administrators state: "and what we are seeing now is just the tip of the iceberg."

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[4] New York State Commission of Corrections, Acquired Immune Deficiency Syndrome: A Demographic Profile of New York State Inmate Mortalities, 1981-1985, March 1986.

[5] New York State Commission of Correction, Update Acquired Immune Deficiency Syndrome: A Demographic Profile of New York State Inmate Mortalities 1981-1986, September 1987.

EDUCATION

According to experts in the field of public health, the most effective weapon developed thus far for combatting the spread of the HIV infection is education. Scientists are not optimistic that a vaccine against HIV infection will be developed within the next five years. While drugs are now being tested and in fact several are on the market, no drug has been totally successful in halting the progress of the virus. Nevertheless, even if a vaccine or drug were developed, public education about AIDS transmission and prevention will continue to be a critical public health measure. [1]

AIDS education and training programs within the correctional setting are essential in reducing the spread of AIDS inside the prisons, as well as outside the walls, and in allaying the persistent fears among inmates and staff that the virus is transmitted by casual contact. Without effective education and training programs, prison administrators will not be able to implement sound policy decisions at the facility level regarding the care and treatment of persons with AIDS/ARC. For instance, ~~despite~~ contrary to Albany's recent policy directive, ~~to the contrary,~~ many prisoners with AIDS/ARC, who have been medically cleared to return to general prison population, still remain isolated in the prison infirmaries because of fear of contagion by staff and prisoners.

This was awkward ←

As discussed above, DOCS officials have reported that some 60-70% of all New York State prisoners have a history of IV drug use. Some prison officials expressed extreme doubt as to whether AIDS education would have any impact on motivating this population to refrain from engaging in high-risk behavior. This attitude ~~is based upon the stereotypical notion~~ reflects a belief that IV drug users are so driven by their drug addiction that they have no regard for the health consequences of injecting drugs. Research conducted on ~~the~~ behavioral change among IV drug users in response to the threat of AIDS, however, has shown that substantial numbers of IV drug users are adopting some form of AIDS risk reduction. [2] Based

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[1] Institute of Medicine, National Academy of Sciences, 1986. Confronting AIDS: Directions for Public Health, Health Care, and Research. Washington D.C.: National Academy Press.

[2] Friedman, S.R., D.C. Des Jarlais, J.L. Southeran, et al. "AIDS and Self-Organization among Intravenous Drug Users," International Journal of the Addictions, 22(3), 201-219, 1987. In 1984, based upon a sample of 59 methadone maintenance patents interviewed, all had heard of AIDS; 55 (93%) of them knew that IV drug use is a mode of transmission of the disease; 59% of these reported some form of risk reduction to avoid AIDS; 54% reported changes in injection-related behavior. Thirty-one percent reported the use of clean needles and/or the cleaning of needles;

upon the results of these studies, one can expect that many prisoners will respond positively when provided with information about AIDS and engage in risk reduction behavior.

In this section, the need for education and training of both prisoners and staff will be discussed. It will focus on the attitudes of the prison community regarding HIV infection and persons with AIDS/ARC, the potential for HIV transmission inside the prison walls and outside after release, and the efforts made thus far by DOCS to provide AIDS education and training to prisoners and staff.

Attitudes of Prisoners and Staff

There is an enormous amount of misinformation regarding AIDS among inmates and staff. The persistent fears expressed by both prisoners and staff that the AIDS virus can be spread by casual contact and the general misunderstanding of how the virus is actually transmitted were prevalent at all facilities visited. This general lack of understanding often results in reactions ranging from hostile to malicious toward those persons with or suspected of having AIDS/ARC.

A prisoner with AIDS housed in the infirmary at Clinton told us: "In the prison, the gossip mill is worse than a bunch of old ladies. You are a marked prisoner when you are housed on the AIDS ward. When you go down for x-rays, you see other inmates and they would say to you: 'I heard you were dying'. And their hand would go out as though they were about to shake hands with you but then they would hesitate and put it down. Some inmates stand up on the bench in the x-ray area so that they don't have to go near you. It really hurts. You can't wait to get out and get the 'sign' off -the one around your neck that says 'he's got AIDS'."

29% reported reducing needle sharing; and 14% reported reducing their level of IV drug injection (subjects primarily injected cocaine, for which methadone has no chemotherapeutic effect.) Fifty-one percent of the group reported that friends had changed their behaviors to avoid AIDS. Similar results were found in a 1985 study of IV drug users in jail and methadone maintenance clients. Selwyn, P.A., C.P. Cox, C. Feiner, et al, "Knowledge about AIDS and High-risk Behavior among Intravenous Drug Users in New York City," Presented at Annual Meeting of American Public Health Association, Washington D.C., November 18, 1985. See also, Friedman, S.R., D.C. Des Jarlais, J.L. Sotheran, "AIDS Health Education for Intravenous Drug Users," Health Education Quarterly, 13(4), 383-393, Winter, 1986; and Des Jarlais, D.C. and S.R. Friedman, "AIDS and The Sharing of Equipment for Illicit Drug Injection: A Review of Current Data," Prepared for the National Institute on Drug Abuse, January 12, 1987.

At ~~Auburn~~, inmate barbers refused to give haircuts to persons with AIDS despite repeated requests. More aggressive action has also been undertaken by some inmates. It should be noted, however, that according to high-level officials in DOCS Central Office, there have been no cases of any prisoners with AIDS/ARC having been assaulted by another inmate because of their AIDS diagnosis. One prisoner explained to us: "If the guys in general population suspect that someone has AIDS [prisoners in general population insisted that it was often the correction officers who informed them of who has or is suspected of having AIDS], first they throw water into that persons's cell when they are not there. If that doesn't work, they burn out the cell. So some guys are scared to leave their cells if they think that people suspect them of having AIDS. Or if guys see someone with sores on their arms while taking a shower or while working in the messhall, they might try to get him out [either off the housing block or out of the messhall]. Indeed this could be viewed as not be part of the quote

During our meetings with prisoners in general population, invariably the topic of mass testing for the HIV antibody would surface. While many supported mass testing, there was much disagreement about whether all seropositives should be isolated in one prison. In addition, many inmates felt strongly that any prisoner suspected of having AIDS or being gay should not be permitted to work in the kitchen.

Despite these strong viewpoints expressed by many of the prisoners in general population, practically every inmate with whom we spoke agreed that they were inadequately informed about the disease and that more information was greatly needed. At Auburn, three inmates were so struck by the lack of AIDS information among the prison population that they presented a proposal for an intensive prisoner education and counseling program. This is currently under consideration by the administration. At Bedford, ILC and IGRC requested . Prisoners with AIDS/ARC have offered to address the general prison population about their own battles against the disease and discourage the sharing of needles. While many prisoners have expressed concern for prisoners with AIDS and ARC, the overwhelming fear of contagion and ignorance regarding AIDS prevails in all of the facilities visited.

Over the last three years, prison officials have told us that the hysteria initially expressed by the security staff has subsided considerably. Medical staff said that fewer officers who work in the infirmary are using masks and gloves when escorting prisoners. Nonetheless, prison adminstrators are still very concerned about the attitudes of staff, particularly those of the uniformed employees. Some superintendents at maximum-security facilities intimated that it was the uniform staff who posed greater obstacles than the prisoners in mainstreaming medically cleared inmates with AIDS/ARC into general population.

The staff is most concerned about the possibility of contracting AIDS from prisoners through casual contact or by aggressive inmates biting, spitting or throwing feces at them or while breaking up fights, or providing first aid. Generally, the staff exhibited a low level of understanding about AIDS prevention and transmission and expressed reluctance to come to ~~terms~~ terms with the reality of the disease. Some were extremely sceptical about the information that they received from DOCS and CDC and bitter. As one officer put it: "DOCS is not moving fast enough. They are taking their sweet time. The Department waits until a catastrophy occurs. The people who run the facilities should come first...We feel cheated - that we aren't worth anything. I didn't take this job to deal with AIDS." At a downstate maximum-security prison, a captain told us: "Just get rid of them [prisoners with AIDS/ARC]. I don't care about them. I care about my family. Send them to a hospital or wherever. Empty a psych facility run by OMH or OMR and put them in there." An officer added: "DOCS's philosophy is to get closer to the inmate. How can we get closer with this disease. I have yet to go into an AIDS room." Even the superintendent at that prison refused to deal with the AIDS reality when he said: "I just want to get rid of them. I wish they would go someplace else." Underlying these attitudes are often feelings of contempt and hostility toward prisoners and particularly those with AIDS/ARC. As one guard put it: "We have to deal with the scum who come into the prison." Such attitudes were also expresssed by some of the medical personnel and counselors.

Practically every correction officer with whom we spoke wanted to know the name of every inmate with AIDS/ARC. Most feel strongly that all prisoners should be tested for the HIV virus and housed in one facility.

These attitudes are prevalent throughout the system and are acted out in a variety of ways. At Auburn, after the commissary sheets of prisoners with AIDS/ARC are completed, they are passed to the officer on the ward, who after putting on surgical gloves, fills out a new form which is taken by the officers down to commissary. In this way, the persons working in commissary need not touch the sheet that has been "exposed" to the virus. At Attica, the AIDS/ARC prisoners are only permitted to use the telephone located one flight below, even though there is a telephone located some ten feet outside their living area. The nearer phone can only be used by the other hospital patients. At Clinton, there are several officers assigned to the AIDS area of the infirmary who, according to both prisoners and medical staff, have said such things as: "Why don't you just die and get it over with already" and "I don't know why we should to take you for an x-ray, it is just a waste of equipment." At Attica, one of the transporting officers took an AIDS patient to an outside hospital. On the way back to the prison, the officers made several stops at a deli and gas station where they asked if anyone there wanted to take a look at "a nigger with AIDS". It should be noted that there is an informal arrangement between the security officers union and

DOCS that all transporting officers will be told if any of the transportees have a communicable disease. We looked into this case and learned from an attorney in DOCS Counsels Office that the officer had been "reprimanded."

As one prisoner with ARC housed in the infirmary at Clinton stated: "We have got to get better officers. Some are real sadists. Some of the others want to be sympathetic but because they live with these c.o.s they act the same way. There is only one c.o. on the day shift who doesn't care what these officers think and he jokes with us and comes in and has conversations with us. The officers on night are excellent. What I mean is that they do what they are suppose to do. They are cooperative. They don't joke with us or anything, but they get us what we need...We try our best to laugh with the nurses. Most of them are great."

Many of the prisoners' concerns regarding AIDS were also expressed by the staff. Practically every correction officer with whom we spoke wanted to know the name of every inmate with AIDS/ARC. Most feel strongly that all prisoners should be tested for the HIV virus and housed in one facility. Many still refuse to step foot inside the area where AIDS patients are housed in the infirmary. Others expressed concern over breaking up any fights among inmates. [this para may be redudant]

There are numerous examples that we could provide which would demonstrate why education and training on AIDS is so essential for both prisoners and staff. We do not mean to suggest that all staff and prisoners are hostile, cruel and malicious to prisoners with AIDS/ARC. Clearly there are those who have been extremely caring and supportive of this population. However, there ~~remain~~ are ~~too~~ many persons in the system ignorant of basic and essential information about AIDS transmission and prevention.

Transmission Inside the Prisons

Prison officials, staff and prisoners spoke quite candidly about the occurence of IV drug use and anal intercourse inside the prisons. A superintendent of a maximum-security facility said: "I know that there are all kinds of drugs in here. As long as we have visits and packages there will be drugs. But it's like a mission impossible. We use urine tests to try and identify these persons. You have to try to squeeze off the supply. About two weeks ago, there were close to three hundred in inmate possession. That means that there is over $4,500 in drugs in one facility. We bust people for heroin. People take the risk and know it. This shows you how addictive it is. All else is thrown to the wind. Health doesn't enter the picture. The vast majority of homosexual contact here is consentual. All those who have gotten AIDS here are iv drug users."

An inmate with ARC told us: "In practically any penitentiary in the state you can get drugs. A half to one ounce of heroin comes

If we have to have a few long quotes, they should be set off in type

into Clinton per day through families or staff. you shoot up in the yard where you can easily exchange needles. On the outside there were very few times that I ever shared a needle because for two bucks you can get new works. But inside you do share. I stopped using heroin at Clinton because I found out that friends of mine at Sing Sing had come down with AIDS. So I just smoked grass. I was lucky because it really didn't become a habit for me as bad as it did for other guys. IV drug use is the biggest problem. Then comes homosexuality and tatooing...For IV drug users, it's more dangerous in jail than on the street. On the street you can buy new needles or bleach to clean the works, but not in the prisons. You may not be able to stop the use of drugs for prisoners, but at least you have to stop people from using the same needles. If we don't do something today about AIDS in the prisons, the prisons will be tomorrow's death camps. The administration just doesn't understand this."

[get stats on prison rape and articles on consentual sex + any info. on tatooing] Discussions with staff and prisoners did indicate that homosexual activity occurs inside the prisons among both gay and heterosexual inmates. However, we were unable to obtain any data regarding the frequency with which this activity occurs inside the prisons. Two recent studies do shed some light on this topic.

The possibility of HIV transmission between prisoners and their spouses is also of concern. The Family Reunion Program, available in 11 of the 53 prisons throughout the state, enables eligible prisoners and their lawful spouses (and/or members of their immediate family) to spend 48 hours together in a trailer on the prison grounds. The benefits of this program cannot be stressed in improving ties between inmates and their families, and in helping prisoners adjust to the outside world after release. While condoms we are told are available to prisoners and their spouses during trailer visits, there is no "safe sex" information being distributed regarding AIDS transmission and prevention.

We have to explain what all this is or the very beginning

TRANSMISSION OUTSIDE THE PRISONS

Approximately 17,000 prisoners each year are released from the New York State prison system. A high proportion of these prisoners are believed to have a history of IV drug use and are therefore at high risk of having the HIV virus. One can estimate that some 10,000 prisoners this year will be released who are infected with the AIDS virus. [Over 90% of the AIDS cases in the state corrections system are men, the majority of whom are single and assumed to be sexually active. Research conducted by DSAS [get site] reveals that approximately 75% of the 150,000 male iv drug users in New York City have female sex partners who have not engaged in IV drug use.] The potential for HIV transmission from IV drug users in prisons to their sexual partners and unborn children is significant. Therefore, it is essential that prisoners be armed with information regarding risk reduction

long

anyone reading this knows anything?

behavior prior to their release from prison. It is far more productive to educate this "captive" audience while incarcerated than to attempt to undertake such efforts on the streets of New York City.

EDUCATION AND TRAINING OF PRISONERS AND STAFF
[rework this section - do it as a history of programs since '21]

Efforts have been made to provide some education and training to uniformed and civilian staff and prisoners, however, much more needs to be done. DOCS takes the position that except for the distribution of some literature on AIDS and any programs that the training lieutenants at each facility set up, AIDS education for staff and prisoners is left up to the AIDS Institute of the state's Department of Health (DOH). Thus, there are no systemwide, continuous face-to-face AIDS education and training programs for staff and inmates operated by DOCS. As a result, any DOCS programs that exist at the facility level do so because of initiatives taken by individuals at those prisons. Despite the well- meaning efforts made by these staff persons, none of the programs at the facilities visited were conducted on a regular ongoing basis.

The only staff currently providing education to prisoners and staff are five employees of the AIDS Institute who devote part of their working time to the state's prison system. As initially conceived, the Prison Exit Program (PEP), an ambitious one-year project funded by CDC, was to offer AIDS education, HIV pre-test counseling and testing referrals to individual prisoners and groups of prisoners just prior to their release from prison. As one can well imagine, with approximately 17,000 prisoners having been released last year from about 53 of the state's facilities, this task is far beyond the PEP staff's numbers. Thus PEP quickly evolved into a group AIDS education program for staff and some prisoner organization heads. In its first year, 44 presentations were made at 22 facilities, reaching 1479 correctional staff and administrators, out of a total of, and 1246 inmates out of a total of 40,000. The usual PEP format is to provide three live presentations at each facility visited. All presentations are on a voluntary basis; the first is provided to the uniform staff, the second to the civilian staff and the last to a group of inmate organzation heads. Each presentation runs for an hour and a half and includes a videotape and a question and answer period. It is basically a one-shot deal, entailing basic consciousness-raising and education but not training. One-to-one counseling is offered to inmates after each presentation, but this rarely occurs. PEP staff can enter a prison only if invited by the superintendent, as communicated through DOCS training academy in Albany.

The PEP team has also recently started to provide an hour and a half basic AIDS education session to recruits at the Albany and Harriman training academies. This is particularly important for

~~these~~ prisons such as Bedford and Sing Sing ~~who~~ which serve as training facilities for recent graduates of the academy. [develop this more]

Unfortunately, In addition to the AIDS Institute, the regional AIDS Task Forces what are the have occasionally provided educational sessions for prisoners and staff over the past years. The ~~various~~ AIDS Task Forces ~~ticket in~~ to enter the facilities is based upon ~~each~~ superintendent's willingness to give them access. While some superintendents have taken advantage of the services that the Task Forces are able to provide, including basic AIDS education and buddy program for prisoners with AIDS/ARC, the majority have not. Even in some of the prisons where they have gained access, Task Force members have described numerous obstacles placed in their way such as delays of up to an hour at the front gate, others?

No AIDS training programs for the non-uniformed staff is available. This means that the DOCS chemical abuse counselors, who provide group and one-to-one sessions to some prisoners, as well as the pre-release counselors, who reach some prisoners each year, remain without AIDS-specific training.
[check into clergy and medical - can't find any programs but keep checking]
[also special DOCS statewide programs - who attends]
[check union programs - council 82 and PEF]

ASAT

~~DRAFT #1 - AIDS in Prison Project Report~~

SEGREGATION OF PRISONERS WITH AIDS/ARC

The question of whether or not to segregate prisoners with AIDS and ARC is one of the most difficult and complex decisions for correctional administrators. For those prisoners who need continuous medical attention or monitoring, the decision is a relatively easy one, based purely on medical considerations. However, there is a growing number of prisoners with AIDS/ARC whose illnesses are in remission, and therefore need not be segregated for medical concerns. This group poses the most difficult managerial problems to the administrators.

~~The New York State prison system has not been immune to these complex problems.~~ In a May 7, 1987 memorandum to superintendents, and facility health service directors, the DOCS Assistant Commissioner for Health Services wrote: "There appears to be some element of confusion regarding the Department's official policy relating to isolation of AIDS/ARC inmates." This confusion was expressed to us over and over again ~~during our prison visits~~ by administrators, health care providers and clergy. ~~and~~ was generally attributed to the lack of a clearly articulated policy on isolation of prisoners with AIDS/ARC, especially those who are not in need of intensive medical monitoring and/or nursing care. As one senior chaplain in a maximum-security prison told us: "There is no classification for those persons with AIDS/ARC in the prison infirmary. Are they medical or protective custody? Why are they isolated in that room? There is no medical reason for them to be in the hospital right now. Albany has to decide why they are there. No one makes any decision in this system. Decisions just happen. We need a policy on how we handle these prisoners. We need to know what services we can provide to them."

~~DOCS~~ The current DOCS directive on AIDS, entitled "Policies, Procedures and Guidelines Manual on AIDS" (December 23, 1985) contains a brief section on "Cohorting" which provides no guidance to the appropriate facility administrators on housing accomodations and programming of this population. It states in part:

> "Inmates who do not require hospitalization nor an infirmary setting will be cohorted in designated special needs units that will allow for access to selected activities and programming as determined jointly by health care professionals and the institution program committee."

Since ~~none of the facilities except~~ Sing Sing ~~have~~ has the only facility which has a special needs units for AIDS/ARC inmates, most facility administrators interpreted this policy to mean that they could not house these inmates in general population ~~in their respective facilities with the exception of~~ Wyoming appears to be the exception, where prisoners with AIDS/ARC have been successfully integrated

into general population based upon the medical staff assessment. At the other facilities visited prior to May 1987, health providers told us that the placement of AIDS patients in general population was not only considered a medical decision but rather a security one. Therefore, reintegrating medically cleared AIDS prisoners into general population was often quite difficult to implement.

In May 1987, the Assistant Commissioner for Health Services attempted to clarify DOCS policy on cohorting in a memorandum which stated: "The decision to place an AIDS/ARC inmate who does require hospitalization or an infirmary setting is strictly a medical determination". Since June 1987, there has been a greater effort made at the facility level to place medically cleared AIDS/ARC prisoners into general population. According to DOCS Central Office, Health Services, of the 89 reported AIDS cases, 12 are currently in general population. However, at a number of the maximum-security prisons, this policy has been difficult to implement because of the attitudes of some of the administrators, civilian and security staff and prisoners. Without a continuous and comprehensive statewide AIDS educational program for staff and inmates, it may be difficult to dispel many of their irrational and unfounded fears about AIDS.

From July 1986 until June 1987, most of the diagnosed prisoners with AIDS and ARC, who did not require acute medical care or intensive monitoring, were segregated from the general population. Except for recreation, most of these prisoners ~~with AIDS/ARC~~ spend their days in the prison infirmary, either on a ward with ~~anywhere from two to~~ 1-11 other patients, or alone in a single room. The living accomodations for the AIDS/ARC patients in the prison infirmaries vary from facility to facility. However, one characteristic common to all of the prisons is that the infirmaries were never designed to accomodate for long periods of time ambulatory patients not in need of daily monitoring. Regardless of the best intentions of administrators and staff at the facility level, the serious physical limitations of the infirmaries make it extremely difficult, if not impossible, for them to provide the necessary programs. Adequate program and recreational space and family visiting areas are non-existent. The vast majority of these prisoners are confined to a small area or room of the prison infirmary for much of the day.

In only one of the facilities visited, Bedford, were segregated prisoners with AIDS/ARC permitted to attend religious services with the general population. In the other facilities, ~~visited,~~ they were not permitted to participate, as they had prior to the onset of illness, in educational, vocational and work programs, attend religious services or grievance hearings, go to the law or general libraries, and utilize the visiting facilities for family and friends. ~~For instance,~~ a chaplain at Attica asked us: "How do you conduct a worship service for one guy and maintain the privacy of the [four] others who share that room?" Furthermore, the chaplain pointed out to us: "a worship service is not just

for one person but rather is a fellowship - a community - of people singing and praying together."

The makeshift visiting areas in the infirmaries are generally not conducive to a positive visiting experience. At a time when privacy between the prisoner and visitor is of greatest necessity, it is often difficult to obtain. For some of the inmates, the onset of the disease has triggered the first opportunity in a long time to confront their family, make amends and plan for the future. For many it is their only opportunity to express their feelings about death and dying to a trusting and caring person. For others, particularly the women - most of whom are single parents - the visiting period is their only time to spend with their children. An energetic incarcerated mother with AIDS at Bedford stated: "Some of us have children that we are going to leave behind. I have a son who is 15 years old. He came to see me here in this unit, but I sure wish that we could visit in the nice visiting room with the other inmates."

I think a lot of the quotes in report are unnec. I think they add to minimized / unless really dramatic. Otherwise straight narrative makes the report better

An AIDS prisoner at Clinton ~~with AIDS~~ told us: "I also worry about my wife who visits me every other weekend. She comes on the DOCS bus. It takes nine hours each way. She leaves at 11:00 the night before and arrives at 8:00 in the morning. Then she has to wait in line to be processed into the prison. The visiting room up here is obsolete - it's just got picinic benches. It is very hard to sit here all day without any back support. There are no vending machines to buy food like in the visiting area for population. At 3:00 she gets on the bus for the trip back to the city." At Auburn, the conference room in the infirmary is used for visiting. If the conference room is being utilized by staff or for another prisoner visit, then an empty isolation room is used. One prisoner explained to us: "My 'sister', she is not really a sister, just a friend that I have known for many years who comes up to see me. She is very sympathetic and tries to help me through the situation. We visit in the conference room unless someone else is using it. Then we have to use an empty isolation room. The visitor has to sit on the chair in the hallway and I have to sit in the chair in the room. There is not much privacy." At Attica, there is no designated room, but rather a hallway that is used outside the AIDS ward.

For most of these prisoners, the outdoor recreation period is their only opportunity to get out of the infirmary area. For instance, at Auburn, Attica and Clinton, there are no alternatives to outside recreation when weather does not permit. Hence, from November to April and on inclement weather days between April and November, these AIDS/ARC inmates are restricted to the infirmary. For the past year, outdoor recreation areas specifically reserved for AIDS/ARC patients have sprung up at the most of the facilities. Unfortunately many of these recreational areas have little, if any, equipment. For instance at Green Haven, the yard for the AIDS/ARC patients commonly referred to as "no man's land" was not equipped with any recreational equipment or games. One of the health care providers at Green Haven told us

that the only exercise the patients get is "walking the perimeter." At Auburn the prisoners with AIDS have a chin up bar and some hand weights in their yard. At Sullivan, a new maximum-security facility, no outdoor recreation is provided; however, indooor recreation is available three times a week for a half hour in the mental health unit's rec area, which is equipped with bicycles, body building machines and games and staffed by a recreational therapist.

While prisoners are required under state law to be provided with at least one hour of recreation each day, we received many complaints from AIDS/ARC prisoners segregated in the infirmaries that this was not the case. The most common reason for this occurrence was the unavailability of a correctional officer escort. For instance, at Sullivan, outdoor recreation is not provided because of lack of available guards to escort the men to and from the yard. At Attica, if the officer who is assigned to the AIDS area of the infirmary is pulled off his post, then there is no movement on the ward. The inmates cannot take recreation, or may not be able to make their weekly telephone call, or the law clerk may not be escorted to the ward to provide their only access to the law library.

At most of the facilities, individual efforts have been made by administrators and staff to try to overcome the lack of programming for the AIDS/ARC patients by providing them with books, games, paints and televisions. For instance, at Auburn, the administration gave them flowers to plant. A prisoner at AUburn stated: "they gave us 48 flowers and we planted them all around the hospital. It killed 2 days. I was able to stay out until 3:45 because I had something to do. I would be happy to plant flowers all over the facility. How long can I lift weights ecah day. when it rains we are stuck inside and when winter comes we will be stuck inside for months. I can't beat this. I am going on 20 months in this room."

While most of the patients in remission admit that these items help pass the time, nevertheless, they deeply resent and are often very angry about being denied access to programs and services for which there is no medical reason for exclusion. "They don't let you forget that you have AIDS," said one prisoner at Auburn. "But they sure don't have to remind you of it every day."

As one prisoner with AIDS at Bedford Hills ~~Correctional Facility, the state's only maximum-security prison for women,~~ told us: "It took me a long time to adjust to the infirmary. When I was in population I went to college. I had the run of the facility. Now I am just in the hospital. There are no activities for us. If I could participate in programs, I wouldn't mind being here. But if you keep me dying in here for years, forget it. I couldn't take it. There is no reason that we have to be stuck in a closet. There is no reason that we have to live with all the fear and loneliness locked up inside of us. We are able body

beings. Nobody seems to realize that. Our self esteem is not very high to begin with and this illness certainly doesn't help." Another prisoner with AIDS at a men's maximum-security facility wrote: "I live in isolation. I am ostracized. I need support not to stay alive, but to stay sane. I must keep growing, learning and doing so I don't stop and die."

These sentiments were supported by almost every health care provider and clergy with whom we spoke. One health administrator at Bedford Hills stated: "A lot of the AIDS patients don't belong in this unit. There are no programs for them. If they were at home in their communities, they would not be isolated like this. Truly they do not belong in this hospital. Security gets upset, but most of the other inmates are very understanding." One nurse at Green Haven who is assigned to the area of the hospital where the AIDS patients are confined stated: "There has to be some type of housing made available that would meet their needs. Like a dormitory with individual rooms where there is more freedom for them to get around." A doctor at Green Haven feels that the Department must begin to address the social aspects of the illness. "Afterall," he told us, "the necessity for isolating the AIDS prisoners is not medical, but rather a social problem. They need more sophisticated programs."

Since June more medically cleared prisoners with AIDS/ARC have been placed in general population. But this is not to say that all have been reintegrated. There have been no reports of any inmate physical assaults against these persons. The ability to be able to move throughout the institution, to participate in programs, to be productive and to have human contact has been an extremely uplifting experience for those persons with AIDS/ARC who had previously been confined to a small area of the prison infirmary.

how many were

One prisoner with AIDS who had been recently transferred and placed in general population described his "rebirth", as he put it, as follows: "I was elated, yet apprehensive as to where I was going and if I'd be put in general population. And if I were put in population, what would be the reaction of people to me and me to them. Would I have to lie? Would I have fight? and mostly, could I give the strong serious beating needed to keep the other inmates away from me? Or would I punk out because of the possibility of someone contracting the disease from the fight? These questions ran and still run through my mind, for something has hapened to me in the past twenty months. I think it's called growing up and being responsible. How ironic to be forced into something I've been running away from all my life. My image just doesn't seem to be that important. I have a new image that is the real me, and I don't care if it doesn't fit prison life...When we arrived at the prison my ears perked up and I listened for that word: AIDS. As the c.o. left, he winked at me and said, 'You're going into population.' But the c.o. took me to the infirmary, and I was placed way in the back, in a private room. I was told I was general population and would have

to go to the chow hall for my meals...After I unpacked a few things, I went into the ward and ran into Nick. I hadn't seen him since '70 and we talked up a storm or at least he did. I didn't know what to say or how to act. I was very conscious of myself. I offered Nick coffee and when were alone in the kitchen, I was making the coffee in my cup, and the words just poured out of my mouth. 'Look Nick, I have AIDS and if you don't want the coffee, I'll understand.' Nick said: 'I'm dying of a brain tumor,' and grabbed my neck. A sigh of relief escaped my lips and we went back to his bed and talked. Nick and I talked until 5 in the morning and I went back to my room. The fact that I hadn't taken my medication hit me and for the first time I realized I was back in control of my life again. No more nurses to come and give me my pills. I had to do it now...I had the freedom to go where I chose and that in itself was a high that I can't explain. After that first day I didn't think about AIDS once, not even when I was taking the AZT."

leads ← you to think may be only older people who are dying will be accepted

— who knows what that is?

However, for those inmates with AIDS/ARC who are in need of medical monitoring or are acutely ill, the isolation of the prison infirmary can have devastating effects. This aspect will be covered in the last three sections of this report.

The Sing Sing Special Needs Unit:

the unit or S-S? — which means?

Established in 198, Sing Sing Correctional Facility is the only prison in the state that has a special needs unit for prisoners with AIDS. This 12 bed ward located in the prison infirmary, contains a small visiting area for families and attorneys, a lounge with a television and vcr, access to a kitchen for food preparation to supplement prison meals, an outdoor recreation yard with such equipment as volleyball paraphenalia, weights, punching bag, table and benches, and , such programs as . A law clerk has regular , access to the unit as does..... . The easy access by train and close proximity of this unit to New York City, where the families of all the patients on the unit reside, is one of its major assets.

how far?

Prison administrators, staff and inmates living on the unit agreed that the spacial limitations of the unit restrict the movement of the men on the unit and the ability to implement more programs [check this].

[note: must speak with Sr. Antonia and visit again on Oct. 7]

not on disk

would help us to understand why what is happening in the prisons is so bad. This would be an earliest section, a more complete description of AIDS phenomenon known to prisoners

PSYCHOLOGICAL ASPECTS OF AIDS/ARC

The fatal nature of AIDS, the social stigma associated with contagion and its appearance in certain groups - gays, bisexuals and IV drug users - who have long been the object of much discrimination in our society create enormous psychological and social trauma for persons diagnosed with this disease. ~~The psychological and social aspects of~~ AIDS/ARC are often ~~associated with such~~ psychiatric symptoms, such as anxiety ~~and~~ uncertainty about the disease and treatment, or a new or recurring physical symptom; depression characterized by sadness, hopelessness and helplessness; sense of isolation and reduced support exhibited by guilt, low self-esteem, worthlessness and anticipatory grief; and anger directed toward the illness, medical care, discrimination and experiences of rejection. The ability of persons with AIDS/ARC to tolerate the consequences of the disease depends on their emotional strength and the availability of social support.[1]

In addition to the psychological aspects of the disease, neurologic complications occur in most patients with AIDS. The most common of these are encephalopathy and dementia. The initial clinical symptoms of encephalopathy - forgetfulness and poor concentration - resemble depression. Psychomotor retardation, apathy, withdrawal, diminished interest in work and decreased alertness develop soon after. Over several months confusion, disorientation, seizures, mutism, profound dementia, coma and death occur. What is considerably distressing, particularly in the prison setting, is that while encephalopathy usually develops several months after the diagnosis of AIDS, dysfunction in the central nervous system can precede the actual diagnosis.[2] This could mean that prisoners who may have neurologic complications could end up in punitive segregation situations rather than receiving treatment. Because psychological, social, psychiatric and neurologic complications occur frequently and in the early course of the disease, all persons with AIDS/ARC should have access to health care professionals for support and psychotherapy to deal with loneliness and depression. Psychiatric consultation for monitoring mental status and psychotherapeutic and psychopharmacologic threatment of psychiatric symptoms are also essential.

(How does one lead to the other

The emotional consequences of AIDS/ARC can be catastrophic for those afflicted with the disease. Prisoners are no exception. In fact their psychological needs are further exacerbated by

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[1] Holland, Jimmie C. and Susan Tross, "The Psychosocial and Neuropsychiatric Sequelae of the Acquired Immunodeficiency Syndrome and Related Disorders," Annals of Internal Medicine, Vol. 103, Number 5, November 1985.

[2] Ibid.

their incarceration. Since many of the prisons are located far from the home community of the majority of prisoners, ~~resided prior to incarceration,~~ physical separation from ones family, lover or close friends only increases the feelings of isolation and loneliness; for those who have loss contact with their family or friends, these feelings are heightened. The often hostile and tense prison environment, the isolation inside the prison infirmaries, the ostracism and lack of trust in the medical care delivery system add to the anxiety, anger and depressive symptoms.

For incarcerated mothers with AIDS/ARC, most of whom are single parents, the thought of dying and leaving children creates an enormous amount of anxiety. A woman with ARC at Bedford wrote: "I am the mother of three beautiful children. I can't bear the thought of dying and leaving them, and then on other side I keep contemplating suicide. I need help."

Worst of all, many of the inmates told us, is the anxiety over the thought of dying alone inside the prison. "I have family on the outside - in Brooklyn," a prisoner with ARC said. "It's terrible to be up here in Clinton. I just want to die with someone that I love by my side. If I get sick tomorrow and maybe only have a few hours left to live, no one is going to be able to get up to see me in time. That is what really scares me."

One assistant nurse administrator at Auburn told us: "We need social work type counseling for the AIDS patients. They go through stages of denial and fear. It's a hard thing to accept. We have seen the stage of denial, the anger stage, and then back to denial. They basically fluctuate back and forth until they begin to realize it is true. The mental health people come to talk to them, but they need to be talked to every day or every other day, especially when they are first diagnosed. They could also use a recreational therapist. They are locked up twenty-four hours a day with just four walls and television to look at. Even when the door [to their room] is open, you are still locked up. They need to have something to look forward to. They need to vent their feelings. They would benefit to have someone from an outside organization who has dealt with AIDS counseling on a one to one basis to come in."

Practically all of the civilian staff who have contact with the AIDS/ARC patients expressed these same needs for ongoing counseling on death and dying and psychotherapy for the inmates and their families. However, based upon discussions we had with counselors, clergy, mental health and health care providers at the facilities, it appears that no one in these professions had both the time and expertise to provide such services.

Most prisons do not have enough counselors to meet the basic needs of the prisoner population, resulting in increased caseloads and an enormous amount of paperwork, making it practically impossible to provide this needed service. For

(+ the one w/ the lowest prisoner population),

instance at Sullivan, the newest ~~and lowest prisoner population~~ of the state's maximum-security facilities, ~~in the state,~~ each counselor has a caseload of 128, plus some specialized population (e.g. mental health unit, disciplinary segregation, the infirmary) which we were told would make it quite difficult for them to provide any kind of ongoing counseling services to the AIDS/ARC patients. As a senior counselor at Sullivan pointed out to us, "we are in good shape compared to Sing Sing or Great Meadow where they have caseloads of 250, but we could still use another counselor to bring the caseload down to 100."

The demands placed on the clergy are tremendous. They not only provide spiritual counseling inside the prisons and at outside hospitals, but also provide religious services and study. It is often the clergy who inform a prisoner's family of death or admission into an outside hospital, or make burial arrangements if no family members claims the body. Many of the prison chaplains told us that they did not have the staff to provide adequate services to this special population and to their families. For instance, at Attica, the three full-time and two part-time chaplains cannot provide the coverage that is needed. A special unit chaplain is needed to provide services to the segregated housing unit, infirmary, protective custody area and two outside hospitals. Clergy at many of the facilities visited do not have the time to provide the families of inmates with AIDS/ARC the necessary and much needed support.

Some nurses, physician assistants and infirmary administrators try to stop in and talk to the AIDS/ARC inmates in between all the other duties that they have, but most admit that the prisoners need more than the five or ten minutes that they are occasionally able to provide.

The New York State Office of Mental Health (OMH) operates in the state's prison system in order to provide mental health services to inmates. While OMH has no official written policy regarding the care and treatment of prisoners with AIDS/ARC, officials in the Bureau of Forensic Services told us that OMH staff at the prisons are encouraged to provide mental health services to the AIDS/ARC patients just as they would to any other inmate in need of such services. Individual OMH psychologists have given much of their time to provide some counseling and group and individual therapy to the inmates.

As one prisoner told us: "You wouldn't believe the mental problems that I am going through. Thank goodness for Florence and Mike [two OMH psychologists who try to meet with the AIDS/ARC inmates once a week]. I try to talk to them as much as possible. The anxiety gets so bad, being all cooped up on this ward. The harrassment from the c.o.s is awful. They say its a waste of equipment when they come to take us out for x-rays. They say why don't you just die and get it over with already. You are just a waste of money. We're going to be closed up in the back room

{ this is Joseph Fiscella

until we die...I am a grown man. I did my time like a man. I never hurt anyone while in jail. I am scared. I cry at night...I go into the bathroom so that no one will see me...The more you are down, the more it eats at you."

Another prisoner at Clinton shared some of his feelings with us. He was alone in a room in the prison infirmary. Extremely emaciated, we could see his bone protruding through his blanket. He could barely pick up his cigarette on the night table by his bed. "I am surprised the way the c.o.s treat us. They don't know how to talk to you. They make fun of you. When the nurse came in to give me my medication, a c.o. said, "that's a waste of good medicine, he is dead anyway." I've been through the worse stage...the time when I got messed up psychologically. I bugged out for awhile. I don't remember anything that happened during that week. Florence [OMH psychologist] comes to see me once a week. Otherwise I am totally isolated, totally alone. I don't do anything all day but just sit here and think. I've seen several patients die. I'd much rather be with the other AIDS patients. I'm very lonely here all by myself. I think alot about it [death]. Without a television, I would be bugged out. I never had any mental problems. All day long I think about everything but it always comes back to the same thing. I get a pain and wonder if this is it. I get no medication to calm me or help me cope. The Catholic priest comes by to see me. He sits down and talks with me. I'm not Catholic, but the Protestant chaplain just stood at the door so I prefer to talk with the priest. I'm just in this room 24 hours a day with no one to talk to. I just think about dying. I've lost so much weight. They can't do anything for you so they just ignore you. I feel like I'm losing it now. Before I was determined to live but now I'm just giving in to it. This is my first time in prison. It's doubly hard for me. I go to the parole board next month." [He died several weeks later at Clinton]

The physical limitations of the prison infirmaries provide the facility administrators with few housing options for the AIDS/ARC patients. The result is that persons with AIDS - regardless of what stage of the illness they are experiencing - are housed together on the same ward or in close proximity in the infirmary for 24 hours a day and seven days per week. While most prisoners with AIDS/ARC prefer not to be alone but do like to have some privacy, this arrangement takes an enormous psychological toll on many of these prisoners. The most devastating aspect for most of the AIDS/ARC inmates is having to watch someone with whom you spend 24 hours a day die. One cannot interview inmates with AIDS/ARC who have been segregated in the prison infirmaries without hearing at least one of these graphic accounts.

One inmate who shares a room with six other persons with AIDS/ARC at Clinton told us: "I just don't want to get close to the new guys on the AIDS ward because two close friends of mine have already died up here and I just couldn't deal with having to watch them die. I just don't want to go through that again. As

balls?

they took Cooky out to the hospital he squeezed my hand and said to me, 'I won't see you again.' I think about Cooky alot. His scrotum got really large right before he died. He couldn't even hold his bowels. As they took him out to the hospital he joked and said good-bye to the guys: 'I always wanted a big one and now that I have it, I am gonna die.' Cooky kept his humor to the end and that really helped all of us."

At Bedford the "AIDS ward" consists of four single rooms across from each other where the dark narrow hallway serves as a "dayroom". In reference to a fellow AIDS patient, one woman at Bedford stated: "Milda had been at an outside hospital and they brought her back here. She couldn't get up to go to the bathroom. She had a tube down her nose. She stayed here for about a week. We would all take care of her. We checked her regularly and helped change her diapers. She couldn't really talk, but she was aware of everything that was going on and she would nod her head when we asked her questions. We were so happy for her when they finally took her to the hospital; we knew she could get better care there."

Alean- need results of your research.

The family of the prisoner with AIDS/ARC: how much of the State of the Prison report should we pull from to demonstrate how difficult it is under "normal" circumstances and then further complicated by having to deal with a terminal illness of a loved one - There is no one at DOCS to assist them. They must fend for themselves. - visits, location of hospitals, trying to comprehend the medical terminology and what it all really means, trying to find out release dates, For Spanish speaking families the language barrier adds another isolating factor. The guilt for not being able to get up to the prisons enough. The need to just talk to someone, to cry. No one is there to prepare them for the return home of a loved one with AIDS/ARC. The women's anxiety over how they will be able to care for their children and who will take care of them when the time comes.

Thomas A. Coughlin

FYI cp

testimony

TESTIMONY BEFORE THE JOINT SUBCOMMITTEE OF THE

ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK

RE: AIDS IN THE CRIMINAL JUSTICE SYSTEM

THANK YOU FOR INVITING ME TO BE WITH YOU HERE TODAY. MUCH HAS BEEN SAID AND WRITTEN ABOUT THIS DISEASE CALLED AIDS, BUT MANY PEOPLE REMAIN UNINFORMED. TOO MANY PEOPLE CONTINUE TO PUT THEMSELVES AT RISK, UNAWARE THAT THEIR BEHAVIOR MAY LEAD TO THEIR DEATHS. TOO MANY OTHERS SEE RISKS THAT DON'T EXIST.

NEW YORK STATE HAS TAKEN AN ACTIVE ROLE IN THE DISSEMINATION OF INFORMATION ABOUT AIDS. WE WERE THE FIRST STATE IN THE NATION TO ALLOCATE FUNDS FOR AIDS RESEARCH. TWENTY-EIGHT TWO YEAR RESEARCH GRANTS, TOTALING $1.5 MILLION, WERE AWARDED IN 1984. IN THE PAST FISCAL YEAR, AN ADDITIONAL $2.7 MILLION WAS APPROPRIATED FOR RESEARCH.

GOVERNOR MARIO CUOMO HAS ORDERED STAFF TO FORMALIZE ITS CONTACTS WITH HEALTH OFFICIALS THROUGHOUT THE NATION. THAT'S TO ENSURE THAT WE RECEIVE -- AND THEY RECEIVE FROM US IN RETURN -- THE MOST UP-TO-DATE KNOWLEDGE AND INFORMATION AS IT BECOMES AVAILABLE ANYWHERE IN THE COUNTRY AND THE WORLD.

TODAY THERE IS NO CURE FOR AIDS, SO OUR HIGHEST PRIORITY REMAINS PREVENTION THROUGH EDUCATION. BUT WE MUST ALSO ACCEPT OUR COLLECTIVE RESPONSIBILITY TO OFFER AIDS VICTIMS THE SERVICES THEY REQUIRE, WHILE WE INVEST IN RESEARCH TO FIND A CURE.

MUCH OF THE MEDIA ATTENTION AND PUBLIC CONCERN ABOUT AIDS FOCUSED LAST SUMMER WHEN THE WORLD LEARNED ACTOR ROCK HUDSON WAS DYING FROM THE DISEASE.

IN THE NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES, WE HAVE BEEN DEALING WITH AIDS FAR LONGER THAN THAT. IN FACT, SINCE NOVEMBER OF 1981 -- WHEN THE FIRST INMATE DIED OF A CONFIRMED CASE OF AIDS.

THERE HAVE BEEN NEARLY 40,000 CONFIRMED AIDS CASES IN THIS COUNTRY SINCE JUNE OF 1981. OF THAT NUMBER NEARLY 60% HAVE DIED. THUS, IT IS QUITE UNDERSTANDABLE WHY THIS DEADLY VIRUS HAS GENERATED MORE DISCUSSION AND CONTROVERSY THAN ANY OTHER MEDICAL PROBLEM IN THE HISTORY OF MANKIND. SUCH CRITICAL ISSUES AS UNIVERSAL TESTING FOR THE HIV VIRUS, THE ISSUANCE OF STERILE NEEDLES TO I.V. DRUG ABUSERS, AND THE DISTRIBUTION OF CONDOMS TO PRISON INMATES ARE BUT A FEW BEING DEBATED IN LOCAL, STATE AND FEDERAL FORUMS.

THE NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES DOES NOT SUBSCRIBE TO UNIVERSAL TESTING OF INMATES. THIS DETERMINATION WAS MADE UPON THE RECOMMENDATION OF THE STATE HEALTH DEPARTMENT. THIS DOES NOT PRECLUDE UTILIZATION OF THE ELISA TEST AS A DIAGNOSTIC TOOL WHERE IT IS MEDICALLY INDICATED.

THE DEPARTMENT, IN CONJUNCTION WITH STATE HEALTH, HAS SOLICITED FUNDING FROM THE CENTER FOR DISEASE CONTROL TO INITIATE A PROJECT AT THE DOWNSTATE CORRECTIONAL FACILITY WHICH WOULD PROVIDE VALUABLE INFORMATION REGARDING THE DEGREE TO WHICH THE AIDS VIRUS IS TRANSMISSIBLE IN A PRISON SETTING. THIS WOULD ENTAIL TESTING SOME 2,000 INMATES FOR HIV SERO-POSITIVITY, AS WELL AS TESTING FOR THE PRESENCE OF HEPATITIS B.

IT IS NO SIMPLE TASK TO ADDRESS THE MANY SOCIAL ISSUES THAT HAVE SURFACED AS A RESULT OF AIDS. TO ADDRESS AN ISSUE SUCH AS THIS IN A PRISON SETTING IS ALL THE MORE COMPLICATED.

I FEEL THAT IT IS EXTREMELY APPROPRIATE FOR ME TO BE GIVEN THE OPPORTUNITY TO ADDRESS THIS AUGUST BODY ON SUCH A CRITICAL ISSUE. NEW YORK STATE HAS THE UNFORTUNATE DISTINCTION OF HOUSING PERHAPS MORE THAN 50% OF ALL AIDS RELATED CASES IN INCARCERATED SETTINGS IN THIS COUNTRY. AN ANALYSIS OF EPIDEMIOLOGIC DATA ON THESE CASES HAS SHOWN AN INCREASE IN CASES FROM TWO IN 1981 TO 107 IN 1986, WITH AN INCIDENCE OF 302 CASES PER 100,000 INMATES PER YEAR OVER THE PAST TWO YEARS.

IT IS ESTIMATED THAT THERE ARE APPROXIMATELY 1,450 CONFIRMED AIDS CASES IN LOCAL, COUNTY, STATE AND FEDERAL CORRECTIONAL SYSTEMS IN THIS COUNTRY. APPROXIMATELY 65% OF THEM ARE LOCATED IN NEW YORK STATE, NEW JERSEY, FLORIDA AND THE FEDERAL SYSTEM. NEW YORK STATE CORRECTIONS, UNFORTUNATELY, HAS A DISPROPORTIONATE SHARE OF THESE CASES.

TO DATE, THERE HAVE BEEN 532 CONFIRMED CASES. OF THAT NUMBER 309 HAVE DIED, 129 HAVE BEEN RELEASED AND 94 REMAIN IN CUSTODY.

THIS MAY WELL BE THE LARGEST COLLECTIVE GROUPING OF AIDS PATIENTS IN THE NATION. ONE MIGHT ASK WHY WE HAVE THAT UNDESIRED DISTINCTION. THE ANSWER IS REALLY QUITE SIMPLE. ONE OF THE MORE UNIQUE ASPECTS OF INMATES WITH AIDS IN OUR SYSTEM, CONTRARY TO THE COMMUNITY AT LARGE, WHERE THE DOMINANT CHARACTERISTIC IS HOMOSEXUALITY, THE DISPROPORTIONATE NUMBER OF OUR AIDS RELATED CASES ARE IV DRUG ABUSERS. IT FOLLOWS, THEREFORE, THAT AN INDIVIDUAL INVOLVED IN ILLICIT HEAVY DRUG USAGE IS ON THE FRINGE OF THE CRIMINAL JUSTICE SYSTEM, AND THEREBY MORE PRONE TO END UP IN A PRISON SETTING. THIS PHENOMENON IS FURTHER ENHANCED BY THE EXISTENCE OF "SHOOTING GALLERIES" IN NEW YORK CITY AND THE GREATER NEW JERSEY AREA WHERE IT IS COMMON FOR THE MULTIPLICITY OF ABUSERS TO SHARE NARCOTICS, AS WELL AS INTRAVENOUS PARAPHENALIA.

SINCE 1981, OUR DEPARTMENT HAS WORKED CLOSELY WITH THOSE PARTIES CONCERNED ABOUT AIDS. THEY INCLUDE THE FEDERAL CENTER FOR DISEASE CONTROL IN ATLANTA, THE NATIONAL INSTITUTE FOR JUSTICE IN DENVER, THE AMERICAN CORRECTIONAL ASSOCIATION, OUR OWN STATE HEALTH DEPARTMENT, THE GOVERNOR'S OFFICE OF EMPLOYEE RELATIONS PLUS A HOST OF GAY ALLIANCE AND OTHER PRIVATE-SECTOR ORGANIZATIONS.

ALL HAVE THE SAME PURPOSE: TO DISSEMINATE THE FACTS ON AIDS WHILE SCIENCE ATTEMPTS TO FIND A CURE.

WE HAVE INTERDISCIPLINARY TEAMS AVAILABLE TO MAKE PRESENTATIONS TO STAFF AS WELL AS INMATES THROUGHOUT OUR SYSTEM. THE TEAMS INCLUDE NOT ONLY MEDICAL EXPERTS, BUT SECURITY, ADMINISTRATION AND PERSONNEL SPECIALISTS AS WELL.

WE HAVE VIDEOTAPES AVAILABLE OF THESE PRESENTATIONS TO INCREASE THE NUMBER OF SESSIONS THAT CAN BE HELD. AND MEDICAL PERSONNEL HAVE ALSO PROVIDED VIDEOTAPES THAT EXPLORE THE KNOWLEDGE AS WELL AS THE QUESTIONS SURROUNDING THIS DISEASE. ONE VIDEOTAPE IN PARTICULAR WAS PRODUCED BY STAFF AT THE TACONIC CORRECTIONAL FACAILITY WITH THE MAJOR FOCUS BEING ON THE DISCRETE AIDS UNIT AT OUR SING SING CORRECTIONAL FACILITY (THE FIRST OF ITS KIND IN THE NATION). THIS FILM WHICH IS ENTITLED, "AIDS: A BAD WAY TO DIE", HAS BEEN DISSEMINATED THROUGHOUT THE COUNTRY, AS WELL AS ABROAD.

THE GOVERNOR'S CRIMINAL JUSTICE SUB-CABINET, OF WHICH OUR AGENCY IS A MAJOR PART, HAS AUTHORIZED A POLICY FOR DEALING WITH AIDS INSIDE OF STATE CORRECTIONAL FACILITIES. WE WROTE IT IN CONJUNCTION WITH THE FEDERAL CENTER FOR DISEASE CONTROL AND OUR STATE HEALTH DEPARTMENT. IT MAKES NEW YORK ONE OF THE FEW STATES IN THE NATION WITH A WRITTEN, ACROSS-THE-BOARD AND MEDICALLY-APPROVED POLICY FOR THE CARE OF PRISON INMATES SUFFERING FROM THIS DISEASE.

FURTHER, OUR HEALTH DEPARTMENT HAS AUTHORIZED A BOOKLET THAT POSES AND THEN ANSWERS THE 100 MOST OFTEN ASKED QUESTIONS ABOUT AIDS. IT IS THE FIRST BOOKLET OF ITS TYPE IN THE NATION. AND IT IS DISTRIBUTED TO ALL DEPARTMENT OF CORRECTIONAL SERVICES EMPLOYEES AS WELL AS INMATES.

WE ARE DOING MORE THAN JUST EDUCATING.

LATER THIS YEAR, WE WILL OPEN AN ACUTE CARE UNIT IN A PUBLIC HOSPITAL DESIGNED SPECIFICALLY- FOR PRISON INMATES DYING OF AIDS. IT WILL BE THE FIRST OUTSIDE HOSPITAL UNIT IN THE NATION TO BE DEDICATED TOTALLY TO THE CARE OF PRISONERS WITH AIDS. THIS IS A

Did CP know this?

SPINOFF FROM A WELL PUBLICIZED VISIT TO NEW YORK CITY BY MOTHER TERESA -- THE WORLD-RENOWNED NOBEL PEACE PRIZE WINNER. ON CHRISTMAS EVE OF 1985, AS A RESULT OF CONVERSATIONS BETWEEN MOTHER TERESA, GOVERNOR CUOMO AND MYSELF, WE PLACED THREE INMATES IN ST. CLARE'S HOSPITAL WHICH IS OPERATED BY THE ROMAN CATHOLIC ARCHDIOCESE OF NEW YORK.

SINCE THAT TIME, LITERALLY DOZENS OF INMATES HAVE BEEN SERVICED BY THIS FACILITY.

WHERE DO WE GO FROM HERE? THE FUTURE DOES NOT LOOK VERY ENCOURAGING. AS PREVIOUSLY INDICATED, WE CURRENTLY HAVE 94 CONFIRMED CASES IN THE SYSTEM. IN ADDITION TO THIS, THERE ARE APPROXIMATELY 131 AIDS-RELATED COMPLEX CASES. CLEARLY ONE-HALF TO TWO-THIRDS OF THESE INDIVIDUALS WILL BECOME FULLBLOWN AIDS CASES WITHIN THE NEXT SEVERAL MONTHS. THIS, OF COURSE, WILL HAVE SIGNIFICANT BUDGETARY RAMIFICATIONS GIVEN THE SOCIAL RALITY THAT CARE FOR A SINGLE AIDS PATIENT CAN RANGE AS HIGH AS $100,000. ALSO, ONE HAS TO BE MINDFUL OF THE DRAIN THIS PLACES ON HEALTH

CARE RESOURCES INCLUDING, BUT NOT LIMITED TO, INTENSIVE NURSING AND LONG-TERM INFIRMARY STAYS. IN AN EFFORT TO ADDRESS THESE ISSUES, THIS DEPARTMENT WORKS WITH THE CENTER FOR DISEASE CONTROL, THE STATE HEALTH DEPARTMENT AND SIGNIFICANT OTHERS ON A CONTINUUM.

CONTENDING WITH AIDS IN A CORRECTIONAL SETTING GENERATES A HOST OF UNIQUE PROBLEMS. IN THE COMMUNITY AT LARGE, AN INDIVIDUAL WHO CONTRACTS THIS DEADLY VIRUS HAS SEVERAL OPTIONS AT THEIR DISPOSAL. FOR INSTANCE, HE CAN GO TO HIS PRIVATE PHYSICIAN, A COMMUNITY CLINIC AND/OR HOSPITAL OF HIS CHOICE, ETC. UPON RECEIVING A DEFINITIVE DIAGNOSIS OF AIDS AND SUBSEQUENT TREATMENT, WHICH MAY OR MAY NOT RESULT IN HOSPITALIZATION, THIS INDIVIDUAL HAS THE WHEREWITHAL TO RETURN TO A NORMAL EXISTENCE. THE POSSIBILITY OF EMPLOYEES, FAMILY, FRIENDS, ETC., OF DISCOVERING THAT THEY ARE AN AIDS VICTIM, IS CONTINGENT UPON THE DEGREE TO WHICH THE INDIVIDUAL DETERMINES TO MAINTAIN SECRECY. CONVERSELY, WHEN SAID INFORMATION BECOMES PUBLIC KNOWLEDGE, THE INDIVIDUAL MAY WELL BE ABLE TO CHANGE JOBS AND CONCEIVABLY RELOCATE GEOGRAPHICALLY.

INMATES DO NOT HAVE THESE OPTIONS. FOR A VARIETY OF REASONS, IT IS EXTREMELY DIFFICULT TO MAINTAIN CONFIDENTIALITY RELATIVE TO AIDS IN A CORRECTIONAL SETTING. THUS, ASIDE FROM THE TRAUMA OF BEING STRICKEN WITH THIS DEADLY VIRUS, THE INDIVIDUAL ADDITIONALLY IS SUBJECTED TO THE STIGMATIZATION THAT IS ATTACHED TO THE ILLNESS ITSELF.

ANOTHER AREA OF CONCERN IS THE HIGH ANXIETY AND PARANOIA ON THE PART OF CORRECTIONAL WORKERS, BOTH CIVILIAN AND UNIFORMED, AS WELL AS OTHER INMATES CONCERNING AIDS. WE CONTINUE TO WORK WITH THE AIDS INSTITUTE TO EXPAND AND UPGRADE OUR EFFORTS TO PROVIDE ONGOING TRAINING AND EDUCATION TO OUR EMPLOYEES. INDEED, A SEGMENT ON AIDS IS INTEGRATED INTO THE CURRICULM OFFERING FOR ALL NEW CORRECTIONAL OFFICERS.

THROUGHOUT ALL OF THIS, WE HAVE WORKED HAND-IN-HAND WITH THE GOVERNOR'S OFFICE OF EMPLOYEE RELATIONS AND COLLECTIVE BARGAINING UNITS.

IT CONTINUES TO BE OUR INTENTION TO REMAIN OPEN, CANDID AND UP FRONT WITH OUR EMPLOYEES -- AND ALL NEW YORKERS -- CONCERNING AIDS.

NO ONE ALONE HAS COME UP WITH A CURE FOR AIDS, NOR A MANNER TO DISPEL THE SLURS AND INACCURACIES TOSSED OUT ABOUT BOTH THE DISEASE AND ITS VICTIMS.

MAYBE TOGETHER, WE CAN FIND A CURE TO BOTH THE DISEASE AND THE FALSEHOODS SURROUNDING ITS ORIGIN AND ITS VICTIMS.

Newsday
Tuesday, 9/22/87

Number of Inmates With AIDS Rises

The number of state prisoners dying from AIDS continues to climb — up 25 percent between 1985 and 1986 — and the deaths of some long-term inmates raises the question of whether the disease is being transmitted inside the institutions, a new report says.

The State Commission of Correction issued a report yesterday showing that 438 inmates died of AIDS between 1981 and June of this year.

From 1985 to 1986, the number of deaths increased from 114 to 143, according to the report, which surveyed all state prisons and local jails.

The commission reported the deaths of 12 inmates who had been incarcerated continuously for more than five years — raising the possibility they acquired the AIDS virus while in prison.

The authors of the report say there is no firm evidence any of the inmates contracted the disease behind bars, because the incubation period can be more than seven years.

Nevertheless, the commission conceded that the deaths do at least raise the issue of "transmission within facilities."

The report also shows that Hispanics are dying in numbers far greater than their percentage of the jail population. And while relatively few women have succumbed to the illness so far, the numbers seem to be increasing dramatically.

Blacks and Hispanics make up the bulk of the 438 AIDS deaths recorded by state prisons and local jails since 1981. But while Hispanics are only about 28 percent of the prison population, they account for 45 percent of the AIDS deaths.

Blacks make up 50 percent of the state's prisoners and constitute 43 percent of the AIDS mortalities.

Ninety-five percent of the prisoners who died after contracting AIDS admitted to having been intravenous drug users, one of the high-risk groups for acquired immune deficiency syndrome. Male homosexuals are the other major high-risk group.

The issue of whether AIDS is being transmitted inside state jails is being debated by correctional authorities and others.

However, some argue that the homosexual activity known to occur in prisons is a source of transmission. There is also said to be an unknown amount of illegal intravenous drug use taking place inside the correctional facilities.

Reacting to the report, Robert Gangi, executive director of the nonprofit Correctional Association of New York, said the report confirms there is a drastic need to educate prisoners about AIDS, so those who have the virus do not spread the disease when released from prison. —Ron Howell

Homework for Koch?

Mayor Edward I. Koch better be prepared for a couple of tough questions from his seventh-grade students when he shows up to teach at a Brooklyn junior high school next month.

"They really want to ask the mayor about AIDS and housing the homeless," said Linda Nolan, who teaches the class Koch will speak to at the Ronald Edmonds Learning Center. "They want to ask him if there are any cures for AIDS in the future. And they said they want to ask him if he can supply housing for homeless. They are really excited about the mayor coming."

Koch, who will teach Nolan's class a couple of times a month under the new "Adopt-A-Class" [illegible] said he hopes to serve as a role model

NEWSDAY, THURSDAY, MARCH 26, 1987

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ABOUT HEALTH

Out of Sight, Out of Mind

By Cathy Potler

THE NEW YORK STATE prison system houses more inmates with AIDS than any other state's. This fact should come as no surprise. Seventy-eight percent of all state prisoners come from New York City and the metropolitan area, where about one-third of all the nation's AIDS sufferers reside. More than 60 percent of all state prisoners — more than 24,000 — have a history of intravenous drug use.

Since 1981, 312 inmates have died of AIDS. Currently, there are 85 AIDS cases, at least 120 AIDS-related complex (ARC) cases, and an unknown number of prisoners who have been infected with the virus but who show no clinical signs of disease.

Though most of the prisoners who have AIDS or ARC do not require acute medical care or continuous monitoring, prison officials routinely segregate most of them from the general population. Except for one hour of outdoor recreation when weather permits, most prisoners with AIDS or ARC spend their days in the prison infirmary, either on a ward with beds for two to 11 AIDS and ARC patients, or alone in a single room.

Isolating them, however, is usually not a health precaution. At the moment, it just happens to be the easy way out. But as the number of AIDS and ARC inmates grows, prison officials will be forced to return more of them to the general population. They will also have to increase their use of "medical furloughs" for the dying and open intermediate-care units for those needing constant attention.

Generally, AIDS and ARC prisoners cannot participate in educational programs or hold prison jobs. They cannot attend religious services, use the law or general libraries, or make use of the visiting rooms where prisoners see their families.

Dying of AIDS in isolation appears to be particularly hard on women prisoners who are mothers of young children. They worry about what will happen to their children after their own deaths, and the emotional stress can be devastating.

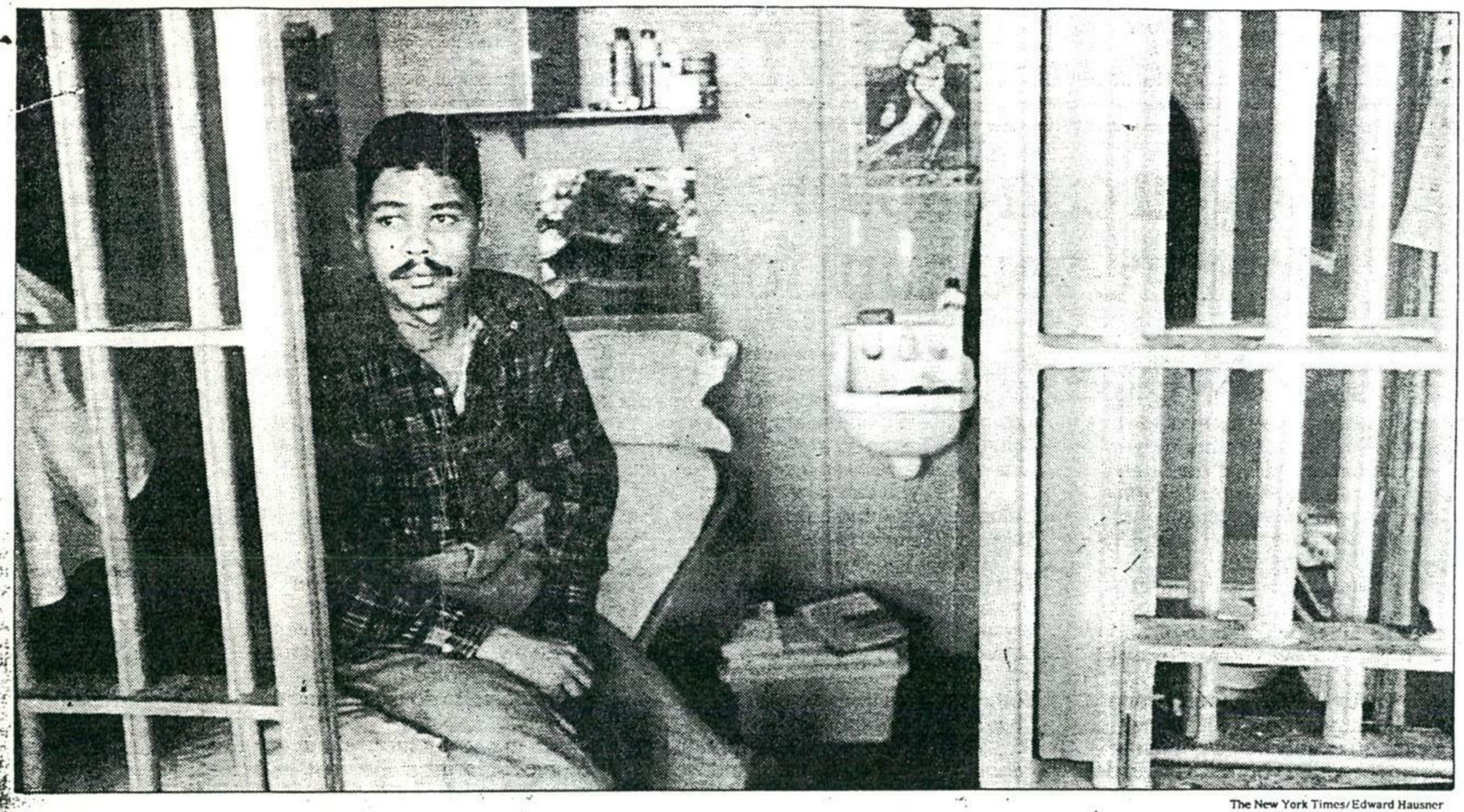
There is no medical reason to keep many of the AIDS and ARC patients isolated in the infirmary, according to prison health-care experts. Instead of isolating those with AIDS and ARC, prison officials ought to be educating the rest of the prison population about the virus, how it is transmitted and what steps help slow its spread. Education is also essential because each year 10,000 inmates leave prison and return to their communities.

Most prison officials claim that segregation is for security reasons. However, in the few prisons where AIDS and ARC prisoners have been quietly integrated into the general population, administrators haven't heard of any incidents in which prisoners with AIDS or ARC have been assaulted by other inmates, or vice versa.

Hundreds of millions of dollars have been poured into the construction of new prisons. Year after year, upgrading medical services has been a low priority for state corrections officials.

No one should expect corrections officials to unravel the complexities of dealing with AIDS in prison on their own. Developing comprehensive medical and education programs will require the involvement of other state agencies and experts.

Cathy Potler is director of the prison conditions project of The Correctional Association of New York.



The New York Times/Edward Hausner

Rafael Rios, who has been diagnosed as having AIDS, sitting in his cell in a segregated block of the Medical Clinic Building on Rikers Island.

AIDS in Prison: Hard Questions for Justice System

3/5/87

By RONALD SULLIVAN

A sharp rise of signs of AIDS at Rikers Island reflects an impending crisis in city and state prisons in New York, justice officials said.

"We are seeing more cases of weight loss, oral thrush, recurring fevers, unexplained physical breakdowns and illnesses over the last three months among new inmates with records of drug abuse," Dr. Wallace C. Rooney of the City Health Department said.

"If my observations are correct and these are early signs of AIDS infection," he said, "we are in for a very significant problem. The health resources in the prison system already are under a lot of strain from this disease, as it is."

District attorneys, judges and parole boards are beginning to question whether defendants with AIDS should be prosecuted and sentenced and whether dying inmates should be released before they have served their assigned time.

Complaints and Degradation

The complications posed by the deadly disease have already had a major impact on prosecutors and prisons. Among the problems are these:

¶Prisoners in the AIDS unit at the Rikers Island Infirmary complain of inhumane conditions, and doctors there say some of the patients should be in hospitals or nursing homes.

¶Some defendants report being shunned, degraded and often deprived of rights because correction and court officers refuse to go near them or even take them into court.

¶Correction officers call for screening the blood of all prisoners for the AIDS virus and segregating those testingpositive, a move strongly opposed by city and state correction and health officials.

¶Prosecutors talk of delaying tactics involving defendants with AIDS, in expectation of their deaths, and of giving some of them "a break by letting them walk." In one case that haunts and has embarrassed the authorities, the defendant committed two armed robberies less than 24 hours after he had been released.

¶Defense lawyers describe how some judges have shown compassion by ordering the release of prisoners and dismissing charges against defendants who are dying from AIDS.

More often, however, inmates with full-scale AIDS diagnoses remain in prison infirmaries such as at Rikers, a city institu

Continued on Page B6

AIDS in Prison: Hard Questions for Justice System

Continued From Page B1

sining, until they die.

The Bronx District Attorney, Mario Merola, said his office had prosecuted scores of defendants diagnosed as infected with the AIDS virus and hundreds of others who probably were. He said 2,700 of the more than 7,000 indictments in the Bronx last year involved drug use.

"In a strange sense," Mr. Merola said in an interview, "in fighting crime, we have become involved in an explosive public health problem.

"Do we prosecute defendants who might die before they are sentenced, or who most certainly will die in prison? And do we push for high bail and prison terms just to keep these people from infecting others? The public will never condone simply letting them off because they have AIDS."

Mr. Merola was not optimistic.

"Traditional legal principles no longer seem to apply," he said. "We are looking at a criminal-justice system that is being abated by death.

"Everyone, including the judges, are looking for an easy way out by simply delaying and delaying until the guy dies. Pretty soon, there will not be any debate in this city about overcrowded prisons. AIDS will take care of that."

One way to cut the spread of infection, Mr. Merola said, would be to screen all inmates and segreate those who test positive for the AIDS virus.

At Rikers, Dr. Rooney said, 50,000 or so inmates were sentenced there last year or held pending indictment or trial. He said a "conservative estimate" was that 11,000 to 12,000 of them were infected with the virus that causes acquired immune deficiency syndrome.

According to the medical director at Sing Sing, Dr. Benjamin Dyett, the fear of AIDS among the guards and 2,200 prisoners has lessened in the last three years. The fear has lessened even though AIDS is now the leading cause of death among the 37,000 prisoners in the state — rising from three deaths in 1982 to 124 last year.

Dr. Rooney said there was no sure way to be accurate about the problem, because state and city policies forbid screening inmates for antibodies to the HIV virus that causes AIDS. As a result, infected inmates who have no confirmed diagnosis of AIDS are placed among the 14,000 inmates at Sing Sing.

Experts say there is no evidence AIDS is transmitted by casual contact.

Dr. Rooney said a recent jump in the number of new Rikers inmates showing possible signs of infection represented a manifestation of what he described as a "major leap of the disease" about three to four years ago, from homosexuals to intravenous drug users, the two major risk groups.

According to prison officials, the increase in infections is most evident among new inmates. The officials also said intravenous drug use was the major cause for any increases inside the prisons.

When AIDS was first diagnosed in 1981, homosexuals accounted for 80 percent of the cases, and intravenous drug users 17. The percentage for homosexuals has dropped, to 56; the percentage of drug users has doubled, to 35.

New York City, which has almost a third of all the cases in the country, has reported 9,000 cases of AIDS. The disease destroys the immune system, leaving victims prey to a variety of fatal infections that often attack drug users about two years after having been infected by a contaminated needle.

Infirmary Ward: A New 'Death Row'

The AIDS cellblock on Rikers is on the third floor of the infirmary. Most of the time, the 26 inmates sleep in their cells, which are unlocked during the day. Recently, the only sound in the cellblock was the rhythmic music from an unwatched black-and-white television set featuring two tango dancers.

Pigeons roosted outside the heavily barred windows, their coos muffled by a biting wind driven across the Hell Gate and into the cells of what Rikers prisoners prefer to call "death row."

"Either the wind or the pigeons are going to get me," said Angelo Rizzo, 36 years old, an inmate who walked around in a bathrobe.

Mr. Rizzo is afraid of the pigeons, because he has ARC, or AIDS-related complex. He has not broken down with the full effects of AIDS. But he fears that his compromised immune system can not withstand a fungus found in pigeon excrement, which blows in through cracks in the window casements on windy days.

On winter nights, he says, the wind roars through the openings, and every chill, he and others fear, could be the first sign of a deadly form of pneumonia that kills more AIDS patients than any other infection.

"Look at this guy," Mr. Rizzo said, pointing into a cell holding Roberto Alvarez, who was recently returned from the AIDS unit at the Bellevue Hospital Center, where he as treated for encephalopathy, which affects the brain.

"He can hardly get out of his bunk," Mr. Rizzo said. "He's just a kid, and he's dying fast. He deserves a better death than being trapped inside a cell sick as a dog and made to lay in his own filth. All he did was drugs. Mass killers get treated better."

Dr. Rooney agreed and said Mr. Alvarez should be in a nursing home. He also said city hospitals were returning prisoners to Rikers sicker than before, overwhelming the limited infirmary.

Fears of Violence From Other Prisoners

But the choice at Rikers, as it is in all city and state prisons, is either a prison infirmary, where nursing care is scarce, or a hospital, where inmates are sent only when they break down with a life-threatening illness or when they are dying.

Last year, the average number of inmates in the unit was 12. This year, Dr. Rooney predicts twice as many, and possibly more.

Mr. Rizzo, who admits to the embarrassment of being caught burglarizing an empty apartment in Queens, faces being transferred to the general prison population on the ground that he has not suffered a confirmed major AIDS illness.

Such a move, he contends, would be like a death sentence.

"I'd never stand a chance out there," he said. "The other prisoners would try get rid of me. I'd be killed for certain."

Mr. Rizzo and other inmates attributed their infections to drug addiction and contaminated needles. He is certain, he said, he was infected two years ago in Sing Sing while serving a three-year sentence.

He, and other inmates said they doubted giving free needles to addicts or condoms to prisoners would reduce the risk of infection.

"The idea of giving addicts free needles is ridiculous," said Thomas Matthews, 47, a reed-thin inmate in the 11-bed AIDS unit at Sing Sing.

"I remember shooting up with 20 or so addicts in a Lower East Side shooting gallery," he recalled. "And someone says, 'Maybe we shouldn't share because of AIDS.'

"But another guy chimes in and says: 'What's the difference? We're all going to die.' "

In interviews, several inmates agreed that their switch from heroin to cocaine in the early 80's sharply increased their chances of infection.

Rafael Rios, 33, awaiting trial at Rikers on charges of narcotics possession, said he thought he had been infected in cocaine shooting galleries in the East New York section of Brooklyn. He said dozens of addicts would line up at the galleries and share the same needles.

His face and neck riddled by the red lesions of Kaposi's sarcoma, Mr. Rios said he and other addicts would "shoot up 20 to 30 times a day, if we could."

At Sing Sing, Thomas Hare, 41, who said he was the first student ever expelled from Jamesburg (N.J.) High School on drug charges, said:

"I can't remember how many times we would shoot up cocaine — 20, 30 times. I wouldn't stop until the needle was so blunt it couldn't penetrate a vein.

"The main thing with cocaine is you can never get enough. If there was a pile of it, you wouldn't stop until it was gone. You don't care whose needle you'd use."

In contrast, he said, a shot of heroin might last a day, lessening the risk of infection.

As for issuing condoms in prison, Eli Adorno, 30, of East Harlem said, "That's totally crazy."

"Do you think someone who is about to rape you is going to stop and think about a condom?" he asked. "No way."

"If they decide to give out condoms, which are like raincoats in the Sahara," Mr. Matthews said, "they'd better give out needles first, because drugs are far more prevalent here than sex."

"Listen," one prisoner said, "I got worse troubles. My wife is dying of leukemia, and somehow I've got to figure out how I tell my 8-year-old son that his mother is dying of cancer and his father of AIDS."

Everyday Conditions Make Life Worse

"It's bad enough to have AIDS on Rikers and face death," Mr. Rios said. "But there are things here that make it worse."

For one thing, Mr. Rios said, the thin mattress pad on his steel bunk rarely protects him from the cold.

"I've already had one case of pneumonia," he said. "With the wind blowing in and turning my bunk to ice, how long can I hold out against another?

"Just as bad was when I was taken to State Supreme Court in Brooklyn on Dec. 17. The correction officers never let me out of the van, because the court officers inside refused to go near me when they heard I had AIDS."

In the Bronx, prosecutors cited a similar case. They said Jose Rivera, 34, was arrested March 9, 1985, for stealing a windshield from an automobile-parts dealer. When Mr. Rivera's case went to court, he was ill from AIDS, and the court officers would not go near him. As a result, he was sentenced in the basement holding cells of the Bronx courthouse.

In contrast, Civil Court Judge Richard A. Goldberg, sitting in State Supreme Court in Brooklyn, approved the release last week of John DiPalo, who had been held in the AIDS unit at Rikers since last June on burglary charges and a parole violation.

Mr. DiPalo, who has a 10-year history of drug addiction, has been seriously ill with AIDS for nearly a year. He tried to commit suicide by cutting his wrists just before he was arrested and charged with burglary.

Mr. DiPalo's condition worsened, as numerous illnesses, including an infection of the bone marrow, forced him into a wheelchair.

According to Mr. DiPalo's lawyer, Catherine H. O'Neill, Judge Goldberg ruled that "it made no sense" to incarcerate him any longer, particularly because he was so ill. But the legal reason given for Mr. DiPalo's release to his family in Far Rockaway, Queens, was that while he was in prison he would be denied any chance of taking part in clinical trials with experimental drugs to fight AIDS.

Successes and Failures With Early Releases

Several judges in the Bronx have made similar rulings.

For example, Victor Comancho was arrested and charged with robbery Jan. 17, 1986. Advised that the defendant had AIDS and had a few months to live, Judge Solomon Katz paroled him to the care of Mother Teresa last December.

But there is one case that haunts Brian Wilson, chief of the major offense bureau in the Bronx prosecutor's office.

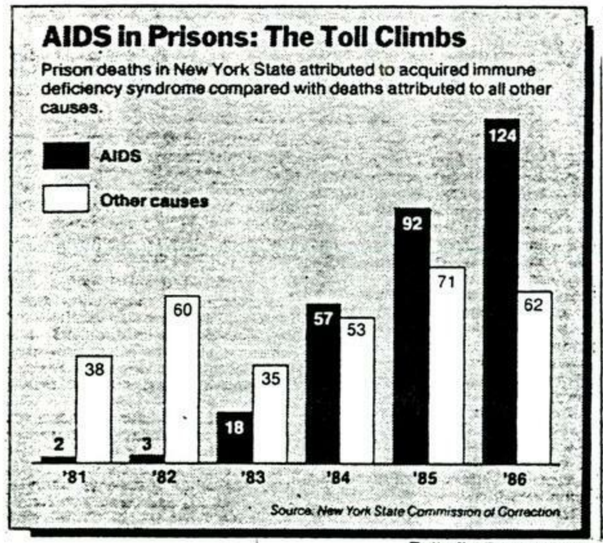
"We had this case against Oscar Frasier, a security guard who stuck up a supermarket that had fired him because he had AIDS," Mr. Wilson said. "He was so sick that he collapsed in court at his arraignment.

"I felt sorry for the guy; so we got out of our way to help. We agreed to his pleading to a lesser charge and his release on parole."

Mr. Wilson said he had also helped arrange medical care, drug counseling and food stamps for Mr. Frasier.

"However," Mr. Wilson added, "a few hours later, he went back to the supermarket and holds it up again, at gunpoint. The employes were in hysterics, and the cops who had arrested him before were bent out of shape. They thought he was in jail.

"The next day, he holds up another supermarket, and he gets caught right away. We never let him go again, and he died in Bellevue Hospital. But can you imagine how I'd feel if he'd ever pulled the trigger during those two holdups? I'd never be able to live with myself."



W.H.O. Casts Doubt on AIDS Tests for Travelers

By THOMAS W. NETTER
Special to The New York Times

GENEVA, March 4 — The World Health Organization has concluded that blood testing of people traveling from one country to another would have minimal benefit in combating the spread of the AIDS virus and could be counterproductive, according to a statement released here today.

In a statement that will be distributed to member nations and government health officials worldwide, a panel of health experts concluded that such screening programs could divert funds from more effective education programs.

Some nations, such as Britain, have considered screening travelers arriving from abroad, especially if they come from areas where AIDS is believed to be widespread, prompting a fierce public debate. The blood tests indicate that a person has been infected with the AIDS virus but not whether that person will develop the incurable disease.

Diversion 'Not Justified'

The panel concluded that "at best and at great cost" the screening of international travelers "would retard only briefly" the spread of the disease "both globally and with respect to any particular country," the statement said. The diverson of resources to AIDS screening of international travelers and away from educational programs and measures to protect the blood supply "is not justified," it said.

The panel recommended that educational progams directed at both national and international travelers on how to avoid infection with the virus would be more effective in combating the disease and that funds would be better used for this rather than mandatory blood testing of arriving foreigners.

The conclusions were reached in a two-day meeting at the health agency's headquarters here this week and come amid rising concern over the spread of acquired immune deficiency syndrome. AIDS, which is spread by sexual intercourse or exchanges of blood, kills by crippling the body's defense mechanisms.

Among the participants were Dr. June Osborn, dean of the school of public health at the University of Michigan; Prof. Robert Black, chairman of the division of international health at Johns Hopkins University in Baltimore; Dr. James Chin, state epidemiologist for California, and health officials from Britain, Australia, West Germany, Japan, France, Mexico, Greece, Tanzania and Kenya.

The health agency has now reported some 40,000 confirmed cases of AIDS, including 30,000 in the United States alone, although the actual number of cases worldwide is believed to to considerably higher, with many cases in Africa in particular not reported.

"We're not trying to say to countries, don't ever screen anybody under any circumstances," said Dr. Jonathan Mann, director of the agency's anti-AIDS program. "What we are saying is don't screen under any circumstances unless you have fully considered the full range of issues."

The panel raised the issue of "logistical, epidemiological, economic, legal, political and ethical problems" that could arise from a program to screen incoming travelers. In addition, it said that any such screening program would have to apply to returning nationals as well as foreigners entering the country. It noted that because months could pass between infection and formation of antibodies, which is what the blood test detects, screening would not reprsent a fool-proof means of detecting AIDS virus carriers.

Death Behind Bars

AIDS in New York State Prisons

by Anne-christine d'Adesky

Fifty-two men are allegedly dying of AIDS in New York prisons. Another dozen inmates are reportedly spending their last days in an AIDS infirmary at Rikers Island correctional facility in New York City, awaiting sentencing or a transfer to the state system. With few exceptions, AIDS inmates are isolated from the general inmate population by a Department of Corrections Services (DOCS) policy based on a stated need to protect inmates with AIDS from potential harm by other prisoners.

In the model Special Needs Unit, or AIDS ward, at the upstate Sing Sing state prison, 11 inmates with AIDS receive what health officials and DOCS authorities consider quality health care by a medical and social services staff sensitive to AIDS. They are also cared for by volunteer inmates, who work as orderlies, clean their rooms, and provide contact with the general population. But in the other 48 state prisons, the DOCS policy of segregating persons with AIDS has meant that some inmates with the disease are facing death alone, in a room with the door closed and only a television set for company.

"It's pretty damn lonesome," stated John Gresham, a lawyer with Prisoners Legal Services (PLS), a criminal justice advocacy group, who represents these inmates. "It's a hell of a way to spend your last days."

As of January 1986, at least 245 cases of AIDS had been reported in New York State prisons since the first case in 1981. Over 60% (153 cases) have died. Another four inmates with AIDS were either paroled or released. Last year, 95 of all 163 inmate deaths in New York State prisons were caused by AIDS. As of March 1986, 21 inmates with AIDS had died in New York City prisons.

There are now 38,000 inmates in the DOCS system. Eighty percent are transferred to the state prisons from the metropolitan New York City area. Among state prison AIDS cases, 80% come equally from the Bronx, Manhattan, Queens, and Brooklyn. The majority are Hispanic men with an average age of 34 and a history of IV-drug use. Prison health authorities estimate that 60% of the inmates at Rikers Island have used IV drugs, and that one-quarter to one-third of the inmates at the state prisons have an IV-drug use history. That makes New York inmates a "high-risk" population for AIDS. Over 90% of inmates who died of AIDS were IV-drug users. Although the incidence of "high-risk" anal sex and needle use are controversial questions, no one is disputing that they occur, however rarely.

Today, AIDS has a severe impact on the already overburdened New York prison system, which generally suffers from overcrowding, inadequate or poorly maintained facilities, and lack of essential services, including education, training, and health care. With the introduction of AIDS, a usually fatal transmittable disease, into an incarcerated population vulnerable to exposure, the delivery of health care and other services is adversely affected.

For now, the percentage of AIDS cases in prison is small and appears to be stable, but the numbers are rising, since the prison population increases annually. There were 75,000 admissions into the system last year, many of them recidivists or repeat offenders. That proportionately increases the odds of the disease entering the prisons and spreading to other inmates. "There has been a definite increase in numbers at the Rikers Island facility," stated Dr. Wallace Rooney, medical director of the Prison Health Service.

AIDS Markers

Aside from sexual activity and drug use, prison authorities are concerned about the spread of diseases such as tuberculosis, a virus that is often a "marker" for AIDS. There are 40 inmates with AIDS-Related Complex (ARC) at Rikers. It was impossible to obtain figures on ARC cases in the state prisons, but one doctor at the Disease Center in Albany, who asked not to be named, speculated that there are three to five ARC cases for each case of full-blown AIDS. They are not publicly identified as ARC patients, and remain in the general inmate population. Hence, in a typically overcrowded setting, the risk of contracting tuberculosis, which can be transmitted by air, is high.

A less verifiable threat are asymptomatic AIDS inmates. Earlier this year, William Gaunay, health systems evaluator for the watchdog New York State Commission on Corrections (NYSCOC) stated that, "In some cases. . .diagnosis of an inmate's AIDS is not made until the autopsy required on anybody who dies while in New York's custody" ("AIDS in Prison" by Susan Darst Williams, *Corrections Compendium*, Vol. X, No. 8, Feb. '86).

In April, Gresham and other PLS attorneys sent a letter to Governor Mario Cuomo detailing their concern over the spread of AIDS in prison, citing figures from Dr. Harold Jaffe of the federal Centers for Disease Control (CDC). Jaffe estimates that, for every diagnosis of AIDS, there are 50-100 undiagnosed, asymptomatic HTLV-III/LAV/HIV carriers. Out of 38,000 inmates, therefore, 2,500-5,500 might be infected and asymptomatic. Using the same ratio, Gresham *et al.* argued that 2,200-4,400 asymptomatic but infected inmates may have been released into the population at large.

The DOCS has worked with the state AIDS Task Force, the AIDS Institute, Council 82 (the corrections guards union), and groups such as PLS to set up educational and counseling programs in the prisons. But critics of the DOCS programs say there is no standard and comprehensive policy on AIDS in prison. As a result, conditions and treatment vary greatly and there is still hostility and anxiety among many inmates and guards, who are afraid of being infected.

Though the incidence of "high-risk" anal sex and needle use in prisons are controversial questions, no one is disputing that they occur, however rarely.

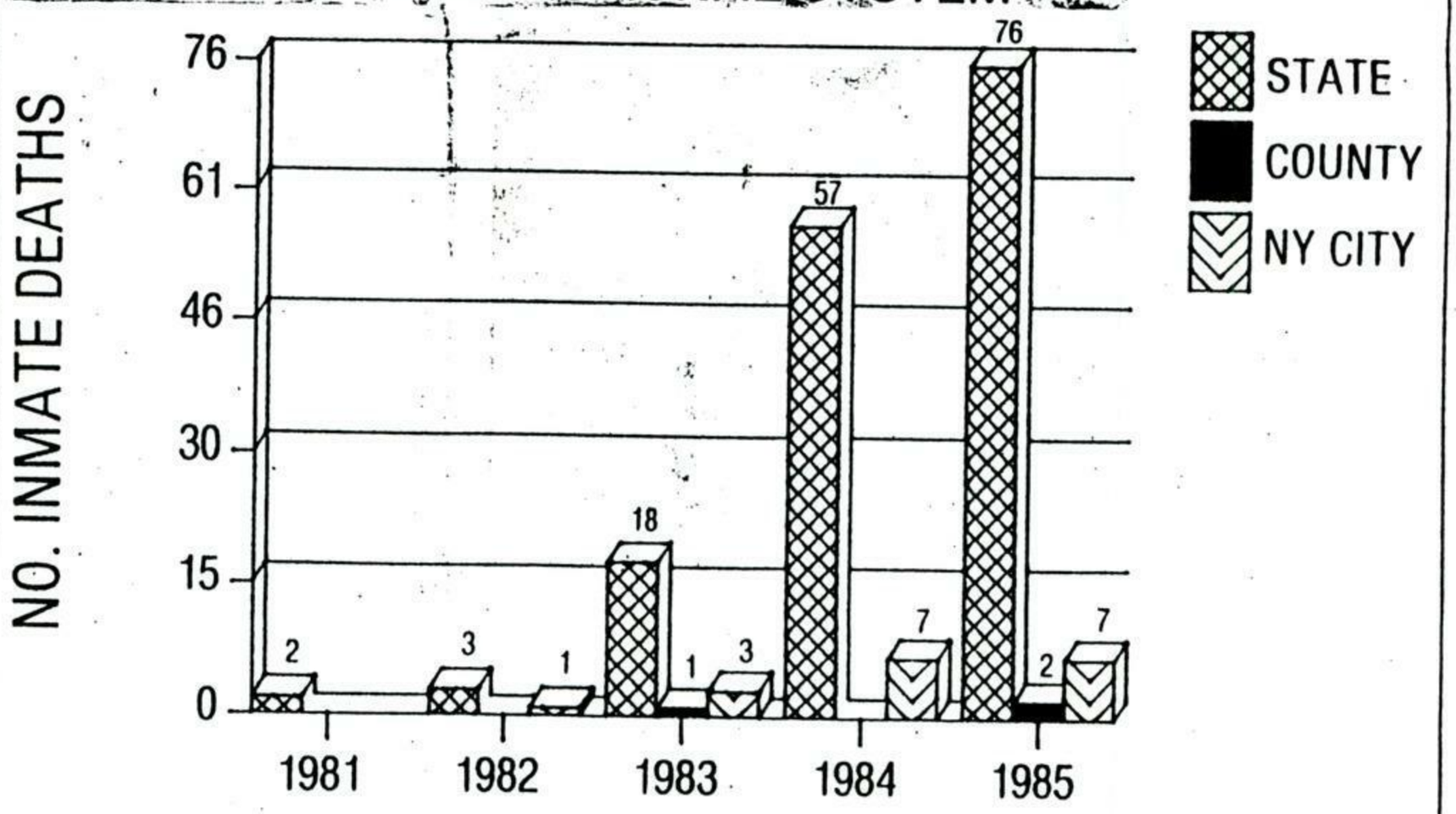
"The lack of foresight and comprehensive planning by DOCS in this area have resulted in increasing tension, in an already difficult prison environment, among both prisoners and prison personnel, as well as intolerable conditions of confinement for those afflicted with this disease," asserts Cathy Potler, director of the Correctional Association of New York's Prison Conditions Project. Potler cites an example of violence by inmates at Clinton correctional facility, when overcrowding forced DOCS authorities to temporarily house six healthy inmates in a medical unit with three AIDS patients. In other cases, "guards refused to work in the medical unit because of the presence of AIDS patients, while others appeared dressed up like 'clowns' wearing surgical gowns and masks," Potler states. A medical worker told Potler that "fear of AIDS is becoming more difficult to treat than the disease itself."

Prison health officials interviewed recently agree that conditions and procedures vary by facility, but argue that, since February, the hysteria and fear of AIDS has greatly abated among prison guards and inmates. They point to the Sing Sing AIDS unit, with amenities such as a visiting room for families and attorneys, a recreational yard, counseling, barber visits, and volunteer inmate care, as a measure of improvement.

Despite the Sing Sing unit, Potler maintained recently that "no one [in DOCS or Albany] is confronting the issues." She said education, counseling, increased funds for medical staff, and vocational programs are still lacking, and that "the whole system lacks policy and procedure."

A major issue is the location of the state prisons, usually far from New York City, which makes it hard for families of stricken inmates to visit. "Children under the age of 16 can't visit the inmates. At Attica, the general population

AIDS MORTALITIES
NY CORRECTIONAL SYSTEM*



*November 13, 1981 - October 31, 1985

Jersey Is Criticized Over AIDS Protocol

NEWARK The state has done little to slow the spread of AIDS among New Jersey prison inmates by failing to educate them about the disease, provide blood tests on demand or segregate convicts who test positive from the general prison population, a lawyer argued yesterday in Federal District Court here.

Prison officials have shown "deliberate indifference to the medical needs" of prisoners and have not followed the Corrections Department's own AIDS protocal, the lawyer, Jennifer Chandler Hauge, said.

She is representing 13 inmates who have sued prison officials over the state's AIDS policy, charging denial of due process and cruel and unusual punishment.

The state contends that inmates with AIDS are segregated to protect other prisoners, and that those who test positive for the virus or have symptoms of AIDS are warned not to engage in "high-risk" activities such as intravenous drug use or homosexual activities. (AP)

FOUNDED IN 1844

February 12, 1987

David Gould
United Hospital Fund
55 Fifth Avenue
New York, New York 10003-4392

Dear David:

Enclosed are the brief proposal and annual budget for the AIDS in Prison Project which the Correctional Association is submitting to the United Hospital Fund.

So far we have received the following grants for this project:

$25,000 - New York Community Trust

$15,000 - Fund for the City of New York

$15,000 - Chicago Resource Center

$55,000 - Total

We are seeking to raise the remaining funds needed for the effort, 44,300, from the United Hospital Fund and other private sources.

Please feel free to contact me if you have questions or would like more information.

Thank you for your consideration.

Sincerely,

Robert Gangi

Robert Gangi
Executive Director

Enclosure
RG:sb

THE CORRECTIONAL ASSOCIATION OF NEW YORK
135 EAST 15TH STREET
NEW YORK, NY 10003
(212) 254-5700

United Hospital Fund

Shaping New York's Health Care:
Information, Philanthropy, Policy.

55 Fifth Avenue
New York, NY 10003-4392
212 645-2500

SPECIAL PROJECT FUND

GRANT APPLICATION

Applicant Institution

Name: Correctional Association of New York

Address: 135 East 15th Street

New York, New York 10003

Project Director: Cathy Potler

Telephone Number 212-254-5700

Contact Person: Cathy Potler/Robert Gangi

Telephone Number 212-254-5700

Institutional Endorsement

This application has the full support and endorsement of the applicant organization and should be considered as the organization's single application for this cycle of the Special Project Fund.

Name: Robert Gangi

Title: Executive Director

Date: February 17, 1987

AIDS IN PRISON PROJECT

ABSTRACT

Background

The epidemic of AIDS has struck disproportionately at the prisons in New York, which houses more inmates with AIDS than any other state. The spectre of AIDS is causing fear and intolerance on the part of both inmates and guards. According to the state, since 1981, 325 prisoners with AIDS have died while in custody.

In contrast to the general population, the illness among inmates has generally resulted from intravenous drug use rather than homosexual activity. 92% of inmates with AIDS have a history of intravenous drug use. About 60% of the state's prisoners are believed to have injected drugs at some point; all of these drug abusers have probably been exposed to the virus. This group may eventually develop symptoms within the next few years or be capable of passing on the illness. Since prisons combine a high risk population with an environment where intravenous drug use and anal intercourse are not unusual, it is feared that transmission of the disease could be occurring in the correctional facilities.

Mainly due to the high number of potential carriers and the enforced intimacy of prison life, the level of hysteria over AIDS is even higher in prison than in the outside world. This climate of uneasiness has led some guards and inmates to refuse to live or work around AIDS sufferers, to prisoner disturbances and to lawsuits aimed at battling the perceived threat of contagion.

Statement of need

Some progress has been made in educating prison staff and inmates about AIDS and how to deal with it, but the anxiety level regarding the disease and the stress levels accompanying it remain so high that stronger efforts are called for. In order to minimize both the transmission of the disease and the hysteria surrounding it within the prisons, The Correctional Association will evaluate the system by which information regarding the disease is disseminated to inmates and staff, and make recommendations for needed improvements. Since instruction regarding preventive behavior is one of the major weapons in the arsenal against AIDS, it is imperative that a system of education be developed not only for AIDS victims confined in prisons but for all prisoners and prison employees.

Most of the AIDS and AIDS Related Complex (ARC) patients in New York prisons are isolated from the general population and placed in the prison hospital, either in an isolation cell or in a ward. Only those victims acquiring acute care are housed in an outside hospital. Thus, the overwhelming majority of prisoners with AIDS and ARC are not permitted to participate in any educational or vocational programs, attend religious services, have access to the law library, or utilize the facility visiting

room for family and friends.

In addition, while over 90% of the victims are New York City residents, AIDS patients remain confined in facilities all over the state, including those close to the Canadian border. Because they are locked up so far from home, many have to face their last days alone without support from their families and close friends.

The quality of medical and psychological care given to AIDS victims in prison is inadequate. There are many questions regarding timely diagnosis of the illness, adequate care and treatment at the facility, delays in outside hospitalization, and lack of leadership and direction from Albany. While desperately needed, counseling and therapy are generally not available in a systematic way to the AIDS and ARC patients.

Apart from the boredom, isolation and personal suffering of each AIDS patient, their greatest torture is their fear of dying while still in prison. Many people familiar with the situation believe that AIDS victims should be released either to the care of their families or to outside medical facilities where they would receive better treatment and have more contact with their families than they do in prison. Some of the high costs of medical care will then be covered by Medicaid, and in some situations private funding, thus partially relieving the state of this expense.

Correctional Association Plans

The Department of Correctional Services (DOCS) may be faced with an ever-expanding AIDS crisis in the future, yet it has so far only barely coped with the many AIDS cases that already exist in state prisons. In response to this situation, the Correctional Association is planning a number of steps designed both to shape public policy around the issue and to enhance the treatment and programs available for this population. First, the Association is researching several relevant questions, including:

- the care and treatment statewide of AIDS and ARC victims in the prisons;
- what outside facilities are available for dying inmates;
- ways in which AIDS educational programs in the prisons can be improved;
- the Division of Parole's plans and programs for dealing with AIDS victims who are released from prison and come under its supervision.

Once the research is completed, the Association proposes the following:

o Prepare literature based upon our research that includes specific recommendations for policy reform and program improvements.

o Based on the literature prepared and recommendations made, perform public education and policy advocacy work with decision-makers, community and professional organizations and media representatives in order to effect necessary changes.

o Coordinate the efforts of concerned organizations and constituencies, including outside care providers, in an effort both to enhance the education and service work around this issue and to ensure that the project's advocacy activity is broad based.

The Association has already enlisted support from a group of professionals in relevant fields which serves as the Advisory Committee (a list of the members is attached). The Committee is in place and plays an active role in developing recommendations based on the Project's research, as well as in creating a stronger public voice and, eventually, gaining support from other organizations.

Additionally, the Correctional Association will arrange sessions with high level officials in the Governor's office, in the legislature and in the relevant state agencies, especially DOCS and the Department of Health, to present our findings and recommendations and to press for specific commitments to ameliorate the problem. The organization will also engage in an ongoing statwide media campaign, including writing myriad op eds and letters to editors, appearing on radio and television news and talk shows, and meetings with editorial boards of newspapers of the state's major cities.

The prison population, in a sense, serves as a microcosm of the larger society. In several ways, therefore, the impact of this project can extend beyond the prison walls, shaping service delivery systems in many spheres. The analyses and proposals developed may very well be relevant and useful to settings and constituencies outside the prison. In addition, if inmates were properly educated, they will carry this important information with them when they ultimately return to their communities.

AIDS IN PRISON PROJECT
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THE CORRECTIONAL ASSOCIATION OF NEW YORK
AIDS IN PRISON PROJECT

ONE YEAR'S BUDGET

Salaries & Benefits	$65,000
Full Time Project Director Half Time Project Assistant	
Consultants	4,000
Office Supplies	1,000
Xerox	1,500
Travel	5,000
Telephone	2,500
Postage	1,500
Printing	2,250
	$82,750
Support Services (20%)	16,550
TOTAL	$99,300

The Correctional Association of New York

FOUNDED 1844

135 EAST 15th STREET, NEW YORK, N.Y. 10003 (212) 254-5700

CONCEPT PAPER

AIDS IN PRISON PROJECT

Background and Overview

The epidemic of AIDS has struck disproportionately at the prisons, particularly in New York, causing fear and intolerance on the part of both inmates and guards. According to the state, as of January 1986, 245 cases of AIDS had been confirmed in New York's prisons; of those victims, 153 had died in custody.

The Center for Disease Control, which has monitored the progress of AIDS, has estimated that 73% of the cases in the general population have been spread through homosexual contact. In contrast, the transmission of this illness among inmates has resulted generally from intravenous drug use rather than from homosexual activity.

The AIDS virus is widespread among New York drug users. Since about 60 percent of all state prisoners are believed to have injected drugs at some point, half of them are estimated to have been exposed to the virus. Five to 25 percent of this group may eventually develop symptoms or be capable of passing on the ailment.

Since prisons combine a high-risk population with an environment where homosexual activity often takes place among those who, under ordinary circumstances, would not be so inclined, it is feared that correctional facilities could easily become breeding grounds for transmission of the disease. Although at this time most prisoners with AIDS entered prison

with the disease and did not contact it behind the walls, most prison medical authorities believe that it is only a matter of time before cases acquired in prison are identified.

Despite the low level of documented contagion, the level of hysteria over AIDS, well out of proportion to the actual threat of acquiring the disease, is even higher in prison than in the outside world. This is probably caused by the high number of potential carriers and the enforced intimacy of prison life. The uneasiness has led some guards and inmates to refuse to live or work around AIDS sufferers, to prisoner disturbances and lawsuits aimed at battling the perceived threat of contagion. AIDS victims in New York prisons are isolated from the general population, not only to protect them from infections, but to spare them from the threats and reprisals by other inmates.

Statement of Need

Some progress has been made in educating prison staff and inmates in New York about AIDS and how to deal with it but the anxiety level regarding the disease remains so high that stronger efforts are in order. Two additional key issues regarding AIDS victims in the prisons are whether these people are receiving appropriate medical and psychological care, and whether, perhaps most important of all, terminally ill people should be subjected to the additional wrenching indignity of dying in custody. Neither the Board of Parole nor the Department of Correctional Services (DOCS) generally makes a special effort to release dying prisoners early.

At the present time, when a New York inmate is diagnosed with AIDS, he is separated from the rest of the population and placed in the infirmary, either in a isolation cell or in a ward. Only those victims requiring excessive care are sent to an outside hospital. Despite some efforts on the Department's part to centralize and plan for this growing population, patients

remain spread out all over the state, including in prisons close to the Canadian border. Most victims are New York City residents, and many have had to face their last days alone because their families and friends found the journey to see them prohibitive.

While AIDS cases in general are expected to double in the next few years, AIDS cases in the prisons could increase more dramatically. Drug abusers in the general population once comprised only 18 percent of AIDS victims. Now their percentage is estimated at 33 percent. The Department's planning to meet this crisis has been both slow and inadequate. Outside hospitals, meanwhile, have often turned away inmates with AIDS, exacerbating the problem and pointing up the immense need for more facilities to care for them both inside and outside prison.

Statewide guidelines on dealing with AIDS cases have recently been developed. Inmates in many cases now have more access to counseling and reading matter. Nonetheless, the quality of care given AIDS victims leaves a lot to be desired. For example, inmates on Sing Sing's AIDS ward, viewed as the best AIDS facility in the state, stated that inadequate medical care there is causing "premature death and unnecessary suffering." Some patients have been denied hospitalization due to insufficient bed space at outside hospitals. Nursing staff and rehabilitation programs are deemed inadequate, and proper diet and/or drugs to ease pain and prolong life are not available. Infirmary beds have no buzzers to signal the medical staff if a patient is in distress. Patients are kept in the twelve-bed ward until they are on the verge of dying, at which point they are sent to an outside hospital. Fellow sufferers at early stages of the illness or those in remission are forced to repeatedly watch the horrifying and depressing last stages of AIDS. As one inmate has stated: "We all know we're going to die, but why do we have to watch?"

Apart from the boredom, isolation and personal suffering of each AIDS patient, their greatest torture is their fear of dying while still in prison. This anguish is often translated into negative attitudes directed toward the prison staff. At Sing Sing, staff members are rotated every six months to avoid the depression associated with the constant exposure to dying inmates as well as the hostility expressed by inmates who are angered and depressed by their diagnosis. Stress management training is currently non-existant for staff members, but is sorely needed. A few seminars have been conducted and pamphlets distributed, but the staff has largely been untrained in dealing with this disease and its terrible repercussions.

Is prison the appropriate place for AIDS victims to spend their last days? Many people familiar with the situation believe that AIDS victims should be released either to the care of their families or to outside medical facilities where they would receive better treatment and have more contact with their families than they do in prison. Some of the high costs of medical care will then be covered by Medicare and private funding, thus partially relieving the state of this expense.

Despite offers by the New York Catholic Archdiocese to make room for these patients in certain hospitals, the Governor has so far made no move to commute the sentences of dying prisoners. DOCS officials claim that they have no authority to release such victims, despite having recently freed three prisoners on a medical leave of absence to the care of Mother Teresa, the Noble Prize recipient. This provision could be used far more widely but the state, thus far, has chosen to take no further action in this area.

Correctional Association Plans

DOCS may be faced with an ever-expanding AIDS crisis in the future, yet it has so far only barely coped with the many AIDS

cases that already exist in state prisons. The Correctional Association proposes three things that it can do to help resolve this crisis:

* Research the conditions under which AIDS suffering inmates live, the state's plans for future accommodations and feasible alternatives, including outside placement for dying prisoners.

* Make recommendations based on this research.

* Perform advocacy work with decision-makers and media representatives in order to effect necessary changes, and work with outside care providers who might be able to assist these efforts.

In performing research, the Association will:

1. Investigate the care and treatment of those prisoners not in the special AIDS ward at Sing Sing, who are probably even more vulnerable to the isolation and problems the disease entails.

2. Examine the treatment of inmates diagnosed as ARC-AIDS Related Complex victims. About one quarter of these patients will eventually develop AIDS. They have largely been ignored in the AIDS debate, although many of them will eventually suffer the same symptoms and possibly die.

3. Review the DOCS diagnosis system which, some claim, misses many AIDS and ARC cases or diagnoses them too late.

4. Examine the extent to which existing educational programs have addressed the hysteria over contagion, and ways in which they might be improved.

5. Explore what outside facilities might be made available for dying inmates.

6. Determine to what extent prisoners are suffering from other terminal diseases, and the treatment they receive.

7. Examine the Division of Parole's plans and programs for dealing with AIDS victims who are released from prison and come under its supervision.

The Correctional Association will produce a report based on this research, containing a comprehensive blueprint for how the state should handle the problem of AIDS in prison, from the time victims of the disease enter the system until after their release. The prescribed blueprint will focus on such issues as diagnosis and classification, treatment for all stages of the illness, educational programs for inmates and staff, release procedures, and parole programs.

The report will be sent to the Governor, members of the legislature, corrections officials and outside providers of health care to AIDS victims. Reports will also be sent to media representatives in order to present our findings to the public. The Association will work with state officials and others to encourage a faster and more thorough response on the part of the state to the many issues raised by AIDS among prisoners.

Benefits

The following benefits should be gained from this effort:

* Incarcerated AIDS sufferers will receive better medical treatment as well as more humane care.

* More of them will be released, in order to die in peace and dignity with their families.

* Correctional staff and non-afflicted inmates will be better able to deal with the real and imagined dangers of AIDS.

* The state will save millions of dollars in shifting dying patients to private or federally-funded institutions.

* The state will, finally, develop more humane and practical ways of dealing with prisoners suffering from terminal ailments.

The Correctional Association of New York

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January 16, 1986

Here's the concept paper from our consultant on the Aids in Prison issue.

Please give me your feedback as soon as possible.

Bob G.

THE CORRECTIONAL ASSOCIATION OF NEW YORK

Concept Paper

AIDS In the New York State Prison Population

by Kevin Krajick

Background and Overview

The epidemic of AIDS has struck disproportionately at prison inmates, and no prison system has been hit harder than New York's. Of the approximately 15,000 cases of AIDS diagnosed nationwide, at least 420 have appeared among prisoners. More than half of these--232 in all--have appeared in New York. Another 35 percent of the prison AIDS victims have been found in Florida and New Jersey, with the rest being scattered in 20 states around the country.

Almost all the transmission of the disease to this population has come from intravenous drug use, not from homosexual activity, according to prison medical authorities and the Centers for Disease Control (CDC), which has monitored the spread of AIDS. This contrasts with the progress of the disease in the general population, in which 73 percent of the cases have been spread through homosexual contact. In the New York prisons, 95 percent of the cases have been traced to the use of contaminated needles for injecting illegal drugs.

The virus thought to cause AIDS is epidemic among New York drug users. Some 60 percent of the state's inmates are thought to have injected drugs at some point, and medical authorities fear that as many as half of them could be exposed to the virus. An unknown number of them--perhaps five to 25 percent--may develop symptoms or be capable of passing on the ailment.

Because prisons combine such a high-risk population with an environment where homosexual activity often takes place among men who otherwise would

not have sexual relations with each other, some medical authorities expressed fears early on in the epidemic that correctional institutions could become a hotbed for transmission of the disease. The common prison practice of crude tatooing, usually with unsterilized needles, also could spread the disease, some believe.

This fear has not yet materialized; virtually all the diagnosed cases so far have been traced to activities on the street, not in prison. All the available medical evidence indicates that it is only "high risk" activity--the exchange of bodily fluids during sex, or blood-to-blood contact, as with a shared needle--that spreads the disease. Casual contact, such as shaking hands, sharing a room, and even kissing or sharing eating utensils are not thought to transmit the virus. The medical evidence so far indicates that this holds just as true in the crowded, communal prison environment as in the outside world.

Some corrections authorities believe that many inmates have modified their activities to avoid high-risk contacts, which would account partly for the lack of prison contagion. CDC, which inthe beginning collected separate statistics on AIDS among prisoners, dropped the category several years ago after deciding that being a prisoner in and of itself does not place a person in a high-risk category. CDC guidelines for precautions that correctional workers should take against acquiring the disease, to be issued in January, are expected to differ little from those already recommended to workers in the outside world. The current guidelines place few restrictions, even on food handlers or health care workers.

However, some prison medical authorities still are monitoring the possibility of AIDS transmission in the institutions, and most feel that it is only a matter of time before cases acquired in prison are identified. In fact,

some exposure to the virus already has been documented. In the first study of its kind, the Maryland Division of Correction released research in December showing that at least two long-term inmates--1.5 percent of the total tested--had been exposed to the virus, probably while in custody. The inmates have not actually developed the disease.

Despite the low level of documented contagion, the level of hysteria over AIDS, apparently well out of proportion to the actual threat in the outside world, is even higher in prisons. This probably is caused by the high number of potential carriers and to the enforced intimacy of institutional life. The uneasiness has led to guards and inmates refusing to work or live around AIDS sufferers, to prisoner disturbances, and to lawsuits aimed at battling the perceived threat of contagion.

Most state correctional systems, including New York's, isolate AIDS victims from the general population, not only to protect them from the infections that could attack them, but more often, to calm the fears of the others and to protect the victims from threats of other inmates, which prison medical people say are common. Because of these problems, the issue of how to deal with the often-overblown fear of the disease is at least as important as dealing with the disease itself, especially in the potentially explosive environment of a prison.

One manifestation of the fear and misunderstanding of the disease has been the demands from both inamtes and correctional staff that all inmates be tested for antibodies to HTLV-III, the virus thought to be associated with the disease, and that all those testing positive be quarantined. Inmates have filed lawsuits to this effect in New York, Indiana and Alabama. The New York plea, La Rocca v. Dalsheim, was dismissed by a state Supreme Court judge in August 1983, but some inmates are pushing for renewed litigation.

The question of whether inmates should face mandatory testing for the HTLV-III antibody goes to the root of many of the civil liberties and medical issues surrounding the outbreak of AIDS. For one thing, not enough is known about the disease to say whether the blood test, originally designed only to detect the presence of the antibody in donated blood, offers any useful information about whether a person testing positive is a threat. It is not known whether those testing seropositive carry the virus itself or merely an antibody to it, developed as the result of some previous exposure.*

Prison officials point out that once an inmate tested positive, he would probably become an outcast were the results to be found out by others. In effect, the test, especially if it was mandatory, would violate the inmate's rights to due process, privacy and equal treatment since there would be no clear medical reason to justify the ostracization he might have to suffer as a result.

Some prison systems, especially New York's, would end up with so many "seropositives" that there would be no way to isolate them anyway. "If every potential AIDS case were isolated, there would be no one left in general population," said William Gaunay, a New York State Corrections Commission official who monitors AIDS cases in the prisons.

In New York, as in other states, the blood test has so far been used very selectively, as an adjunct in diagnosing inmates who already show visible AIDS symptoms.

Statement of Need

Since the initial panic in New York prisons about AIDS, which has included inmate boycotts of dining halls, wearing of protective gear by

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* The New York judge who rejected the lawsuit ruled that the test does not accurately diagnose, and pointed out that there is no law outside prisons requiring that AIDS sufferers be quarantined.

correctional officers and a disturbance by inmates who found that they had been sharing a bathroom with AIDS victims who prison officials had placed in ~~a disciplinary wing,~~ the infirmary apparently without telling anyone ahead of time--some progress has been made in educating the staff and inmates about the realities of the disease and how to deal with it. However, the anxiety level in many institutions remains at such a high level that the DCS clearly needs to supplement these efforts. Critics claim that an ever-growing number of cases is straining the prison medical system, and that the state is not doing enough to plan for the care of potential new victims. Some also question whether AIDS prisoners are receiving appropriate medical and psychological care, especially since the DCS has a serious shortage of beds specifically for AIDS sufferers. Even the one specialized AIDS unit, in Sing Sing, is the subject of a lawsuit brought by patients there. Finally, there are many who question whether terminally ill people should be subjected to the wrenching indignity of dying in custody, which the great majority of AIDS prisoners do.

Of the 232 AIDS cases that have surfaced in the state prisons, 140 have died in custody (usually they are shipped to an outside hospital for their last hours) and 45 currently are in the system. The others have been released. Parole officials say they make no special effort to release dying prisoners early, and Governor Cuomo has never commuted a sentence because a prisoner was dying of AIDS.

Currently, when an inmate is diagnosed with AIDS, he is isolated in the prison infirmary in whichever institution he is in, or put in a single isolation cell. Only if he requires acute care that he cannot get at the institution is he sent to a community medical facility.

Some patients have only a few of the AIDS symptoms. They may be classified as suffering from ARC--AIDS-Related Complex. It is thought that about a

quarter of them will develop full-blown cases of the disease. They are handled on an individual basis with treatments ranging from hospitalization to, in a few instances, return to the general population. There are currently about 40 ARC cases in the system; no cumulative numbers are kept on ARC, according to DCS spokesperson James Flateau.

The state has made some effort to centralize and plan for the care of the growing AIDS population, but for the most part, patients remain spread out all over the state. Virtually all the victims are from New York City, and in what seems an unnecessarily cruel twist, some of them kept in remote upstate institutions where they die alone because their families and friends cannot make the journey to see them.

Sing Sing has room for only twelve patients. Nearby Westchester County Medical Center has 18 beds reserved for DCS patients, and occasionally these are filled with as many as a dozen AIDS victims, though the normal number is two or three. The state, in collaboration with New York City, has been planning a 22-bed AIDS unit for the past two years, but because of bureaucratic snags and political infighting, it is only now going out for bids. It is to be installed in an existing wing of the city's Metropolitan Hospital, and is scheduled to open this summer.

Some observers find this response inadequate and slow, since it will barely treat the number of cases now in the system. Fran Tarlton, a spokesperson for the state Department of Health, said the number of AIDS cases in the DCS could increase dramatically in the next few years. She pointed out that since 1981, the proportion of New York State AIDS victims who are drug abusers has grown from 18 percent to 33 percent, which may portend even more of an upswing in the number of prison victims than in the general population, where cases are expected to double. One DCS medical

official, who declined to be identified, called the state's plans "inadequate," estimating that the system probably should plan for at least 75 acute care beds for AIDS victims within the next two years.

The need for more facilities may be exacerbated by outside hospitals' reluctance to accept AIDS victims. Officials of the Westchester County Department of Corrections, which shares responsibility for the medical center's secure unit, have indicated that they want to lower the number of AIDS victims the unit accepts, possibly to just three or four at a time.

Lawyers representing AIDS victims at Sing Sing assert that Westchester and at least one other outside hospital occasionally have turned away inmates AIDS sufferers. The state did announce plans this month to open 10 to 15 regional AIDS centers to treat free-world victims, but it is not clear whether these would be made available for DCS wards.

The quality and appropriateness of care within the DCS also has been a major issue. In 1984, AIDS patients at Downstate, Sing Sing and Green Haven sued to the DCS to enjoin it from placing them in isolation. They claimed the conditions under which they lived inflicted cruel and unusual punishment on them and deprived them of their rights to privacy, free expression and free association. The suit, Cordero v. Coughlin, claimed that AIDS sufferers, by virtue of their placement in segregated areas, are denied access to all prison recreational, work and education programs, and that visits and access to the law library and other reading matter are severely limited.

The suit detailed other alleged cruelties of this double isolation; it claimed that at least one AIDS patient had his mail pushed into his isolation room with a long pole; another was forced to wear a surgical mask while walking through the corridor, both measures that are not medically necessary.

The inmates complained that the enforced inactivity and isolation pushed them into severe depression.

A federal district judge dismissed the suit in August 1984, saying that the patients' segregation bears "rational relation to prison officials' objective to protect both sufferers and other prisoners from tension and harm."

Since the dismissal of the suit, many observers say that the state has made strides in dealing with AIDS patients. Statewide guidelines on how to deal with AIDS cases, lacking until a few months ago, have been developed. Inmates in several institutions are said to now have more access to counseling and reading matter.

The Sing Sing ward is viewed as an advance by most; it has a recreation yard, a dayroom, access to a law clerk, and a staff that seems to put genuine effort into caring for the patients. A prison chaplain has donated a VCR to the unit, and one corrections officer rents a new tape each day from an outside store. Still, inmates there complain of little constructive activity, and inappropriate medical care, even though it is considered to be the best the system has to offer.

A new lawsuit, filed by six Sing Sing AIDS patients, claims that inadequate medical care there is causing "premature death and unnecessary suffering." Specifically, the complaint alleges that some Sing Sing patients require hospitalization, but are denied it because of inadequate space at outside hospitals. It says that Sing Sing does not meet the requirements to provide hospital or accredited hospice-level services, including adequate supervision for IV drips of antibiotics to fight infections, sufficient nursing staff and rehabilitation and dermatology staff, nor does it offer proper diets or drugs that could prolong life and ease pain. Carol Kahn, a White Plains lawyer representing the inmates,

said that "everyone at Sing Sing is trying very hard to operate in good faith and be cooperative. They just don't have the latitude and resources."

Margaret Wyke, director of the Sing Sing medical unit, admitted that the AIDS section is poorly supplied and staffed. For instance, one inmate had been waiting for six months to get a set of weights and and a cradle to ease the excruciating pain in his legs, which are covered with skin cancer and are atrophied from lying in bed so long. Nearly all of the daily care for AIDS victims is provided by inmate aides, not medical personnel. "We really don't have enough staff to take care of them," said Wyke.

One inmate aide, who said he volunteered for the job, described his tasks: "I bathe them, I take their temperatures, their blood pressure, their pulse. I assist them with their bedpan and their urine. I give them massages. I clean their wounds. If they have sores in their rectums, which some of them do, I clean those out for them."

The most eloquent testimony on the indignities, small and large, inflicted by the prison environment, came from the patients themselves. One emaciated-looking inmate, suffering from meningitis (a common ailment among AIDS sufferers), is confined to a wheelchair. He complained that the infirmary beds do not have buzzers to signal the medical staff, who are around the corner and down a corridor, in case a patient is in distress. "It's horrible to have to scream for a nurse at 3:00 in the morning while all these guys are trying to sleep," he said.

All the men objected to the fact that patients often are kept in the eight-man common ward until they are nearly ready to die, and then sent to the hospital at the last moment, when they need acute care. The inmates who could still walk and felt relatively healthy said they found it horrifying and depressing to be forced to witness the last stages of the

disease repeatedly. One inmate had passed away the night before my visit; he had been moved out shortly before his death. "Why couldn't they get him out a little sooner?" said one inmate. "He lay on his bed for two weeks eight feet away from me and he wouldn't eat and couldn't get up or anything. He just gave up. We all know we're going to die, but why do we have to watch?

The boredom and isolation of the ward also inflict a great deal of suffering. When asked what there was to do on the ward, Reinaldo Ortiz, a 40-year-old inamte, said, "I walk from that room to this bed, and that's it," pointing to the TV room down the hall. "There ain't nothing to do. You're looking at it." He said his mother and sister used to visit him once a week but they can no longer afford the trip, and now they come only once a month, for a few hours. "I just try not to think too much."

The greatest torture that each of the inmates spoke of was not their fear of dying, but their fear of dying while still in prison. "I've fully accepted the fact that I'm going to die, and I'm not afraid of that at all," said Daryle Morsette, a 27-year-old man who was diagnosed with AIDS in 1982. Morsette is unable to walk or use his arms because of swelling caused by Kaposi's sarcoma, a cancer associated with AIDS that wells up on the skin. "What's hurting, boy, is that I may have to die right here," he said. "As it is, they've taken away all my rights from me. They've taken away my dignity. Then to make me die in prison. That's the only thing I'm truly afraid of."

The tensions of such an environment often run high. Sing Sing staff members are rotated out of the AIDS unit every six months because most can't take the depression caused by the constant dying, nor the hostility from inmates who cannot accept their disease, said Saundra Johnson, the

medical unit's nurse administrator.

"There is a dual hostility and anguish among prisoners that are both incarcerated and dying that is translated into the way the inmates deal with the staff," said Angela DeVito, health director of the Public Employees Federation (PEF), which represents 2,700 correctional workers, including some medical staff. She said the union receives reports of AIDS victims throwing feces and urine on employees, and biting and scratching them. ""You're walking into an angry, unpredictable place, not a healing environment," she said. She called for stress managmenent training for employees, which is non-existent now. "We have seen no creativity from the state on how to deal with this," she said.

Some education programs have been undertaken, mainly to allay fears among inmates and staff that the disease can be spread through casual contact. This has included distribution of pamphlets and seminars by outside medical experts for staff and some inmate leaders in about half the state's institutions. According to representatives of the two other unions representing correctional employees, there is now somewhat less fear and misunderstanding than there was before the programs, but much still needs to be done to distribute information more widely and to update information.

The ultimate issue concerning AIDS inmates is whether prisons are the appropriate place for them. PEF is pushing the state to at least develop one central hospice-like facility for dying inmates who do not yet need acute care, following the lead of California, which sends all its AIDS victims to a special ward in its prison hospital at Vacaville.

A group of Roman Catholic clergy, including some prison chaplains, has been pushing since 1982 to have most AIDS victims released from the prisons to outside facilities. They have argued that the patients would receive better care, have more contact with their families, and that the state would save money because Medicare and private funding would pick up more of the costs. The Church has offered space at New York City's St. Clare's Hospital and other institutions.

The DCS and the governor's office seemed reluctant to follow this suggestion; as late as December, when a group of bishops met with Governor Cuomo to discuss this and other matters, there was no movement on the idea, with the governor apparently unwilling to use his commutation power to release dying inmates, and DCS officials claiming they had no authority to release inmates to die in the free world.

However, just before Christmas, Mother Teresa, the Nobel Prize-winning nun, visited the Sing Sing AIDS ward, and got immediate results when she requested that inmates be released to her new hospice in New York City. The next day, three inmates, including Daryle Morsette, were freed and sent to New York. The releases were made under the Department's authority to grant a medical leave of absence for outside treatment when it is deemed by the commissioner to be in the inmate's best interest to do so. It appears that this provision could be used liberally if the DCS wished to, said Judith La Pook, assistant counsel to the commissioner, as long as inmates were released to some sort of caring facility, rather than their homes. As of this writing, the state has not announced whether it intends to release other prisoners under this provision.

What the Correctional Association Can Do

The Department of Correctional Services may be faced with a growing AIDS crisis in the coming years, and it appears to have coped only minimally with the many AIDS cases that already have come up. Educational programs for staff and inmates are not all they should be, nor is the medical or mental health care given to AIDS victims always adequate. There also are serious questions about whether this group--or indeed, any other group of terminally ill patients--should be subjected to the ultimate indignity of having to live out their last days in prison. The DCS has made some moves to address all of these issues, but in no area has it gone fast enough or far enough.

The Correctional Association can do three things to help the situation:

o Do research on the conditions under which AIDS inmates live, the state's plans for future accomodations, and on feasible alternatives, including outside placement for dying prisoners.

o Make recommendations based on that research.

o Do advocacy work with decision-makers and the media to push for necessary changes, and, if necessary, work with outside care providers who might be able to aid these efforts.

The Correctional Association's research should include the following:

o Investigations of the care and treatment of AIDS prisoners who are living in places other than Sing Sing (they comprise the majority), where they appear to be even more vulnerable to the isolation and other problems that their disease entails.

o Investigation of the treatment of ARC inmates, who by and large have been ignored in the debate over AIDS prisoners, even though they may suffer

many of the same problems and ultimately may die in prison.

o A look at the DCS diagnosis system, which some observers claim misses many cases of ARC and AIDS, or diagnoses them too late, when the inmate has already caught one of the fatal secondary infections that AIDS and ARC victims are prone to. This could shorten the lives of some patients and, conceivably, endanger those who are unaware that they should take special precautions to avoid infection from such inmates.

o A look at the extent to which existing educational programs have addressed the hysteria over contagion of the disease, and how such programs might be improved.

o What outside facilities might be made available for dying prisoners.

o To what extent prisoners are suffering from other terminally ill diseases, and what sort of treatment they receive. In fact, the issue of terminal illness in the prisons--whatever the cause--could be made into a fairly large part of the project, if the Association so chose.

The results of the research and the Association's recommendations could be published in a report sent directly to the governor, members of the legislature, corrections officials and outside health care providers concerned with AIDS. The research is certain to contain a great deal of compelling information that could be given to the media to publicize the issues surrounding AIDS prisoners, or used in op-ed pieces distributed by the Correctional Association.

The Association could work with state officials as well as outside care providers to encourage more timely and thorough responses to the many issues raised by AIDS among prisoners, and possibly encourage them to work together.

Benefits

The following benefits would arise from this work:

o Incarcerated AIDS sufferers would receive more appropriate and humane care.

o Should progress be made toward releasing more of them to outside facilities, they and their families would have the benefit of their dying with more peace and dignity.

o Correctional staff and inmates not suffering from AIDS would be able to deal better with the real--and imagined--dangers of the disease.

o The state of New York would save millions of dollars in caring for these patients, were some of them to be shifted to facilities that had some private or federal funding. (Such a cost analysis should be part of the Association's investigation, and could be offered as a rationale for releasing prisoners.)

o Out of this experience, the state might also develop more humane ways of dealing with prisoners suffering from other terminal ailments.

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December 13, 1985

Jean Thelwell, Commissioner
New York State Commission of Corrections
60 South Pearl Street
Albany, NY 12227

Re: Death of Debra Edwards

Dear Commissioner Thelwell:

Knowing as I do, your great concern and compassion for incarcerated women, I bring the following situation to your attention with the hope that you and the Commission of Corrections will commence a thorough investigation of the allegations complained of.

Debra Edwards 81-G-241, an inmate at the Bedford Hills Correctional Facility died at the Westchester County Medical Center on November 27, 1985. Her family was not advised of her death until November 30, 1985 when Reverend Smith went to her sister's home with this information. Linda Edwards, Debra's sister, was told that the cause of death was pneumonia; however, the Catholic Chaplin of the Facility suggested that Ms. Edwards died of AIDS. An autopsy was ordered. The results have not yet been transmitted to the family.

From what we have been able to determine from speaking both with members of Ms. Edward's family and to other inmates at Bedford Hills, we are convinced that Ms. Edward's death was probably caused by the failure of medical personnel at Bedford Hills to adequately diagnose and treat Ms. Edward's medical condition.

Linda Edwards visited her sister at Bedford on November 17, 1985. At that time she noticed that her sister had lost much weight and had a cold. Debra told her sister that the doctors at the Facility told her that for the prior two months she had pneumonia. She was being treated with pills. On November 22, 1985 Debra went to nurse's screening complaining of coughing, weakness and difficulty in breathing. She was sent back to her unit.

Later that day she was called to see a doctor, at which time she was sent to Westchester County Hospital on an emergency basis. On November 26, 1985, Debra called her sister. Her sister said that she sounded fine and requested that her sister bring her some night gowns because she had been told by the hospital that she would be spending two weeks there. The next day she died.

The poor level of care given to Ms. Edwards was compounded by the fact that between October 7, 1985 and October 25, 1985, Ms. Edwards was placed in a cell in the Special Housing Unit of the Facility the walls and floor of which were covered with dried human feces, blood and urine and which was malodorous and infested with flies and other flying insects. According to Ms. Edwards the water in the cell was not turned on until October 11, 1985 and the window of the cell was inoperable. During the time she was in the cell, Ms. Edwards experienced nausea, intermittant vomitting and was unable to eat. Prisoners' Legal Services of New York represented Ms. Edwards in litigation concerning these living conditions. The suit was withdrawn upon the agreement by the facility to move Ms. Edwards to another cell. This was done on October 25, 1985.

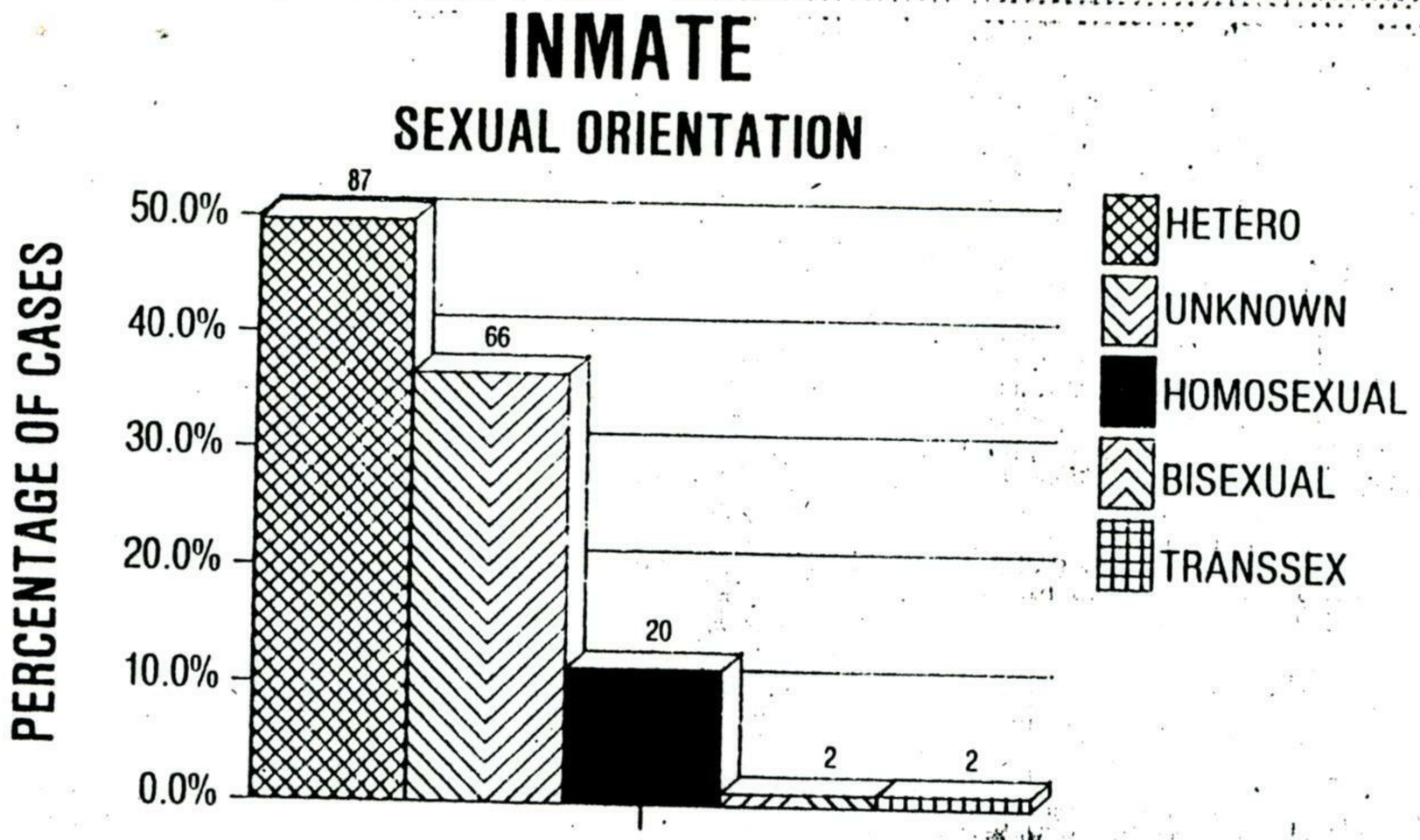
If you need any further information concerning this matter, please let me know. I would expect to be notified of the results in any investigations done by the Commission.

Very truly yours,

Ruth N. Cassell
Senior Attorney

RNC:rf

cc: Thomas Coughlin, Commissioner
Linda Edwards
Judith La Pook, Esq.
Cathey Potler



had daily access to a phone, while inmates at the AIDS ward could use the phone on Sundays, and even then they had to use the phone down the hall, because other people were afraid to catch it [AIDS] by phone," Potler stated.

Prison inmates are educated about AIDs through seminars, pamphlets, and, in some cases, face-to-face counseling by members of the State AIDS Task Force. Prison staff view videotapes and attend training sessions given by prison health workers. Deputy Medical Director Charles Braslow, a physician who treats inmates with AIDS at Montefiore Hospital in the Bronx, said that his staff "was well-educated about AIDS." Not all the guards had attended training sessions, he said, but "a lot of the hysteria among correctional officials has died down." According to Braslow, "Things are in a fairly stable situation."

DOCS Public Information Director James Flateau stated that, "The prison staff and inmates are educated about the disease," and mentioned that outside groups, such as a gay rights organization from Rochester, counseled DOCS inmates with AIDS about safe sex.

In their letter to Governor Cuomo, the PLS attorneys stated that only 660 of the (then) 36,000 (now 38,000) inmates had received face-to-face counseling, which is the best type of education, since so many of the inmates could not read. They listed 29 facilities with a combined population of nearly 9,000 inmates which had not been covered as of late April. Gresham said the DOCS had "made a good beginning," and advocated "more face-to-face counseling."

No Special Treatment For Prisoners

New York and New Jersey prisons do not use the ELISA test for antibodies to HTLV-III/LAV/HIV, the so-called "AIDS virus," due to concerns for confidentiality and inmate safety. Upon entry at Rikers Island, all inmates are given a medical exam, which includes a skin test for tuberculosis and serology for syphilis and other sexually transmitted diseases, and are questioned about "high-risk" behavior. At Rikers, prisoners have access to a clinic at each of the island's 13 facilities. If AIDS or ARC is suspected, they are sent to a city hospital, such as Montefiore or Bellevue.

Instead of the ELISA test, an inmate is given an "anergy skin test panel, composed of four antigens which are viewed as exclusionary steps to pinpoint exposure to HTLV-III/LAV/HIV. Inmates with ARC who may be infectious go to the Rikers Island infirmary, which is limited to a small number of beds. In the more acute stages of the illness, inmates are sent to prison wards at Bellevue and elsewhere. A 22-bed in-patient AIDS unit for downstate prisoners is scheduled to open at Metropolitan Hospital in Manhattan this fall, but for now, some critically ill AIDS patients remain in upstate medical centers far from their families.

The dependence on outside medical centers and special clinics respresents what one physician called "the glitches in the system." The physician, who requested anonymity, said that "access to the hospital system is unfortunately through the emergency room. A person waiting in shackles may be sitting for six hours before seeing a doctor. There is no special treatment because they're inmates. Like any other citizens, they have to take their place in line." He added, "It may take weeks and weeks to get people

Continued on page 41

AIDS in Prison

Continued from page 12

through" at specialty clinics.

Montefiore's Braslow stated that "AIDS has become an important and time-consuming subject over the years," and admitted that, despite access to "sick call," treatment at clinics varies. According to Braslow, while AIDS is not the dominant health issue in prisons, "There has been an increased number of visits to the clinics." He attributed this to the fact that IV-drug users "may be a sicker group in general."

"What we seem to see in people with ARC-type symptoms is that they are going quickly from ARC to death," Braslow said. He isn't "convinced that there is a greater degree of risk [among prisoners] than in the general population," but believes that ARC and AIDS "have been slowly increasing." With regard to tuberculosis, he said, "My sense is that there are more patients with active TB." One explanation for the increase is the admission of more homeless people from New York City, since, according to Braslow, "Homeless people have more TB."

"High-Risk" Behavior

The question of whether "high-risk" behavior occurs in prison and results in the spread of AIDS is a controversial one. The DOCS does not condone homosexual sex acts, and claims that anal sex and needle use are rare in New York prisons. Braslow noted that "needle usage has always occurred" inside the prisons, "although it is rare." "Every few months we see somebody who may have overdosed," he stated, adding that there have been reports of needles taken from clinics or smuggled into the jails.

"I would say from personal experience over the past ten years, I have seen about 20 cases of IV-drug use," said Rooney at the Prison Health Service.

Gresham was more critical: "There is a tendency in state prisons to say that there is not much sex or drugs." He thinks that, "There is a significant number who have anal sex. The riskiness is heightened by the fact that a goodly percentage of inmates have an IV-drug background." Citing a past federal study of sex in U.S. prisons, Gresham said, "Twenty to 30% of inmates engaged in sex. It was primarily voluntary and it didn't vary by region or race."

"In a detention system, in a situation of long-term confinement, there is homosexual activity," Rooney said. One prison newspaper editor in Stillwater, Minnesota put it more bluntly: "The she-men [sic] do not lack for partners." The editor told Leroy Siegel, warden's executive assistant at the facility, "Sexual activity in prison hasn't decreased."

Lawrence Kurlander, director of Criminal Justice in Albany, replied on August 27 to the PLS letter concerning AIDS and its potential spread due to "high-risk" sex. He said that the health department had evaluated more than 200 AIDS cases in state prisons and found no evidence of AIDS transmission. Kurlander argued that the putative two-to-five-year incubation period for AIDS made it difficult to assess any links between sexual behavior and inmate needle usage, since most inmates stay in prison less than two years. He dismissed condoms as a way of limiting potential exposure, noting that health officials were not convinced that condoms would be effective in a prison situation.

Upon the advice of the AIDS Institute, the DOCS rejected condoms, since, Kurlander stated, "They do not wish to endorse or condone homosexual activity in prison." He concluded that the "sharing of infected needles and anal sex involving infected inmates is extremely rare."

Countering this opinion is evidence that eight inmates who died of AIDS had been continuously incarcerated in the DOCS system for five to seven years, far longer than the presumed incubation period for AIDS. According to "AIDS: A Demographic Profile of N.Y. State Inmate Mortalities 1981-85" (*NYCCOC*, March 1986), five of them had been imprisoned four and a half to six years before the onset of symptoms of AIDS.

After further research, the National Institute of Justice concluded this year that, "Even in the best-managed correctional institutions, there may be at least some transmission of the AIDS virus occurring among inmates." ■

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Prisons Are On the Alert Against AIDS

By ROBERT PEAR

WASHINGTON — Despite early concerns that AIDS might become rampant in prisons, officials say there is little evidence that the disease has spread behind bars.

"We have no evidence that any inmate in our system has ever contracted AIDS from another inmate," said Dr. Bealer T. Rogers Jr., chief health officer of the Florida Department of Corrections, which has diagnosed the disease in 36 prisoners.

Some people had believed that prisons would be a breeding ground for AIDS because many inmates have been intravenous drug users and some have had homosexual contacts in prison. But state officials say AIDS is apparently not spreading any faster in prisons than in the general population. Since the disease sometimes has an incubation period of several years, however, it is possible that the virus has been passed from one inmate to another in some institutions without yet being detected.

The Government has recorded 16,138 cases of AIDS, or acquired immune deficiency syndrome, and 8,220 deaths from the disease. Almost one-third of the reported cases were in New York City. A recent survey by the National Prison Project of the American Civil Liberties Union found that about 420 cases of AIDS had been diagnosed in state prisons across the country. More than half of the prisoners with the disease have died. New York State has reported 245 inmates with AIDS, of whom 153 died in prison, 40 have been released and 52 remain incarcerated. There have been 97 cases of AIDS in New Jersey state prisons and 25 in Federal prisons.

On Christmas Eve, New York released three prisoners with AIDS, at the request of Mother Teresa and the Roman Catholic Archdiocese of New York, which opened a hospice in the West Village. Thomas A. Coughlin 3d, the State Commissioner of Correctional Services, said last week that 40 inmates would be transferred to St. Clare's Hospital in Manhattan, and from there some will go to the hospice. Mother Teresa said she hoped the AIDS victims would "live and die in peace" because "each one of them is Jesus in a distressing disguise."

In the absence of clear guidance from the Government, prison officials have adopted varying policies for handling inmates with AIDS. Some states isolate them. A few routinely conduct blood tests to determine whether new prisoners have been exposed to the virus, which attacks the body's immune system.

In prisons as elsewhere, the initial reaction to the disease is often alarm. In mid-1984, Dr. Robert L. Cohen, director of the Montefiore Medical Center program that treats New York City inmates on Rikers Island, wrote, "When patients with AIDS are discovered in the prison system, there is a crescendo of concern leading to panic

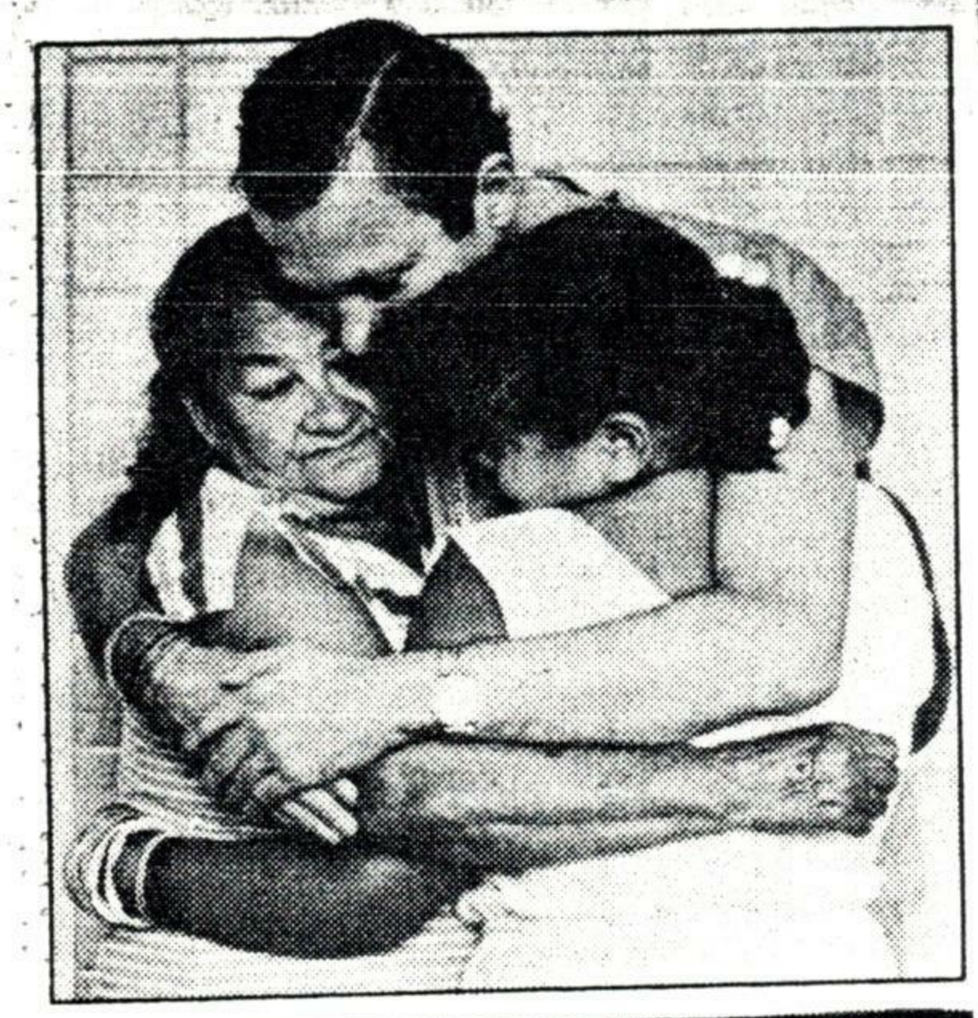
on the part of prisoners, correctional staff, as well as the medical staff." Some correctional officers have worn hospital gowns, gloves and masks.

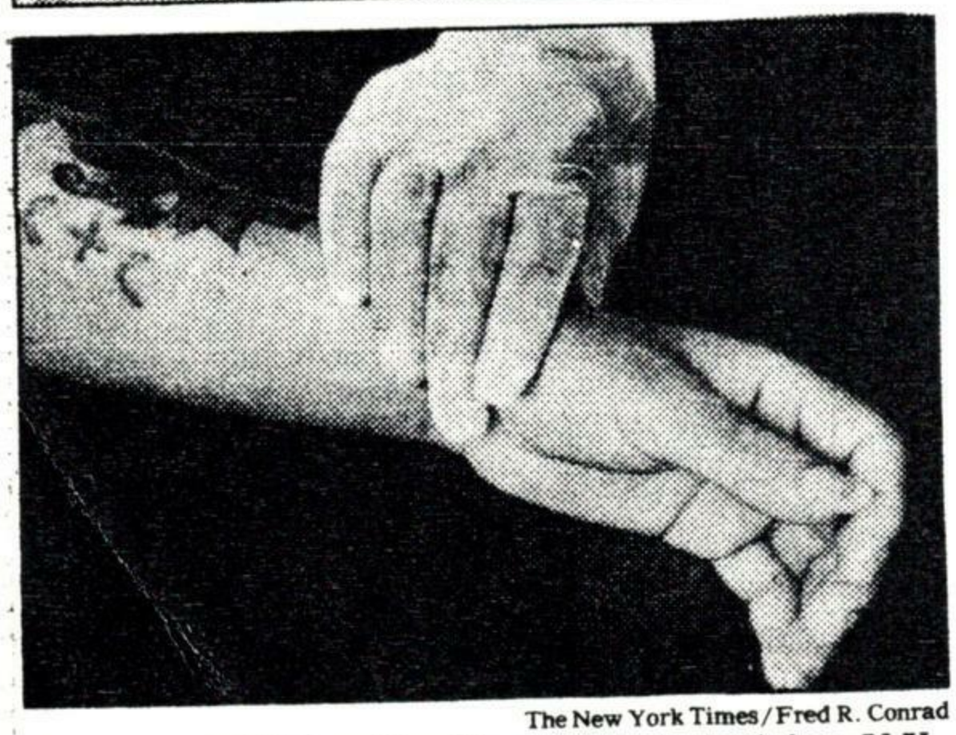
But with more experience and with education, inmates and correctional officers have come to accept the experts' assurance that AIDS is not transmitted through casual contact. Dr. Cohen says prisoners should not be routinely subjected to blood tests because the disease is diagnosed "by clinical evaluation, not by this test." Moreover, he says, "there is no reason to segregate inmates based on the results of this test." Raymond C. Brown, director of the National Institute of Corrections, said most prisons separate inmates with active cases of AIDS by putting them in infirmaries or hospitals.

Many lawyers, doctors and prison officials say inmates should receive more information about AIDS. "Prisoners need to be repeatedly informed how AIDS is transmitted," said Urvashi Vaid, a staff attorney with the National Prison Project. "The information has to be factual, clear and explicit."

Since intravenous drug use is common among inmates before incarceration, Dr. Cohen said, it is useful to warn prisoners that AIDS can be spread through the sharing of syringes. In New York State, 13 to 15 percent of prisoners have been convicted of drug-related offenses, and 75 percent acknowledge having used illegal drugs before entering prison, state officials say.

Some prison officials say it is awkward to talk frankly about the transmission of AIDS through homosexual acts because such acts are forbidden in their institutions. Dr. Robert L. Brutsche, medical director of the Federal Bureau of Prisons, said officials talk instead about the precautions that should be taken when prisoners return to the community.





The New York Times/Fred R. Conrad

A victim of AIDS at Sing Sing prison in Ossining, N.Y., with his mother and daughter; another inmate patient

New York State Paroles 50 Men Sick With AIDS

By RONALD SULLIVAN

About 50 New York State prison inmates have been paroled early within the last two years because they have AIDS, parole officials said yesterday.

The paroles were granted for humanitarian reasons but have raised fears of a possible threat to the health of the families and associates of those released and pit the inmates' right to privacy against the need to protect public health.

Prison officials are barred by Federal and state law from disclosing the medical condition of an inmate; yet, some officials fear that the released men will not disclose their illnesses and will spread their infections, becoming "death threats" to their communities.

However, the executive director of the State Division of Parole, Edward Elwin, said: "Based on our experience, the risk of these men infecting others in the community is minimal. It's a risk that has to be made in each case.

"Not every inmate with AIDS is paroled, and those that are are usually sick or have shown us strong predictions of good behavior. Except for a bizarre case in Albany, in which a released inmate took advantage of a woman, we know of no case in which a parolee with AIDS went hog wild with women or went around sharing nee-

50 With AIDS Are Paroled Early; Privacy and Health Rights Clash

Continued From Page 1

policy was adopted two years ago on humanitarian grounds by the 15-member State Parole Board as the number of AIDS cases in prisons began to rise dramatically.

Leading Cause of Inmates' Deaths

"It does no good to force inmates with confirmed cases of AIDS to spend their remaining days alive languishing in prison," Mr. Elwin said.

Mr. Elwin predicted that increasing numbers of inmates would be paroled as the number of AIDS cases in the prisons rose. He said even more inmates with AIDS would have been released, if they had not died before their cases had been considered.

AIDS is the leading cause of death among the 37,000 inmates in New York prisons, rising from three deaths in 1982 to 124 last year.

Mr. Elwin said that the AIDS policy on parole, which was not announced, was not automatic and that parole officials considered a number of factors before considering any release.

Most important, he said, was that the inmate be regarded as no danger to the community and have suffered from at least one of the opportunistic diseases associated with the deadly AIDS virus, which destroys the immune system.

"We believe such inmates who are prisoners who were infected with the AIDS virus but showed no signs of illness. Virtually all AIDS cases in prison involve inmates who used intravenous drugs and who had been infected by contaminated needles.

Mr. Elwin said whenever an inmate with AIDS was considered for parole, an effort was made to obtain his permission to contact his family and "have an open and frank discussion as to the nature of the illness."

Criticism From Union

"If that is not possible," Mr. Elwin said, "we try to impress the inmate with the importance of revealing his illness, to lessen the risk of spreading infection."

Parole officials said Federal and state laws on confidentiality prohibited disclosing the medical condition of an inmate.

However, members of the New York State Parole Officers Association contended that many paroled inmates with AIDS refused to disclose their illnesses to their families and that the laws barred the officers from warning the families about the risks.

The president of the 900-member association, George Torodasch, said in an interview, "Of course, many of the parolees are going to have sex, and no parole officer is going to be able to stop them."

According to one officer, such a

dles."

Mr. Elwin said the early release off outside a prison, where there are more adequate medical facilities and where they have a chance of being more comfortable," Mr. Elwin said.

Policies in Other States

The New York policy differs from those of four other states that rank behind New York in having the most AIDS cases — California, Florida, Texas and New Jersey. None has a policy permitting early paroles for inmates with AIDS, parole officials in each state said yesterday.

All told, the five states account for 72 percent of all AIDS cases in the country, with New York having the most — 9,891, or 31 percent of the national total of 31,834 cases.

According to parole officials, the problem of AIDS in prisons in other states is comparatively small, and the question of early parole for inmates with AIDS has not been a major issue.

The executive director of the New Jersey Parole Board, Robert Egles, said, "We have no such policy, nor are we considering one." New Jersey has 1,891, or 5.9 percent of the country's total.

Use of Intravenous Drugs

New Jersey correction officials report a total of 156 AIDS cases and 102 deaths from AIDS since 1981 — from among 16,000 prisoners.

Similarly, California, which has had 6,974 cases, or 21.9 percent of the national total, has no such policy, according to a spokesman for the State Department of Corrections, Jack Gray. He said there were 50 AIDS cases among 60,330 inmates in the system.

Florida, with 2,127 cases, or 6.7 percent of the national total, has had 57 cases of AIDS in its prisons since 1981. Connecticut has reported four cases of AIDS among 6,500 prisoners.

New York parole officials said the early parole policy did not apply to woman, child or family that comes in close contact."

'We Can't Do Anything About It'

"I had one guy assigned to me who simply didn't care," he said. "The guy was given about a year to live, and he was in total despair. He told me he was going to have sex with as many prostitutes as he could get his hands on, just to get even.

"What do I do, since he isn't violating his parole? He can kill someone, and we can't do anything about it."

But Mr. Torodasch was clear about what he would do, even if it violated the laws on confidentiality.

"I wouldn't hestitate to inform a family that a parolee has AIDS," he said. "You have a duty to inform a wife or a family. Our principal responsibility is to protect the public. It's our No. 1 concern.

"Unfortunately, the Parole Board has not acted intelligently on the issue of confidentiality. We try to erase that mistake."

Mr. Elwin said, in response: "I'm aware that parole officers are pushing to have families informed of the risks. There are no simple answers. The issue has made all of us uncomfortable."

Fraternity Jokers Arrested

MONTGOMERY, Ala., March 6 (AP) — Twenty police cars on Thursday halted a city bus in which uniformed, apparently armed men were making obscene gestures and apparently pushing passengers. The 32 occupants of the chartered bus were members of Sigma Phi Epsilon at Huntingdon College on their way to a party whose theme was combat. The weapons were plastic. "It was all a practical joke," said Lieut. Tommi Hord. Four students and the bus driver were charged with disorderly conduct.

3/12/87

Slow Rise Found in Prison AIDS Cases

By MATTHEW L. WALD
Special to The New York Times

CAMBRIDGE, Mass., March 11 — The number of AIDS cases is rising more slowly among prison inmates than in the population at large, and indications thus far are that AIDS is rarely transmitted in prison, according to prison officials and medical experts around the country.

A survey of 58 Federal, state and local prison systems found 1,232 AIDS cases among inmates as of Oct. 1, 1986, up from 766 cases 11 months earlier. That represents a 61 percent increase. In contrast, the nation as a whole had an increase of 79 percent, from 14,519 AIDS cases on Nov. 4, 1985, to 26,002 on Oct. 6, 1986.

The figures also cover AIDS victims who died or were released at the end of their terms or were paroled. New York State has paroled 50 prisoners early within the last two years because they had acquired immune deficiency syndrome and other states have paroled a few prisoners.

The survey was compiled by Abt Associates of Cambridge for the National Institute of Justice, an agency of the United States Department of Justice. It will be published next month.

Drug Users and Prisons

Officials have long been concerned about the explosive potential of AIDS in prison, as people sentenced to prison are more likely to be intravenous drug users, one of the groups at risk for contracting the disease that cripples the body's immune system.

The disease is caused by a virus that spreads through sexual intercourse or exchanges of blood, such as in shared hypodermic needles, and most victims in the United States have been male homosexuals or intravenous drug users and their sexual partners.

The incidence of AIDS is greater among prisoners than in the general population, according to the survey. But the number of cases in prison is

population than outside. "It's encouraging but hard to explain," Mr. Hammett said in an interview. "It may be a fluke this year."

At the American Correctional Association, Anthony P. Travisono, the executive director, said that although the number of AIDS cases in prisons was expected to rise, "We feel good about the future. This is not going to be the problem we once anticipated."

According to Mr. Travisono, whose group represents prison administrators, guards, probation officers and others in related positions, experts had expected that the confluence of drug abusers and homosexuals coming into prisons with AIDS would create a third group with the disease, those who caught it behind bars.

"Everyone just assumed," he said, "that because we had a lot of drug addicts, a lot of homosexuals, we'd get

> 'Its encouraging but hard to explain. It may be a fluke this year.'

those two groups, and we'd get the third group ourselves," through contagion in the prisons. But he added, "That group doesn't exist, to my knowledge."

Regarding the apparently low rate of transmission of the disease in prison, the Federal survey cites results from studies in two states.

In one, blood tests conducted on Maryland prisoners incarcerated since before the virus appeared in this country found that 1.5 percent had been exposed to the AIDS virus. But the prisoners studied were volunteers, which researchers said could have introduced a bias into the study.

posure to the AIDS virus, but none al lege that an inmate contracted the dis ease in prison. No cases among staff workers are attributable to contact with inmates, according to the Federal study.

A few states have gone to unusual lengths to cope with AIDS. They are states without substantial numbers of AIDS victims in prison. Vermont, for example, recently began offering prison inmates condoms, and South Dakota, Nevada and Colorado have been giving blood tests to all incoming prisoners. Iowa did the same to 800 prisoners early last year but quit after finding no one tested positive.

In contrast, the states that could expect to find a large number of people testing positive for exposure to the AIDS virus may be avoiding general blood tests because testing would create other problems, experts say.

"Somebody may show positive, and never have anything, never transmit anything," said Alvin J. Bronstein, director of the National Prison Project of the American Civil Liberties Union. "Yet they're put at risk if the results are known to anyone; pretty soon, all the prisoners in a cellblock know."

He said that such prisoners could be the targets of assaults. Mr. Bronstein said that if they were segregated they would have reduced access to such things as recreation, telephones and the prison library.

'It Would Be a Problem'

Mr. Hammett said, "If you did screen, there would be irresistible pressure to segregate them, or do something with them. Logistically and fiscally, it would be a real problem."

Screening "can be seen as a false panacea for the problem," he added. "You screen and segregate, and that says to the other inmates, 'O.K., you don't have a problem.' "

the vast majority of the cases are among inmates in a few states. More

While most big companies have yet to confront the AIDS problem, some have decided the disease can no longer be ignored. Page D1.

than two-thirds are in New York, New Jersey and Pennsylvania, with most of them in New York. Twenty state prison systems and six of the city and county penal systems surveyed had no cases at all.

The author of the study, Theodore M. Hammett, said he did not know why the increase was smaller in the prison

recently concluded that of inmates with AIDS, all had had the opportunity to contract the disease on the street, but that study is also considered inconclusive by experts.

AIDS has not been a major problem in the Federal prison system, which now has about a dozen cases in a population of 42,000, according to Daniel G. Kelly, associate director of health care services for the Federal Bureau of Prisons.

Prisoners File Suit

The Federal survey noted that numerous prisoners around the country had filed lawsuits asking for segregation of those who test positive for ex-

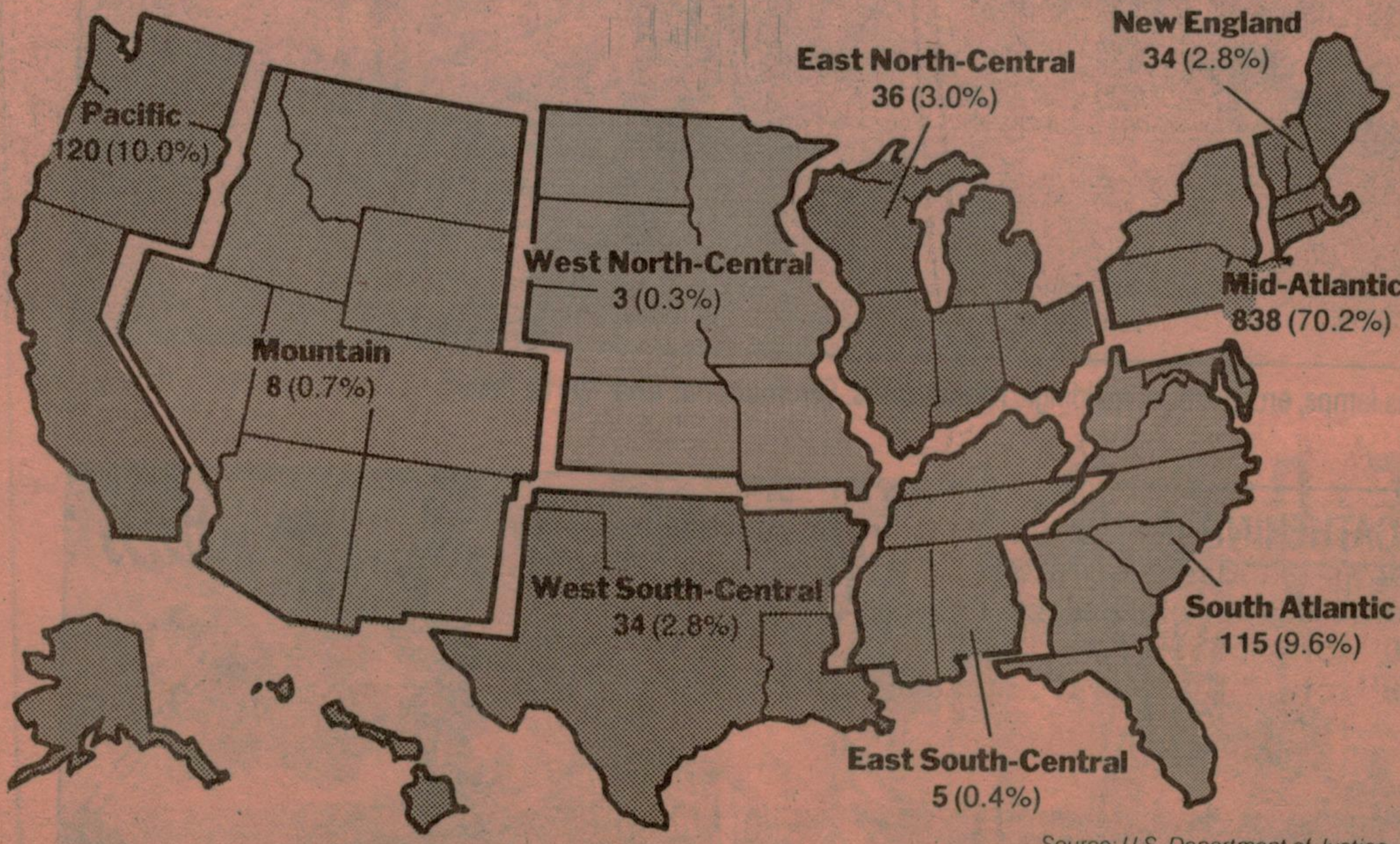
the programs that most prison systems have undertaken to educate inmates about AIDS.

California, with 14 active AIDS cases in a prison population of 60,330, is currently segregating 67 prisoners who have tested positive to the virus but show no symptoms of the disease. The move was "for their own protection," according to a spokesman.

In the first survey by the National Institute of Justice, in November 1985, 13 city and county systems, or 41 percent of such systems, were segregating all those who had tested positive to the AIDS virus. In the October 1986 survey, the number of systems doing this had fallen to 9, or 27 percent.

AIDS in Prisons

Number of reported cases of acquired immune deficiency syndrome in each region's state, city and county prisons and jails in October 1986 and the percentage of the total number of prison cases in the country. As of Oct. 1 Federal prisons reported 27 deaths, 3 releases and 9 active cases; these figures are not included.



Source: U.S. Department of Justice

1/7/86

Prisons to Release Victims of AIDS

ALBANY, Jan. 6 (AP) — The State Correction Commissioner, Thomas A. Coughlin 3d, said today that he would release more prisoners with AIDS into the care of Mother Teresa, the Nobel Peace Prize recipient.

As an act of mercy on Christmas Eve, Governor Cuomo and Mr. Coughlin approved the transfer of three Sing Sing prisoners to the AIDS unit at St. Clare's Hospital in Manhattan, a unit operated by the Roman Catholic Archdiocese of New York in cooperation with Mother Teresa.

Last Thursday, Mother Teresa asked Governor Cuomo to extend the gesture and release all prisoners terminally ill with AIDS, or acquired immune deficiency syndrome.

Mr. Coughlin said that as many as 40 prisoners would be sent in the next month or two to St. Clare's.