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# PRISONERS' RIGHTS

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## I. Introduction<sup>1</sup>

The United States has the highest incarceration rate in the world.<sup>2</sup> The dramatic increase in imprisonment in the U.S. has been accompanied by epidemic rates of HIV among prisoners. At the end of 2001, the rate of confirmed AIDS cases in state and federal prisons was more than three times higher than the rate found in the total U.S. population (1.9 percent of male inmates and 2.9 percent of all female inmates were known to be HIV positive).<sup>3</sup> A study of infectious diseases among people passing through prisons in 1996 found that 17 percent of all prison and jail releasees were HIV positive.<sup>4</sup> Furthermore, the rate of death due to AIDS is more than two times higher in the prison population than that of the entire U.S. population between the ages of fifteen and fifty-four.<sup>5</sup>

These astonishing statistics, reflecting the rapid increase in HIV/AIDS within the prison community, bring with them a multitude of legal issues. This chapter addresses the wide range of concerns that prisoners living with HIV/AIDS might bring to an ALRP attorney. These prisoners have many of the same needs as those living outside the prison setting, including access to health care, treatment, and counseling. However, prisoners also have very distinct and critical needs, such as protection in the confidentiality of their HIV diagnosis throughout the prison, and protection from harassment and discrimination by guards and inmates. Despite the disproportionately high HIV infection rate among prisoners and their pressing needs, most penal systems in the U.S. have not developed comprehensive strategies for HIV treatment, education, prevention, or harassment reduction.

*Section II* begins with an overview of the most important federal statute in this area, the Prison Litigation Reform Act (PLRA), which imposes significant restrictions on a

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<sup>2</sup> ALEXANDER C. LICHENSTEIN & MICHAEL A. KROLL, THE FORTRESS ECONOMY: THE ECONOMIC ROLE OF THE U.S. PRISON SYSTEM IN CRIMINAL INJUSTICE: CONFRONTING THE PRISON CRISIS 16,17 (Elihu Rosenblatt ed. 1996).

<sup>3</sup> LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, *HIV IN PRISONS*, 2001 (January 2004).

<sup>4</sup> MICHAEL F. HAGGERTY, *INCARCERATED POPULATIONS & HIV*, *CRIA UPDATE*, VOL. 9 No.3 (2000).

<sup>5</sup> MARUSCHAK, *supra* (January 2004).

prisoner's right to litigate federal constitutional violations. *Section III* discusses the issue of HIV testing in prisons, including examples of specific testing policies and practices. Discrimination against prisoners with HIV/AIDS has been a consistent feature of correctional facilities' response to the epidemic. *Section IV* addresses the potential challenges to statutes and prison policies in the areas of segregation, program exclusion, and other forms of discrimination. *Section V* examines the ramifications of a correctional facility failing to protect a prisoner from harm, and *Section VI* discusses prisoners' right to privacy concerning HIV infection in the prison setting as a matter of federal constitutional law, state confidentiality statutes, and prison policy. Access to health care is a crucial issue for prisoners with HIV/AIDS. Therefore, *Section VII* includes a detailed discussion of the various aspects of prison health. Finally, *Section VIII* provides an overview of early release programs for prisoners with AIDS.

## **II. Prison Litigation Reform Act (PLRA)**

The PLRA was enacted by Congress as part of a 1996 federal appropriations bill.<sup>6</sup> It is an amalgamation of amendments to several federal statutes designed to significantly restrict federal judges' authority to remedy unlawful prison conditions.

The PLRA's impact is widespread, affecting and limiting virtually all prison litigation. The majority of appellate courts have thus far upheld the constitutionality of its major provisions. The PLRA imposes significant obstacles for local, state, and federal prisoners and pretrial detainees attempting to vindicate their rights under the U.S. Constitution and federal civil rights statutes. On its face, the PLRA governs civil proceedings arising under federal law with respect to the conditions of confinement or the effects of government officials' actions on the lives of the persons confined in prison. It does not govern habeas corpus proceedings challenging the fact or the duration of confinement in prison.<sup>7</sup> Courts have held "government officials" to be supervisory officials, such as those who affect the way a prison is run.<sup>8</sup> However, courts have also held that a government entity can be liable even if no official is found personally liable.<sup>9</sup>

### **A. Exhaustion of Administrative Remedies**

The PLRA states "no action shall be brought by a prisoner in response to prison conditions until such administrative remedies as are available are exhausted."<sup>10</sup> Therefore, prior to filing a complaint in federal court based on constitutional or statutory claims, prisoners must first file a written complaint (commonly referred to as a "grievance") with the prison that describes specifically the nature of the complaint and what remedy the prisoner is seeking.<sup>11</sup>

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<sup>6</sup> 28 U.S.C.A. § 3626 (West Supp. IV 1998).

<sup>7</sup> 18 U.S.C.A. § 3626(g)(5) (West Supp. IV 1998).

<sup>8</sup> See *Giannattasio v. Artuz*, 2000 WL 335242 at 12, citing *Baskerville v. Goord*, 1998 WL 778396 (S.D.N.Y. Nov. 5, 1998).

<sup>9</sup> *Doe v. Washington County*, 150 F.3d 920 (8<sup>th</sup> Cir. 1998).

<sup>10</sup> 42 U.S.C.A. § 1997(e)(a) (West 2004).

<sup>11</sup> See, e.g., 42 U.S.C.A. § 1983 (West 2004).

Each unsatisfactory response to the grievance must be appealed to higher officials until all the stages of the grievance procedure have been completed. This process is commonly referred to as “exhaustion of administrative remedies.” Grievance procedures vary from state to state and prison to prison. Therefore, it is important to follow the specific step-by-step procedures that govern the prison where the problem (or complaint) occurred and to document each step that was taken by recording the nature of what was filed and date(s) when each action was taken.

In the event of an unsatisfactory response to a grievance, prisoners may need to file a complaint in federal court. Complaints should state that the prisoner exhausted all administrative remedies and describe the grievance procedure, the nature of each grievance filed, and the date(s) when each grievance, decision, and appeal was filed and resolved. Proof of exhaustion of the grievance procedure, whether in the form of signed receipts of filed grievances and appeals, copies of filed documents, or certified statements from the prisoner and Department of Corrections staff, should be attached to and referenced in the complaint. Many courts have dismissed prisoner complaints that fail to state (and, in some cases, document) exhaustion.<sup>12</sup>

The PLRA exhaustion requirement may not be avoided even if the remedy sought is not available through the grievance process. An administrative remedy may not provide the relief sought (e.g., damages), or may be otherwise futile in some manner. Some courts have held that it is not necessary to exhaust administrative remedies when there is unavailable relief through such procedures.<sup>13</sup> The U.S. Supreme Court ruled, however, that prisoners must exhaust the administrative process, even if that process does not provide the sought after remedy, such as monetary damages.<sup>14</sup>

## **B. Claims for Mental or Emotional Injury**

When bringing a federal suit under the PLRA, a lawyer must consider the nature of the injuries alleged by the client. The PLRA bars any federal civil action “by a prisoner confined in a jail, prison, or other correctional facility, for mental or emotional injury

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<sup>12</sup> Wendell v. Asher, 162 F.3d 887 (5th Cir. 1998) (dismissing unexhausted, at time of filing, disciplinary due process and excessive force claims brought by prisoner with AIDS seeking both injunctive relief and damages, and rejecting plaintiff’s unsubstantiated assertion that administrative procedures were inadequate); Alexander v. Hawk, 159 F.3d 1321 (11th Cir. 1998); Larkins v. Wilkinson, No. 97-4183, 1998 WL 898870 (6th Cir. Dec. 17, 1998) (holding that plaintiffs must demonstrate that they have exhausted all administrative remedies prior to filing and attach institutional decisions); Raine v. Galteka, No. 98-4076, 1998 WL 747166 (10th Cir. Oct. 20, 1998), *cert. denied*, 525 U.S. 833 (1998); Bark v. Crowell, No. 00-3112, 2001 WL 1222204, 1 (D. Kan. Sept. 20, 2001); Soto v. Elston, 993 F.Supp.163 (W.D.N.Y. 1998); Russo v. Palmer, 990 F.Supp. 1047, 1050 (N.D. Ill. 1998); Moore v. Smith, 18 F.Supp.2d 1360 (N.D. Ga. 1998); Gibbs v. Bureau of Prison Office, 986 F.Supp. 941, 943-44 & n.12 (D.Md. 1997) (dismissing damages claim for failure to exhaust plaintiff’s moot injunctive claim and damages claim).

<sup>13</sup> *See, e.g.*, Whitley v. Hunt, 158 F.3d 882, 887 (5th Cir. 1998) (holding that federal prisoners seeking exclusively monetary relief need not exhaust prison remedies); Lunsford v. Jumao-As, 155 F.3d 1178, 1179 (9th Cir. 1998); Garrett v. Hawk, 127 F.3d 1263 (10th Cir. 1997); Hollimon v. DeTella, 6 F.Supp. 2d 968 (N.D. Ill. 1998); Lacey v. C.S.P. Solano Medical Staff, 990 F. Supp. 1199, 1205 & n.8 (C.D. Cal. 1997); Basham v. Uphoff, No. 98-8013, 1998 WL 847689 (10th Cir. Dec. 8, 1998) (reversing dismissal of unexhausted court access claim where plaintiff was unable to file a grievance because he was out of the state system); *see also* Parra v. Wilkinson, No. 97-3890, 1998 WL 887271 (6th Cir. Dec. 10, 1998) (reversing dismissal on exhaustion grounds and remanding where plaintiff contended he had exhausted administrative remedies of all claims, contradicting defendants’ argument).

<sup>14</sup> Booth v. Churner, 121 S.Ct. 1819 (2001), affirming 206 F.3d 289 (3d. Cir. 2000).

suffered while in custody, without a prior showing of physical injury.”<sup>15</sup> This provision is applicable to prisoners convicted of a felony and incarcerated while awaiting sentencing or while serving a sentence.<sup>16</sup>

This physical injury requirement has been applied primarily to cases seeking damages that were filed after the enactment of the PLRA.<sup>17</sup> The U.S. Courts of Appeals are divided regarding the question of whether the PLRA’s physical injury requirement governs claims arising from constitutional violations.<sup>18</sup>

Consequently, this provision may be invoked by prison officials and courts to bar various claims of prisoners with HIV/AIDS, such as insufficient medical care, segregation and exclusion from programs or services, breach of confidentiality by disclosure of HIV status, subjection to unsafe or unhealthy prison conditions, and threats of violence or assaults that have not yet resulted in physical injury.<sup>19</sup> There is no clear standard to determine what constitutes physical injury, (i.e., how serious the physical injury must be to satisfy the PLRA). One interpretation that appears to be emerging is that the physical injury “must be more than *de minimis* but need not be significant.”<sup>20</sup>

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<sup>15</sup> 42 U.S.C.A § 1997e(e) (West 2004).

<sup>16</sup> 28 U.S.C.A § 1346(b)(2) (West 2004).

<sup>17</sup> See, e.g., Perkins v. Kansas Dep’t of Corrections, 165 F.3d 803, 808 (10<sup>th</sup> Cir. 1999); Davis v. District of Columbia, 158 F.3d 1342, 1346 (D.C. Cir. 1998); Zehner v. Trigg, 133 F.3d 459, 462-63 (7<sup>th</sup> Cir. 1998).

<sup>18</sup> See Doe v. Delie, 257 F.3d 309, 314 n.3 (3d Cir. 2001) (claims seeking nominal damages to vindicate constitutional rights and claims seeking punitive damages to deter or punish egregious violations of constitutional rights not barred by PLRA physical injury requirement); Rowe v. Shake, 196 F.3d 778, 781-82 (7<sup>th</sup> Cir. 1999); Canell v. Lightner, 143 F.3d 1210 (9<sup>th</sup> Cir. 1998) (holding that PLRA physical injury requirement does not apply to First Amendment claim against staff’s religious proselytizing); Friedland v. Fauver, 6 F. Supp. 2d 292, 309-10 (D.N.J. 1998) (holding that PLRA physical injury requirement is not applicable to Fourth Amendment claim for unconstitutional incarceration challenging arrest and detention without probable cause); Warburton v. Underwood, 2 F. Supp. 2d 306, 315 (W.D.N.Y. 1998) (upholding Establishment Clause claim without proof of physical injury). But see Clarke v. Stalder, 121 F.3d 222, 227 n.8 (5<sup>th</sup> Cir. 1997) (suggesting in dictum that First Amendment violation in disciplinary proceeding might be barred by PLRA’s physical injury requirement), vacated on other grounds and rehearing en banc granted, 133 F.3d 940 (5<sup>th</sup> Cir. 1997), dismissed on rehearing, 154 F.3d 186 (5<sup>th</sup> Cir. 1998), cert. denied, 525 U.S. 1151 (1999).

<sup>19</sup> See Davis v. District of Columbia, 158 F.3d 1342, 1346 (D.C. Cir. 1998) (holding that plaintiff’s damages claims alleging that prison staff violated his constitutional right to privacy by their disclosure of his HIV status were barred by PLRA’s physical injury requirement, and refusing to accept on appeal allegation of weight loss, appetite loss, and insomnia; upholding constitutionality of physical injury requirement as to damages claims only); Luong v. Hatt, 979 F.Supp. 481, 485-86 (N.D. Tex. 1997) (dismissing plaintiff’s claim of failure to protect because medical records reflected de minimus injuries [cuts, scratches, abrasions, redness, and bruises] that did not require “treatment by a medical care professional” but rather were “treatable at home with over-the-counter drugs”).

<sup>20</sup> See Siglar v. Hightower, 112 F.3d 191, 193 (5<sup>th</sup> Cir. 1997) (dismissing claim based on plaintiff’s sore, bruised ear). See also Zehner v. Trigg, 133 F.3d 459, 461 (7<sup>th</sup> Cir. 1997) (dismissing prisoner’s damages claim for exposure to asbestos for lack of proof of “disease or other adverse effects”); Plasencia v. California, 29 F. Supp. 2d 1145 (C.D. Cal. 1998) (dismissing plaintiff’s claim of emotional distress and holding that “weight loss is insufficient to constitute a prior physical injury”); Thomas v. Vaughn, No. Civ. A. 97-6929, 1998 WL 647270 (E.D. Pa. Sept. 21, 1998) (holding plaintiff’s damages claim against one officer who failed to protect him from assault resulting in injury and mental and emotional harm not barred by PLRA); Valentino v. Jacobson, No. 97 Civ. 7615 (WK), 1999 WL 14685 (S.D.N.Y. Jan. 15, 1999) (dismissing pro se prisoner’s due process claim for mental and emotional harm due to extended confinement in segregation under PLRA physical injury requirement); Singleton v. Alameda County Sheriff’s Dep’t, No. C98-4037 VRW (PR), 1998 WL 754593 (N.D. Cal. Oct. 26, 1998) (dismissing plaintiff’s claim of “severe emotional trauma” due to dizziness caused by order to get out of bed and take medication); Flannery v. Wagner, No. 97-3154-JWL, 1998 WL 709762 (D. Kan Aug. 10, 1998) (dismissing damages and injunctive claims for emotional distress against prison officer who allegedly initiated rumor that plaintiff was a white supremacist subjecting him to possible, but not actual, physical injury). See Oliver v. Keller, 289 F.3d 623, 627-29 (9<sup>th</sup> Cir. 2002).

## **C. Avoiding the Prison Litigation Reform Act**

There are several litigation options that avoid the application of the PLRA. Options include bringing claims on behalf of parties not subject to the PLRA, asserting state tort claims, and asserting claims based on federal or state disability non-discrimination laws.

### **1. Plaintiffs Exempt from the PLRA**

On its face, the PLRA applies only to “any person incarcerated or detained in any facility....”<sup>21</sup> Courts have consistently held that the PLRA does not apply to individuals who were formerly imprisoned.<sup>22</sup> Therefore, prisoners who are exempt from the PLRA, including those who died while imprisoned, have successfully brought individual and class action lawsuits.

### **2. State Law Tort Claims**

Since the PLRA applies only to claims arising under federal law, its limitations may be avoided by bringing a state law claim. Many rights covered by federal civil rights laws are also protected by state tort laws. For example, instead of bringing an Eighth Amendment claim in a case involving negligent medical care, the action could be brought in a state court as a tort action for medical malpractice. Without asserting federal civil rights claims, however, such lawsuits will lack a basis for federal court subject matter jurisdiction and thus jeopardize the availability of certain remedies. Therefore, litigants should be careful to weigh the advantages and disadvantages of a state or federal venue depending on the specific state tort law in question.

### **3. Disability Discrimination Claims**

Prisoners’ rights litigants should also consider framing federal claims under statutes, such as Title II of the Americans with Disabilities Act (ADA) of 1990<sup>23</sup> and the Rehabilitation Act of 1973,<sup>24</sup> or analogous state statutes, if applicable. Explicitly, the PLRA only covers claims brought under the Civil Rights Act of 1871.<sup>25</sup> It has not generally been extended to statutory claims such as those under the ADA or the Rehabilitation Act. Two U.S. Courts of Appeals, however, have applied the PLRA’s physical injury requirement to ADA plaintiffs seeking damages for emotional harm.<sup>26</sup>

### **4. Reasonable Modifications**

In treating HIV disease, doctors usually recommend necessary lifestyle changes in order to stay healthy. Prisons have very strict protocols about when to get up in the morning, when and what to eat, access to exercise space and equipment, when medication is

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<sup>21</sup> 18 U.S.C.A. § 3626(g)(3) (West 2004).

<sup>22</sup> See *Grieg v. Goord*, 169 F.3d 165, 167 (2d Cir. 1999).

<sup>23</sup> 42 U.S.C.A. § 12101 *et seq.* (West 2004).

<sup>24</sup> 29 U.S.C.A. § 701 *et seq.* (West 2004).

<sup>25</sup> 42 U.S.C. § 1983.

<sup>26</sup> See *Davis v. District of Columbia*, 158 F.3d 1342, 1346 (D.C. Cir. 1998); *Zehner v. Trigg*, 133 F.3d 459 (7<sup>th</sup> Cir. 1997).

distributed, when to go to sleep, etc. A prisoner may have difficulties complying with the doctor's instructions due to the lack of control prisoners have over their lives. Reasonable modifications are allowed under Title II of the ADA for public services and programs as long as they do not fundamentally alter the program or create an undue burden.<sup>27</sup> For example, many prisons refuse to serve fruit to prisoners, as it can be fermented and turned into an alcoholic beverage. What happens if part of a medical treatment plan for a person with HIV includes eating fresh fruits and vegetables? It would be appropriate in this type of situation to request a "reasonable modification" of the rules so that a prisoner is allowed to follow the medically prescribed diet. A certain type of physical exercise is another common medical instruction that might require a request for reasonable modification. Other examples include getting the right amount of sleep and taking regular naps, or needing to eat at certain times of the day because a medication requires an empty stomach or that it be taken with food.

### **III. HIV Testing in Prisons**

Most prison systems maintain some type of HIV testing program or policy. Testing takes place under several circumstances, including voluntary or consensual HIV testing, routine HIV testing, and mandatory HIV testing of all inmates or those who belong to specific high risk groups, such as injection drug users, or those with HIV-related symptoms.

A guard who witnesses activity that is known to transmit HIV may require the inmates involved to submit to HIV tests. An inmate can request that an HIV test be performed on another inmate if there is an allegation of possible exposure, but the prison medical officer must first determine that there was a significant chance of infection before testing will be ordered.

#### **A. The Possible Choices**

##### **1. Voluntary Testing**

The majority of systems conduct voluntary HIV testing. "Voluntary" is divided into two types of testing: 1) systems in which staff take an active role in offering and recommending testing, and 2) systems providing a passive approach in which testing is available solely upon request. Most systems also recommend HIV testing if a prisoner has exhibited HIV-related symptoms, although such testing may also be imposed on a mandatory basis.<sup>28</sup>

Several organizations, including the American Public Health Association and the World Health Organization, have issued recommendations on HIV testing in prisons.<sup>29</sup> Both

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<sup>27</sup> See *Owens v. O'Dea*, No. 97-5517 (E.D. Kan. May 27, 1998) (stating that the regulations implementing Title II require "reasonable modifications" to public services and programs that discriminate on the basis of disability unless such modifications would fundamentally alter the nature of the service or program.) See also 28 C.F.R. § 35.130(b)(7) (2004).

<sup>28</sup> *Id.* (reporting that 38 states test if the inmate exhibits HIV-related symptoms).

<sup>29</sup> AMERICAN PUBLIC HEALTH ASS'N, *STANDARDS FOR HIV-AIDS CARE IN PRISONS & JAILS* (1996); *Id.*, *OPPOSITION TO MANDATORY HIV TESTING OF PREGNANT WOMEN* (1995) (explaining that the APHA has consistently advocated voluntary

organizations recommend voluntary testing in prisons, including pre- and post-test counseling administered by trained health care professionals. The National Commission on Correctional Health Care also supports voluntary testing as the best means of managing HIV in prisons.<sup>30</sup> Nevertheless, only four states test solely upon prisoner request.<sup>31</sup>

## **2. Routine Testing**

Three state correctional systems have moved to routine testing, an intermediate point between mandatory and voluntary testing, in which prisoners are informed that they will be tested unless they specifically refuse.<sup>32</sup> Texas, for example, currently employs routine testing. Testing remains voluntary in that prisoners have the right to refuse testing, and official policy prohibits disciplinary or punitive action against prisoners who refuse HIV testing. However, routine HIV testing programs still pose the risk that prisoners will not be informed of their option to refuse testing, or may be subjected to disciplinary measures if they refuse.

## **3. Mandatory Testing**

Eighteen prison systems mandate HIV antibody testing for all prisoners.<sup>33</sup> Of the states that conduct mandatory testing, the majority test prisoners upon admission. Four of these systems, including the Federal Bureau of Prisons (FBOP), also require that all prisoners be tested before release.<sup>34</sup> Twenty-four states require mandatory testing after prisoners have been involved in a high-risk incident, such as the exchange of blood or bodily fluids.<sup>35</sup>

Mandatory testing poses several problems. As in communities outside of prison, testing only high-risk prisoners, such as injection drug users and commercial sex workers, can result in the stigmatization of these groups and foster the illusion that other prisoners are not at risk of contracting HIV. Moreover, limiting testing to only those prisoners who exhibited clinical indications of HIV-related disease fails to identify asymptomatic HIV-positive prisoners. Mandatory testing also overrides a prisoner's right to make decisions

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HIV testing with informed consent, education, counseling, and referral for services); WORLD HEALTH ORG., *WHO GUIDELINES ON HIV INFECTION AND AIDS IN PRISONS* 2 (1993).

<sup>30</sup> NATIONAL COMM'N ON CORRECTIONAL HEALTH CARE, POSITION STATEMENT: *ADMINISTRATIVE MANAGEMENT OF HIV IN CORRECTIONS* (amended Sep. 24, 1994).

<sup>31</sup> HAMMETT, *supra*.

<sup>32</sup> Andy Epstein, *Massachusetts HIV-1 Program*, LANCET, May 9, 1998, at 1439.

<sup>33</sup> David L. Thomas, MD, JD, *HIV/AIDS Primary Care Guide*, Florida AIDS Education and Training Center 385 (University of Florida, 2002) (visited March 2004) <[http://www.faetc.org/PDF/Primary\\_Care\\_Guide/26-4\\_HIV-in-Corrections.pdf](http://www.faetc.org/PDF/Primary_Care_Guide/26-4_HIV-in-Corrections.pdf)> (New Hampshire, Rhode Island, Iowa, Michigan, Missouri, Nebraska, North Dakota, South Dakota, Alabama, Georgia, Mississippi, Oklahoma, Colorado, Idaho, Nevada, South Carolina, Utah, and Wyoming).

<sup>34</sup> THEODORE M. HAMMETT, ET AL., NATIONAL INSTITUTE OF JUSTICE, CDC, BUREAU OF JUSTICE STATISTICS, 1996-1997 UPDATE: HIV/AIDS, STDs, AND TB IN CORRECTIONAL FACILITIES 54 (1999) (Alabama, Missouri, and Nevada, and the Federal Bureau of Prisons test prisoners upon their release).

<sup>35</sup> *Id.* The Corrections Officers Health and Safety Act of 1998 authorized mandatory testing of federal prisoners, discussed in Supplement §2.17. Testing of criminal defendants for prosecution purposes is covered in §7.15, and testing in sexual and other assault cases for the purposes of complainant notification is covered in §7.16.

about medical procedures. In some states, such testing may violate state informed consent requirements for HIV testing.<sup>36</sup>

The FBOP conducts several levels of mandatory HIV testing. These programs include a yearly random sample, yearly new commitment sample, new commitment re-test sample, pre-release testing, and clinically indicated testing.<sup>37</sup> Prisoners are required to participate in all mandatory testing programs; those who refuse testing receive incident reports.<sup>38</sup> FBOP policy incorporates pre- and post-test counseling that covers a variety of subjects from false positives to the need for additional testing.

For pregnant prisoners, the majority of correctional systems impose routine HIV testing.<sup>39</sup> So far, only New York and Connecticut have enacted mandatory programs that impose HIV tests without consent when pregnant women decline the “offer” of testing.<sup>40</sup> Such testing is performed with the goal of providing pregnant prisoners with treatments during pregnancy and delivery that will significantly reduce the chances of prenatal HIV transmission.<sup>41</sup>

Despite problems associated with mandatory HIV testing, some state legislators and members of Congress have argued for mandatory testing throughout all prison systems. Calls for widespread testing are most often heard from state legislators and correctional officer unions. In the past, arguments for mandatory HIV testing have focused on the prevention of transmission. With recent advances in HIV/AIDS treatment, arguments for testing now focus on early intervention and treatment. The experience in South Carolina exemplifies this trend.

In 1998, the South Carolina Department of Corrections (SCDOC) became the eighteenth state to require mandatory HIV testing of prisoners. The SCDOC used a mix of old and new arguments to justify their change in policy, including the goals of controlling the spread of disease, providing health education to prisoners living with HIV/AIDS, and making medical care more cost effective.<sup>42</sup> The SCDOC also instituted a policy of segregated housing for prisoners living with HIV/AIDS. Many prisoners in the SCDOC have complained about a variety of problems under the new system, including lack of access to programs, lack of medical staff experienced with HIV/AIDS, and violations of confidentiality.

On the other hand, Rhode Island’s mandatory HIV testing program is considered a model program. A 1996 survey of former prisoners in Rhode Island found that 72 percent of

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<sup>36</sup> See *AIDS AND THE LAW MANUAL: CONSENT FOR TESTING* (§2.23 in Supplement for AIDS AND THE LAW, WEBER, DAVID L. THIRD ED.).

<sup>37</sup> See generally FEDERAL BUREAU OF PRISONS, U.S. DEP’T OF JUSTICE, *JUDICIAL RESOURCE GUIDE TO THE FEDERAL BUREAU OF PRISONS* 34-35 (2000).

<sup>38</sup> 28 C.F.R. § 549.18(a) (2004). See Chapter 24 of the *JAILHOUSE LAWYER’S MANUAL ON PRISON DISCIPLINARY HEARINGS* for further information on prison incident reports.

<sup>39</sup> THEODORE M. HAMMETT, ET AL., NATIONAL INSTITUTE OF JUSTICE, CENTERS FOR DISEASE CONTROL AND PREVENTION, 1994 UPDATE: *HIV/AIDS, STDs, AND TB IN CORRECTIONAL FACILITIES* 57 (1995).

<sup>40</sup> *HIV Testing of Pregnant Women and Newborns*, American Civil Liberties Union (January 1, 2001) (viewed March 2004) <<http://www.aclu.org/HIVAIDS/HIVAIDS.cfm?ID=9486&c=90>>.

<sup>41</sup> *Id.*

<sup>42</sup> *Memorandum of the South Carolina Department of Corrections, Department of Corrections Establishes Specialized Missions for Institutions* (Sept. 14, 1998).



HIV-positive and 88 percent of HIV-negative former prisoners approved of the state prison's mandatory testing program.<sup>43</sup> Researchers attribute the high approval to the quality of the HIV care program in the Rhode Island system. The program includes extensive post-test counseling and support, confidentiality protections, medical care by staff trained in HIV/AIDS, and comprehensive discharge planning. Prisoners surveyed who disagreed with mandatory testing mentioned several reasons for their dissension, such as the coercive nature of the testing, concerns regarding confidentiality, and doubts about receiving proper medical care.<sup>44</sup>

## **B. Federal System Policy**

The federal prison system currently requires HIV testing upon prisoner request once a year. In addition, the federal system tests prisoners after they have been involved in a high risk incident (i.e., an occurrence involving the exchange of blood or bodily fluids), and upon reentry into society.

## **C. California Policy**

At the time of this writing, California has no uniform HIV mandatory testing requirements for prisoners. However, a prisoner may be tested upon his/her request when an incident with the likelihood of transmission occurs within the correctional facility, or when an inmate shows clinical symptoms of the virus.<sup>45</sup>

A person *accused* (i.e., the subject of a police report but not arrested and charged with a crime) of certain sex crimes (including rape, statutory rape, spousal rape, forcible sodomy, oral copulation, or child sex abuse) may be forced to undergo HIV testing at the victim's request. Before testing occurs, a judge must determine that there is probable cause to believe that a possible transfer of bodily fluids took place between the accused and the victim during the crime.

A person who has been *convicted* of a sex crime can be ordered by the judge to submit to an HIV test.<sup>46</sup> In this situation, there is no requirement of a finding that there was a probability of transmission of bodily fluids, except in cases of child abuse. The test results are given to the State Department of Justice and the local health department. Moreover, the prosecutor must inform the victim that s/he has the right to obtain the results. The prosecutor must also offer the victim counseling. Furthermore, the victim has the right to give the convicted person's results to anyone s/he thinks should receive them in order to protect the victim's own health or safety or that of his or her family or sexual partners. California law also requires that individuals convicted of soliciting or engaging in prostitution be tested.<sup>47</sup>

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<sup>43</sup> B. Ramratnam et al., *Former Prisoners' View on Mandatory HIV Testing During Incarceration*, INTERNATIONAL CONFERENCE ON AIDS 1996, July 7-12; 11(2); 171, Abstract No. We. D.3665 (1996).

<sup>44</sup> *Id.*

<sup>45</sup> Cal. Penal Code §§ 7501, 7512.5 (West 2004).

<sup>46</sup> Cal. Penal Code § 1202.1 (West 2004).

<sup>47</sup> Cal. Penal Code § 1202.6 (West 2004).

## **D. Problems in Prison HIV Testing**

### **1. Inadequate Pre- and Post Test Counseling**

Prisoners and their advocates argue that inadequate pre- and post-test counseling continues to pose a significant problem nationwide. Both services are integral parts of the HIV testing process and should be conducted by health professionals in accordance with Centers for Disease Control guidelines.<sup>48</sup> The counseling process is essential in explaining accuracy and consequences of the test. Lack of counseling leaves both infected and non-infected prisoners without the necessary information to prevent infection or further transmission of the virus. Prisoners who test positive must receive the necessary education and counseling to cope with their diagnosis.

### **2. Lack of Confidentiality**

The majority of prison systems have policies that restrict knowledge of prisoners' HIV status to medical staff, but in practice, violations of confidentiality abound. Theoretically, only prison medical staff have access to information regarding a prisoner's HIV status. Many prison systems, however, including California's, believe that those in direct contact with prisoners have a "right to know" who has HIV/AIDS.<sup>49</sup> Fearing disclosure, prisoners may be hesitant to request an HIV test.

### **3. Availability and Quality of Medical Care**

The lack of availability and the quality of medical care also present barriers for prisoners who are considering testing. Facilities that do not have health care staff experienced in providing HIV/AIDS treatment report fewer requests for testing. Without adequate medical care, some prisoners are more reluctant to come forward for testing since they perceive little health benefit resulting from learning their HIV status.

### **4. Medical Segregation**

Discrimination in access to programs and policies of medical segregation or clustering also influence the testing process. Some prison systems employ "medical clustering," or housing of prisoners with HIV in a selected area apart from HIV negative prisoners.<sup>50</sup> This often results in limited access to programs (such as job placement and educational courses) for prisoners living with HIV/AIDS because they cannot access the areas of the institution in which the programs are offered.<sup>51</sup>

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<sup>48</sup> See generally, *AIDS AND THE LAW MANUAL: VOLUNTARY TESTING* (§ 2.18 in AIDS AND THE LAW).

<sup>49</sup> In 1988, California voters passed Proposition 96, an initiative authored by the Los Angeles County sheriff requiring prison and jail physicians to give lists of known or suspected HIV-infected prisoners to prison staff. Elizabeth Kantor, MD, *HIV Transmission and Prevention in Prisons*, HIV InSITE KNOWLEDGE BASE CHAPTER (University of California San Francisco, February 2003) (visited March 2004) <http://hivinsite.ucsf.edu/InSite>; Cal. Health & Safety Code § 121070 (West 2004).

<sup>50</sup> John G. Bartlett, M.D., et al., *HIV in Corrections*, CORRECTIONAL MEDICINE INSTITUTE (July 1, 2000) (visited March 2004) < <http://www.cm-institute.org/hivin.htm> >.

<sup>51</sup> *Id.*

## **5. Lack of Bilingual Staff**

Lack of prison staff who can communicate with non-English speaking prisoners also poses a significant barrier to prisoner HIV testing. Lack of language competency leads to the reluctance or inability of non-English speaking prisoners to access health care, including HIV testing services.

## **IV. Challenging Segregation and Other Forms of Discrimination**

The segregation of prisoners with HIV/AIDS has been a point of contention for prisoners on both sides of the issue. Relying on constitutional and statutory principles, prisoners have filed cases to challenge their segregation and exclusion from programs and services offered to those in the general prison population. In other cases, prisoners have attempted to force prison officials to segregate them from prisoners with HIV/AIDS.

Applying the deferential standard of *Turner v. Safley*, the majority of courts have been unwilling to second-guess prison officials' professional judgments regarding housing and classification decisions.<sup>52</sup> Prisoners who challenge conditions and practices face an uphill battle, but the chances of prevailing are enhanced by careful litigation strategy and factual development.

### **A. Constitutional Challenges to Segregation**

Prisoners may challenge their placement in segregation on constitutional grounds under the Due Process Clause, Equal Protection Clause, the right to privacy, and under the Eighth Amendment.<sup>53</sup> In all cases, it is critically important that plaintiffs move for detailed discovery and present relevant supporting factual evidence. Such evidence should be presented to refute prison officials' claims of security concerns. For example, plaintiffs might demonstrate that there was an insignificant number of incidents of violence aimed at prisoners with HIV and AIDS in the general population, and that the prisoners do not commonly engage in high-risk behavior (e.g., needle sharing and sexual conduct) so as to warrant their segregation. In addition, prisoners should present medical expert testimony regarding the ways in which HIV is transmitted, and ways to properly diagnose and treat infected prisoners that would not require segregation.

There are two basic legal standards governing prison litigation in this area. First, prisoners' constitutional civil liberties claims are governed by the standards set by the U.S. Supreme Court in *Turner v. Safley*, which states, "[W]hen a prison regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests."<sup>54</sup> The *Turner* standard applies generally to prisoner claims invoking constitutional privacy rights, rights under the First Amendment,

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<sup>52</sup> *Turner v. Safley*, 482 U.S. 78, 84 (1987).

<sup>53</sup> Prisoners may also challenge their segregation and discriminatory exclusion from programs and services under the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act.

<sup>54</sup> *Turner*, 482 U.S. at 89.

and the Equal Protection Clause. Second, the Court in *Farmer v. Brennan* refined the “deliberate indifference” standard, which holds prison officials liable under the Eighth Amendment for unconstitutional conditions of confinement based on whether the officials “know of and disregard an excessive risk to inmate health and safety.”<sup>55</sup>

### **1. Legitimate Penological Interest Standard**

Under the four-part *Turner v. Safley* test, courts review evidence to assess: (1) whether the segregation policy or practice is reasonably related to the governmental interest put forth to justify it; (2) whether there are “alternative means of exercising the right that remain open to prison inmates;” (3) the impact that “accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of prison resources generally;” and (4) whether there are ready alternatives that fully accommodate the prisoner’s rights “at de minimis cost.”<sup>56</sup> Courts have differed regarding which party bears the burdens of persuasion and production under this standard, but have generally agreed that it is a factual inquiry.<sup>57</sup>

Applying the *Turner* standard, courts have generally rejected prisoners’ constitutional claims against segregation policies, determining that they are reasonably related to prison officials’ goals to reduce the transmission of HIV infection and reduce the level of violence in prisons.<sup>58</sup> However, one court found that the plaintiff’s segregation in a unit for inmates with mental disabilities and suicidal tendencies was not reasonably related to any legitimate penological interest.<sup>59</sup> Accordingly, the court found the policy irrational and arbitrary under the *Turner* test.<sup>60</sup>

### **2. Eighth Amendment Deliberate Indifference Standard**

Prison conditions violate the Eighth Amendment when they involve “serious deprivations of basic human needs” or fall below the “minimal civilized measure of life necessities.”<sup>61</sup> Among the legally recognized basic human needs of prisoners are “food, clothing, shelter, medical care and reasonable safety,”<sup>62</sup> as well as “warmth and exercise.”<sup>63</sup>

Some cases challenging segregation of HIV-positive prisoners are based on allegations that conditions within the segregated setting constitute unconstitutional conditions of confinement under the Eighth Amendment’s prohibition against cruel and unusual

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<sup>55</sup> *Farmer v. Brennan*, 511 U.S. 825 (1994).

<sup>56</sup> *Turner*, 482 U.S. at 89-91.

<sup>57</sup> See, e.g., *Shimer v. Washington*, 100 F.3d 506, 509-10 (7<sup>th</sup> Cir. 1996); *Mann v. Reynolds*, 46 F.3d 1055, 1061 (10<sup>th</sup> Cir. 1995); *Allen v. Coughlin*, 64 F.3d 77, 80 (2d Cir. 1995); *Muhammad v. Pitcher*, 35 F.3d 1081, 1085 (6<sup>th</sup> Cir. 1994); *Walker v. Sumner*, 917 F.2d 382, 386-87 (9<sup>th</sup> Cir. 1990); *Salaam v. Lockhart*, 905 F.2d 1168, 1174 (8<sup>th</sup> Cir. 1990). But see *Amatel v. Reno*, 156 F.3d 192 (D.C. Cir. 1998), cert. denied, 527 U.S. 1035 (1999).

<sup>58</sup> See, e.g., *Harris v. Thigpen*, 941 F.2d 1495, 1521 (11<sup>th</sup> Cir. 1991); *Moore v. Mabus*, 976 F.2d 268 (5<sup>th</sup> Cir. 1992); *Callaway v. Smith County*, 991 F. Supp. 801 (E.D. Tex. 1998).

<sup>59</sup> *Nolley v. County of Erie*, 802 F.Supp. 898 (W.D.N.Y. 1992).

<sup>60</sup> *Id.* at 906.

<sup>61</sup> *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981).

<sup>62</sup> *Helling v. McKinney*, 509 U.S. 25, 32 (1993).

<sup>63</sup> *Wilson v. Seiter*, 501 U.S. 294, 304 (1991).

punishment.<sup>64</sup> In Eighth Amendment cases, the Supreme Court has applied the “deliberate indifference” standard, holding prison officials liable under the Eighth Amendment for unconstitutional conditions of confinement if officials “know of and disregard an excessive risk to inmate health and safety.”<sup>65</sup> Therefore, in bringing these cases, prisoner-plaintiffs must present factual evidence establishing that prison officials knew of and disregarded a substantial risk of harm faced by the plaintiff(s), i.e., evidence that shows the conditions at issue threatened their health and safety, and that prison officials knew about these risks but failed to take necessary steps to eliminate them.<sup>66</sup> Some conditions of confinement may constitute an Eighth Amendment violation in combination with other conditions, but only if the conditions have a mutually enforcing effect that deprives the plaintiff of a specific need such as food, warmth, or exercise.<sup>67</sup>

## **B. Disability-Based Exclusion from Programs and Services**

### **1. Discriminatory Exclusion from Programs and Services**

Prisoners and their advocates may want to consider various statutes that protect prisoners from discrimination based on their HIV status. The Americans with Disabilities Act (ADA) prohibits public entities from discriminating, excluding, or denying qualified individuals with a disability from benefits, services, programs, or activities.<sup>68</sup> Furthermore, the Federal Rehabilitation Act (FRA) prohibits discrimination, or the denial of program participation on the basis of disability, by federal, state, or local government agencies, or by any recipient of federal funding.<sup>69</sup> In 1986, the U.S. Supreme Court recognized HIV as a disability under the ADA.<sup>70</sup>

In two circumstances, correctional facilities may place limitations on prisoners’ protection against discriminatory exclusion from programs and services:

- (1) the HIV infection poses a significant risk to the health or safety of others; or
- (2) an accommodation would cause an undue burden on the prison facility.

The only difference between the FRA and the ADA is that the FRA is limited to public government entities, while the ADA regulates both private and public entities. Since most prisons are funded by public entities, they will be subject to the regulations of both statutes. There is no question that these statutes are applicable in the prison setting. The

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<sup>64</sup> See, e.g., Cordero v. Coughlin, 607 F.Supp.9 (S.D.N.Y. 1984) (dismissing Eighth Amendment claim due to plaintiff’s failure to present evidence to establish a deprivation of basic needs); Tokar v. Armontrout, 97 F.3d 1078, 1082 & n.4 (8<sup>th</sup> Cir. 1996) (affirming summary judgment for defendants, citing plaintiffs’ failure to produce evidence that broken windows, leaky roof, unsanitary and inefficient plumbing in segregation violated the Eighth Amendment).

<sup>65</sup> Farmer v. Brennan, 511 U.S. 825 (1994).

<sup>66</sup> See *Id.*, Helling v. McKinney, 509 U.S. 25 (1993); Wilson, 501 U.S. 294.

<sup>67</sup> Wilson, 501 U.S. at 304; Hutto v. Finney, 437 U.S. 678 (1978); Rhodes v. Chapman, 452 U.S. 337 (1981).

<sup>68</sup> 42 U.S.C.A. § 12132 (1995) (West 2004).

<sup>69</sup> 29 U.S.C.A. §§ 791-94 (1999) (West 2004).

<sup>70</sup> Bragdon v. Abbott, 118 S.Ct. 2196 (1986).

U.S. Supreme Court held that the plain language of the ADA “unmistakably includes state prisons and prisoners within its coverage.”<sup>71</sup>

### **a. Challenges under Disability Discrimination Statutes**

For purposes of the FRA or the ADA, prisoners have different rights than others who are “disabled” simply because they are incarcerated. A significant factor in disability discrimination claims relating to HIV in prisons is whether the challenged policy can be justified as preventing a significant risk of HIV transmission. The Ninth Circuit Court of Appeals upheld a prison exclusion policy that barred HIV-positive prisoners from working in food service in 1994.<sup>72</sup> The court rejected the prisoners’ argument that the ban violated the FRA, basing its ruling on prison officials’ testimony of their security concerns, the classic penological interest cited under *Turner*. The court determined that the prison’s penological interest in the significant risk to the prison community’s health and safety outweighed the prisoners’ rights under the FRA to be protected from discrimination, despite the lack of scientific evidence that HIV can be transmitted through food service.

A prisoner may also be prevented from invoking rights under the FRA or the ADA if the prison would suffer an undue burden to accommodate the disabled prisoner. A California court held that prison officials may have a justifiable penological interest in discriminating against HIV-infected prisoners by prohibiting their spouses’ participation in a family visiting program.<sup>73</sup> In this case, however, the defendants failed to show that such accommodations would be an undue financial or administrative burden.

### **b. Equal Protection Challenges to Discriminatory Exclusion**

To challenge discriminatory exclusion from programs and services on constitutional grounds under the Equal Protection Clause, HIV-positive prisoners must show that they are similarly situated to HIV-negative prisoners who are allowed to participate, and that they were excluded arbitrarily. Exclusionary policies are generally upheld based on the prison officials’ evidence that their policies have a rational basis.<sup>74</sup> Prisoner challenges to program exclusion on constitutional grounds may be stronger in systems, such as California’s, that do not have mandatory HIV testing. This is because the governmental interest in preserving institutional security and preventing transmission does not hold as much weight when officials are unable to identify more than a portion of individuals in a facility who are HIV infected. A potential response to this argument, of course, is the imposition of mandatory testing of all prisoners.

### **c. Challenges to Disciplinary Sanctions**

Under the Due Process Clause of the Fourteenth Amendment, prisoners may challenge the imposition of disciplinary sanctions. This is of particular importance to prisoners

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<sup>71</sup> *Pennsylvania Dep’t. of Corrections v. Yeskey*, 524 U.S. 206, 209 (1998).

<sup>72</sup> *Gates v. Rowland*, 39 F.3d 1439 (9<sup>th</sup> Cir. 1994).

<sup>73</sup> *Bullock v. Gomez*, 929 F. Supp 1299 (C.D. Cal 1996).

<sup>74</sup> *Anderson v. Romero*, 72 F.3d 518 (7<sup>th</sup> Cir. 1995).

with HIV who allege they have been disciplined unjustifiably or disproportionately because of their HIV status. Prisoners and their advocates may also choose to base their challenges on state law grounds, such as state prison regulations or statutes.

The U.S. Supreme Court severely limited challenges to disciplinary sanctions by holding that prison regulations do not give rise to protected due process liberty interests unless they place an “atypical and significant hardship” on a prisoner.<sup>75</sup> Prisoners must establish this through factual evidence and show that the state regulation or statute grants prisoners a protected liberty interest in remaining free from that confinement or restraint. To meet the “atypical and significant hardship” standard, prisoners must present evidence of the actual conditions of the challenged punishment as compared to ordinary prison conditions. HIV- positive prisoners, like the general prison population, may find due process challenges to disciplinary actions more difficult to prove in the future in light of a general trend toward normalizing increasingly punitive responses to prison misconduct.

## **V. Failing to Protect Prisoners from Harm**

### **A. Liability for Failure to Protect**

Prison officials have a duty to protect prisoners from violence at the hands of other prisoners.<sup>76</sup> While several recent court decisions involve prisoner-plaintiffs who were allegedly assaulted by HIV-positive prisoners, constitutional “failure to protect” claims may just as likely be brought by HIV-positive prisoners who allege they were injured by HIV-negative prisoners.

Prison officials are liable under the Eighth Amendment when they “know of and disregard an excessive risk to inmate health and safety.” Defendants’ failure to segregate (or classify properly for housing purposes) vulnerable prisoners, knowing they will be exposed to menacing prisoners, is legally actionable. Whether a prison official knew of the risk faced by a prisoner is a “question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence.”<sup>77</sup> The plaintiff must therefore allege sufficient facts in the complaint to establish that each named defendant knew of the risk of harm and disregarded it. The complaint also serves as notice to the defendants in the event that the plaintiff is subject to threats of harm.

### **B. Lawsuits Resulting from Contracting HIV While in Prison**

Many lawsuits have resulted from prisoners who have acquired HIV while incarcerated. Causes for lawsuits range from prison rape to assigned duties leading to the transmission of the virus.<sup>78</sup> In these types of cases, the court seems to apply the deliberate indifference standard as required by the PLRA. Unless the court can find that prison officials

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<sup>75</sup> Sandin v. Connor, 115 S.Ct. 2293 (1995).

<sup>76</sup> Farmer v. Brennan, 511 U.S. 825, 833-34 (1994).

<sup>77</sup> *Id.*

<sup>78</sup> See Randles v. Hester, No. 98-CV-1214 (M.D. Fla, filed Aug. 10, 2001) (holding that requiring the plaintiff to clean other inmates’ blood spills without using readily available protective clothing exposed the plaintiff to a condition of confinement that was likely to cause serious illness, i.e., the HIV virus). See also Spruce v. Sargent, 149 F.3d 783 (8th Cir. 1998).

deliberately and knowingly put an inmate in a situation where transmission of HIV was probable, the court usually rules in favor of the defendant.<sup>79</sup>

### C. Access to Bleach and Condoms

Numerous studies have found that condoms are essential in the prevention of HIV.<sup>80</sup> Properly cleaning needles with bleach will prevent transmission through intravenous drug use. The Centers for Disease Control and Prevention strongly supports the distribution of both condoms and bleach within the prison system, yet only four percent of jails - specifically the urban jail systems of New York, Washington D.C., San Francisco, and Philadelphia - make condoms available to inmates. Only ten percent allow condom distribution. Twenty percent make bleach available.<sup>81</sup> The remaining facilities consider syringes, needles, bleach, condoms, or any latex barrier to be contraband.

A commonly held estimate of the annual cost of incarceration is \$25,000 per prisoner. The Correctional HIV Consortium estimated in 2001 that the cost of caring for an HIV-positive inmate was \$80,396 per year and \$105,963 for those diagnosed with AIDS.<sup>82</sup> Preventing HIV in prisons, therefore, proves to be not only life-saving, but also cost-effective.

### D. Liability for Excessive Use of Force

HIV-positive prisoners can challenge excessive use of force and physical abuse that they suffer at the hands of corrections staff. Physical abuse of prisoners by staff who use force “maliciously and sadistically for the very purpose of causing harm” is unconstitutional if it causes physical harm.<sup>83</sup> Prisoners need not submit evidence of severe or permanent injury to maintain a claim of excessive force by staff.<sup>84</sup> Any unjustified use of force is sufficient to violate the objective component of the Eighth Amendment.

## VI. Privacy Rights Regarding HIV Status

Confidentiality of one’s HIV status is of primary concern to prisoners. Prison officials may use HIV antibody test results to determine a prisoner’s housing, work assignment, and visiting privileges. Likewise, prisoners face difficult challenges in keeping medical information private. If a prison segregates or “quarantines” HIV-positive prisoners in

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<sup>79</sup> James J. Park, *Redefining Eighth Amendment Punishments: A New Standard For Determining The Liability Of Prison Officials For Failing To Protect Inmates From Serious Harm*, 20 QLR 407, 409, 420 (Winter 2001). See also Christopher D. Man and John P. Cronan, *Forecasting Sexual Abuse In Prison: The Prison Subculture Of Masculinity As A Backdrop For Deliberate Indifference*, 92 JCRLC 127, 141-143 (Fall 2001/Winter 2002).

<sup>80</sup> See, e.g., *USAID: HIV/AIDS and Condoms*, USAID (April 2003) (visited March 2004) [http://www.usaid.gov/our\\_work/global\\_health/aids/TechAreas/condoms/condomfactsheet.html](http://www.usaid.gov/our_work/global_health/aids/TechAreas/condoms/condomfactsheet.html); *Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention*, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES 14 (July 20, 2000) (visited March 2004) <<http://www.niaid.nih.gov/dmid/stds/condomreport.pdf>>.

<sup>81</sup> NIJ/CDC Survey, 1997.

<sup>82</sup> *Incarcerated Populations and HIV/AIDS*, POLICY FACTS 3 (July 2001) (visited March 2004) <<http://www.aidsaction.org/communications/publications/index.html>>.

<sup>83</sup> *Witley v. Albers*, 475 U.S. 312 (1986).

<sup>84</sup> *Hudson v. Macmillian*, 503 U.S. 1 (1992).



separate facilities, confidentiality is obviously impossible. Furthermore, persons other than medical staff often handle medical records, making breaches of confidentiality even more likely.

Although the constitutional basis and parameters of the right to privacy have never been clearly defined, the U.S. Supreme Court in *Whalen v. Roe* suggested that such a right exists and identified two interests that underlie confidentiality concerns regarding medical diagnosis.<sup>85</sup> The two interests are: (1) avoiding disclosure of personal matters; and (2) the interest of independence to ensure certain kinds of important decisions can be made (i.e., prisoners can base their decisions as to whether to take HIV medications on medical reasons without fear of disclosure to the prison community).

A majority of courts have relied on these two principles and have recognized a qualified constitutional right to privacy. Moreover, courts have extended these principles to prisoner-plaintiffs and have upheld the privacy rights of prisoners. Prisoners have a right to privacy in their medical status and records, unless the prison officials have a legitimate penological interest in its disclosure, as established by *Turner v. Safley* (see prior discussion of *Turner* in *Section IV*).

#### **A. Preventing Disclosure in Litigation**

Prisoners with HIV/AIDS who litigate against corrections officials need to consider two negative consequences prior to filing their cases:

- (1) by filing suit, they are likely to reveal their condition to other prisoners and staff; and*
- (2) they may be subject to retaliation by staff named as defendants.*

To avoid these ramifications, plaintiffs may seek protective orders (see Chapter 16 on Confidentiality for more information regarding anonymous pleading and sample forms) to allow them to file either anonymously or under a pseudonym, to file papers under court seal, or to restrict disclosure of their medical status.

Courts will weigh the prisoner's privacy rights against the interests of the state, if any, in obtaining and disseminating the information.<sup>86</sup>

#### **B. Federal Prison Confidentiality Policy and Practices**

If your client is a federal prisoner, note that the Federal Bureau of Prisons has a policy designating medical information as confidential. All information regarding infectious diseases, including HIV/AIDS, is limited to the medical staff and institutional psychologist. However, there are exceptions to this rule. Information is available to the

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<sup>85</sup> *Whalen v. Roe*, 429 U.S. 589, 599 (1977).

<sup>86</sup> See *HIV Positive Status Justifies Proceeding Anonymously*, 14 No. 7 FEDLIT 167; *Roe v. City of Milwaukee*, 37 F. Supp 2d 1127 (E.D. Wis. 1999)

warden and case manager as needed for discharge planning. This information is also shared with the probation officer and the director of the community correctional center as part of post-release management. Additionally, in cases of exposure to blood or bodily fluids, staff may be authorized to obtain access to medical information.<sup>87</sup>

### **C. California Confidentiality Standards**

California, in a purported effort to preserve the health of prison personnel, limits a prisoner's right to privacy of their medical information. In 1988, California voters passed Proposition 96, an initiative requiring prison officials to notify all prison staff about HIV-infected prisoners, which is still in effect at the time of this writing. The initiative, codified as Health & Safety Code § 121070, mandates prison medical staff to notify the officer in charge of the facility about any information received regarding a prisoner exposed to or infected with the HIV virus. Furthermore, the officer is required to inform all employees, medical personnel, and volunteers who have direct contact with the inmate.<sup>88</sup> California policy additionally requires that probation and parole officers be notified when an inmate infected with HIV/AIDS is being released from prison.<sup>89</sup> Officers then have the authority to notify those who will "come into contact" with the prisoner once paroled.

## **VII. Access to Health Care**

### **A. Barriers to Care for Prisoners with HIV/AIDS**

With the development and use of combination therapy and protease inhibitors to treat HIV disease, AIDS-related deaths in many prison systems have declined. California in particular has experienced a significant decline; in 2000, there were twelve AIDS-related deaths, down from ninety-one deaths in 1995.<sup>90</sup> Despite the decrease in prisoner AIDS-related deaths, prisoners commonly face several barriers to health care. These problems include inadequacies in the distribution of medications, prescription of sub-optimal antiretroviral therapy, lack of choice of anti-HIV therapy, inadequate monitoring of antiretroviral treatment regimens, lack of access to HIV/AIDS specialists, and lack of monitoring for opportunistic infections.

The distribution of medications can involve significant problems for prisoners living with HIV/AIDS. In most prisons, medications are distributed by pill line or they are self-administered (also known as KOP, for "keep on person"). Attending pill line requires prisoners to stand in line multiple times during the day to receive medications from nurses. In the pill line, prisoners with HIV/AIDS must contend with a variety of factors including standing in line while feeling sick, missing meals or receiving them late,

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<sup>87</sup> CORRECTION OFFICERS HEALTH AND SAFETY ACT OF 1998

<sup>88</sup> Cal Health & Safety Code § 121070 (a), (c) (West 2004).

<sup>89</sup> Cal Penal Code § 7501(c) (West 2004) (pursuant to § 7555, this title of the California Penal is operative until January 1, 2005, and as of that date is repealed).

<sup>90</sup> LAURA M. MARUSCHAK, *HIV IN PRISONS*, BUREAU OF JUSTICE STATISTICS BULLETIN, October 2002.

missing visiting hours, and conflicts with programs. Many prisons have their pill lines and distribution outside, leaving prisoners with HIV/AIDS standing in the elements several times a day during inclement weather.

Prisoners are also subject to the erratic delivery of medications by medical and non-medical staff. Delays in receiving prescription refills are another commonly reported problem. These problems often lead prisoners to miss dosages of their medications, thereby placing them at risk for developing resistance to various drugs and to increased viral load. Many drug treatment regimens require very strict adherence to the prescribed dose schedule.

Finally, prisoners regularly report that they are not adequately monitored in at least three areas. First, after treatment regimens are begun, there is often inadequate monitoring regarding effectiveness. Second, prisoners face a lack of monitoring for opportunistic infections like cytomegalovirus retinitis (CMV retinitis). In many cases, prisoners' complaints of symptoms related to opportunistic infections are ignored. Third, prisoners face a lack of access to HIV/AIDS specialists. When prisoners do have access to HIV/AIDS specialists, often at university or public hospitals, conflicts arise among the doctors. Treatment regimens prescribed by the outside specialists are often ignored or changed by correctional medical staff.

## **B. Constitutional Challenges to Inadequate Health Care**

Prisoners have a constitutional right to adequate health care that “outsiders” do not have. The Eighth Amendment establishes the government’s obligation to provide medical care for those whom it is punishing by incarceration. The U.S. Supreme Court further defined this right under the Eighth Amendment as prohibiting “deliberate indifference to serious medical need.”<sup>91</sup>

### **1. The Deliberate Indifference Standard**

The Supreme Court in *Estelle v. Gamble* held that prison officials violate a prisoner’s Eighth Amendment rights if they are “deliberately indifferent” to his/her serious medical needs.<sup>92</sup> Specifically, inmates must show that there was reckless disregard for their health or safety.<sup>93</sup> This principle applies regardless of whether the medical care is provided by government employees or by private medical staff under contract with the government.<sup>94</sup>

The “deliberate indifference” standard was further refined in *Farmer v. Brennan*, which held that the test included both subjective and objective components. Prison officials must have a “culpable state of mind” and the deprivation must be “sufficiently serious.”<sup>95</sup>

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<sup>91</sup> *Estelle v. Gamble*, 429 U.S. 97 (1976).

<sup>92</sup> *Id.* at 103.

<sup>93</sup> *Farmer v. Brennan*, 511 U.S. 825.

<sup>94</sup> *West v. Atkins*, 487 U.S. 57-58 (1988).

<sup>95</sup> *Farmer*, 511 U.S. at 825 (1994).

For prisoners to prevail, they must prove that prison officials “knew that inmates face a substantial risk and disregarded that risk by failing to take reasonable measures to abate it.”<sup>96</sup> This narrowed standard can prove difficult for prisoners because it is a highly factual inquiry.

To prevail on a constitutional claim of inadequate medical care, prisoners must show that prison officials were *deliberately indifferent* to their serious medical needs, i.e., that officials knew of and disregarded a substantial risk of serious harm to the plaintiff’s health.<sup>97</sup> A medical need is considered “serious” if it “causes pain, discomfort, or threat to good health.”<sup>98</sup> Budget constraints do not excuse prison officials’ liability for inadequate medical care.<sup>99</sup>

Proof of deliberate indifference may be established by direct or circumstantial evidence. Proof that defendant-prison officials knew of, and disregarded, the substantial risks of harm to the prisoner’s health includes sick call requests for medical attention or records reflecting the date(s) when medical attention was requested, to whom the request(s) were submitted, the medical conditions complained of, the effects of any delay in obtaining access to treating medical staff, treatment provided by particular staff, the nature of follow-up care ordered and whether it was carried out, additional information to indicate the adequacy of treatment, and complaints and formal grievances filed regarding the inadequate care. Plaintiffs may also seek discovery of prison medical documents to establish whether medications were properly prescribed, or administered consistently with the drugs prescribed. Moreover, plaintiffs should seek discovery of their prison medical records, if those records are not provided upon request, to assess whether the overall treatment regimen was appropriate and carried out properly.

In *Farmer v. Brennan*, the Court held that a “factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.”<sup>100</sup> Plaintiffs may thus establish prison officials’ and medical staffs’ knowledge of the risks they faced due to inadequate medical care by presenting circumstantial evidence that their health had deteriorated, as evidenced by such obvious conditions as sharp weight loss,

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<sup>96</sup> *Id.*

<sup>97</sup> *Id.*

<sup>98</sup> *Dean v. Coughlin*, 623 F.Supp. 392, 404 (S.D.N.Y. 1985); *see also Hemmings v. Gorczyk*, 134 F.3d 104, 108 (2d Cir. 1998) (finding that two-month delay in treating ruptured tendon misdiagnosed as sprain was “sufficiently painful to satisfy the objective prong of the deliberate indifference standard.”). Constitutional medical needs may also include special diets that are medically prescribed. *See, e.g., Johnson v. Harris*, 479 F.Supp. 333 (S.D.N.Y. 1999) (the failure to provide a proper diabetic diet constitutes a deliberate indifference to serious medical needs in violation of the Eighth Amendment).

<sup>99</sup> *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 392-93 (1992) (“financial constraints cannot be used to justify the creation or perpetration of constitutional violations.”); *Boswell v. Sherburne County*, 849 F.2d 1117, 1122 (8<sup>th</sup> Cir. 1988) (denying summary judgment and remanding for resolution of factual dispute regarding the delay in providing critical medical care to a pregnant detainee restricting medical care and the county’s restrictions on prisoner medical care to save money); *Monmouth County Correctional Inst. Inmates v. Lanzaro*, 834 F.2d 326, 336-37 (3d Cir. 1987) (requiring prison officials to arrange abortions for female prisoners who request them, requiring the county to fund them, and rejecting defendants’ argument that they lack sufficient funds); *Jones v. Johnson*, 781 F.2d 769, 771 (9<sup>th</sup> Cir. 1986) (holding prison officials liable for refusing prisoner’s hernia surgery for budgetary reasons); *Harris v. Thigpen*, 941 F.2d 1495, 1509 (11<sup>th</sup> Cir. 1991) (stating that lack of funds “will not excuse the failure of correctional systems to maintain a certain minimum level of medical service necessary to avoid the imposition of cruel and unusual punishment”).

<sup>100</sup> *Farmer v. Brennan*, 511 U.S. 825, 842 (1994).

visible blemishes, or extreme weakness affecting ambulatory ability. The Court in *Farmer* stated that a prison official “would not escape liability if the evidence showed that he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist.”<sup>101</sup>

Not surprisingly, the majority of cases challenging the quality of treatment received by prisoners with HIV/AIDS focus on medications provided. In these cases, the court assesses the effect(s) on prisoner-plaintiffs of delays in obtaining medication and whether there is a consensus within the scientific community on accepted treatment regimens. Courts have been willing to grant injunctions to force correctional facilities to follow the federal guidelines for HIV care published by the National Institute of Health (NIH), which recommends a therapy consisting of at least two of the three types of HIV medications.<sup>102</sup>

Though inmates have a constitutional right to some form of AIDS medical treatment, it remains unclear whether inmates have a right to all of the medication commonly used to fight HIV/AIDS. In *Perkins v. Kansas Department of Corrections*, the Court of Appeals for the Tenth Circuit upheld the dismissal of an Eighth Amendment medical claim of a prisoner who sought access to a protease inhibitor.<sup>103</sup> The court characterized the case as a disagreement over the course of treatment between the prisoner and the medical staff, and thus found no sufficient claim of deliberate indifference to a serious medical need in violation of the Eighth Amendment.

### C. Mental Health Care

Mental health care of prisoners is governed by the same constitutional standard as medical care: deliberate indifference. Prisoners with HIV/AIDS who experience serious mental health problems must put mental health care workers and prison officials on notice of their need for care. Then they must exhaust their administrative remedy process prior to challenging the adequacy of care in court.

### D. Death Clusters

In 1995, prison administrators and medical staff of the Central California Women’s Facility (CCWF) in Chowchilla and the California Institute for Women in Frontera were accused of cruel and unusual punishment and ‘deliberate indifference’ to the health needs of inmates.<sup>104</sup> Among the cases at the center of *Shumate v. Wilson*, were instances of untreated or poorly treated pulmonary and cardiac problems, hypertension, sickle-cell anemia and cancer. Attorneys also attributed at least two prison deaths to the poor quality of health care, including the case of a mentally ill woman with gastrointestinal problems. Confined naked to a prison cell, the woman ingested her own body waste and eventually

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<sup>101</sup> *Id.* at 843 n.8.

<sup>102</sup> *Gates v. Fordice*, No. 4:71CV6-JAD, 1999 U.S. Dist. Lexis 13443 (N.D. Miss. July 1999). The three classes of HIV are nucleoside reverse transcriptase inhibitors (NRTI), non-nucleoside reverse transcriptase (NNRTI) and protease inhibitors.

<sup>103</sup> *Perkins v. Kansas Dept. of Corrections*, 165 F.3d 803 (10th Cir. 1999).

<sup>104</sup> *Shumate v. Wilson*, No. CIV S-95-0619 (E.D. Cal. 2000).

died of untreated pancreatitis and starvation. The suit settled in 1997, and the state of California agreed to improve its overall prison health care system.

Nevertheless, in the winter of 2001, the deaths of eight female prisoners within seven weeks at the CCWF demonstrated the extreme inadequacy within California prison systems. Outraged prison advocates and others across the country demanded investigations and reform. The state answered and investigated the situation, which revealed that although four of the women who died were terminally ill, at least two of the women died from inadequate attention after suffering from serious illnesses. Problems with Medical Technical Assistants, guards who act as medical personnel, and poor chronic illness treatment illustrated the problems in the institution. This investigation, along with a public legislative hearing, offered hope for improvements, yet the multitude of lawsuits that continue to be filed demonstrate that the standard of care remains unsatisfactory in California state prisons.

### **VIII. Early Release Programs**

For years, prisoners and advocates have argued that prisoners with end-stage AIDS should be granted early release in order to die with family and friends in the community. In their lobbying efforts, advocates have emphasized everything from humanitarian aspects to the cost savings to tax payers.<sup>105</sup> During the 1990's, several states passed compassionate release or medical parole laws, including the Federal Bureau of Prison (FBOP) and California's prison system.

Despite the implementation of compassionate release and medical parole programs, the strict eligibility criteria and slow application process make release difficult, if not impossible. As a result, only a fraction of dying prisoners are released.

The application process for these release programs involves multiple stages of review, including a medical suitability determination and an evaluation for potential threat to the community. The FBOP requires review and recommendation by directors in six different departments before finally presenting a motion to the sentencing court to reduce the prisoner's term to time served. California, on the other hand, requires review and recommendation by the prison's chief medical officer, warden, and the sentencing judge. Additionally, recommendation is required by the Director of the Department of Corrections (for determinably sentenced prisoners), or the Board of Prison Terms (for indeterminably sentenced prisoners or prisoners serving time for a parole violation).

A crucial element in a compassionate release request is the release plan. Prisoners or their advocates must present to the various review committees a detailed, documented

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<sup>105</sup> See William B. Aldenberg, *Bursting at the Seams: An Analysis of Compassionate-Release Statutes and the Current Problem of HIV and AIDS in U.S. Prisons and Jails*, 24 NEW ENG. J. ON CRIM. & CIV. CON 541, 549-52 (1998). MARUSCHAK, *supra* (October 2002).

<sup>105</sup> *Estelle v. Gamble*, 429 U.S. 97 (1976).

account of what will happen upon release. This plan includes information about where the person will be living, who will be the care-giver, how the person will be financially supported, where s/he will get medical treatment, and what precautions will be taken so that s/he does not re-offend. If the person was incarcerated because of drugs, it may improve the chances of release if the prisoner will be going into a “clean and sober” residential facility. If the prisoner will be supported by Social Security Disability, it is helpful to set it up in advance to the extent possible, and include it in the plan. Letters from the care-giver and the residential program make a stronger application.

Sometimes being released to a new community may look more appealing to the release committees than returning “home,” especially if “criminal known acquaintances” are still in the area. The release committee wants assurances that the prisoner will not fall back into a life of crime. Their concern about this underlines their apparent lack of understanding as to the gravity of the prisoner’s health. Many potential releasees are so sick they cannot even get out of bed, let alone run around selling drugs.

Overall, confirming proposed release plans, as well as obtaining approval of numerous officials, renders the application and selection process so lengthy that a significant number of the applicants die in prison while their early release is pending. In theory, the process could take a minimum of one month. However, in reality, the process generally takes between two and three months in the absence of appeals. Another obstacle in securing release is the prisoner’s physical and/or cognitive ability to advocate on her or his own behalf. Diligence, concentration, and tenacity are essential to push through a successful appeal. This comes at a time when the prisoner is close to death and far too weak and ill to muster the energy for such a fight. Furthermore, many of the HIV medications prisoners take have side-effects that further compromise their cognitive ability. Finally, many prisoners with end-stage AIDS may suffer from AIDS-related dementia, rendering them virtually unable to perform the necessary tasks to obtain release.

The compassionate release program has an inherent Catch 22: in order to qualify under the eligibility criteria, prisoners must be close to death; so close, in fact, that they are usually too ill to submit and follow through with an application. Without an attorney or a prisoners’ rights organization advocating on their behalf, dying at home surrounded by family will remain an elusive wish of terminally ill prisoners with AIDS.