BE IT RESOLVED, That the American Bar Association, recognizing the special problems which the criminal justice system faces in dealing with issues related to the Human Immunodeficiency Virus (HIV) epidemic, recommends the following:

A. RECOMMENDATION CONCERNING CRIMINAL SANCTIONS

Because existing civil and criminal remedies are available to prosecute the instances in which specific criminal sanctions might apply, HIV-specific criminal sanctions should play a limited role in combatting the HIV epidemic. Accordingly, a program of aggressive public education about the Human Immunodeficiency Virus (HIV) should be implemented as the most effective method of deterring behavior which poses a high risk of transmitting HIV.

B. RECOMMENDATIONS CONCERNING CRIMINAL PROCEDURE AND COURTROOM PROCEDURE

1. Criminal justice personnel must be educated about the medical and legal issues arising from the HIV epidemic.

2. Public agencies should make available victim counselling and testing programs which assist crime victims who have reason to believe they have been exposed to the virus. These programs should be
offered at no cost to victims. Where appropriate, offenders should bear or share the cost for these programs.

3. An attorney should not refuse to represent, or limit or modify representation, because of a person's known or perceived HIV status. A person should not be denied access to counsel because of his or her known or perceived HIV status. Where the person has a right to counsel, the court shall insure that the person's access to counsel is scrupulously honored.

4. A criminal prosecution involving a defendant known or perceived to be infected with HIV should proceed in the same fashion as any other case. No unusual safety or security precautions should be employed, unless the defendant is violent or poses a demonstrated risk of escape.

   (a) Unless a defendant's physical condition prevents him or her from attending court, a defendant's HIV status should not be the basis for denying or limiting his or her access to the courtroom, or a reason for avoiding court appearances.

   (b) Where, in a jury trial, the defendant's HIV status may become an issue in the case, the court should permit or conduct a full voir dire on the issue. If the defendant's status has been publicized or is apparent, at the request of the defendant, the court should permit or conduct a full voir dire on the issue.

5. Where the court has determined that a defendant's HIV status is relevant in a criminal case, the court must be provided with the most current, accurate and objective medical information about a defendant's condition. Unless the defendant's HIV status is at issue in the prosecution, only those with a demonstrable need or right to know should receive medical information about a defendant's HIV status. Criminal justice personnel who receive such information must safeguard its confidentiality.

C. RECOMMENDATIONS CONCERNING CORRECTIONAL FACILITIES

1. Appropriately funded training and educational programs regarding HIV should be instituted in all correctional facilities.
2. Inmates in correctional facilities should be afforded appropriate medical care for the full range of HIV infections and should be afforded appropriate counseling services.

3. A prisoner should not be segregated from the general population of the correctional facility or be placed in other special areas solely because of the prisoner's known or perceived HIV status. Consequently, mass HIV-antibody testing should not be done for the purpose of segregating inmates in special areas or cells.

4. Unless an inmate consents, information about his or her HIV status should not be disclosed except to the warden, key supervisory staff who have a legitimate need for the information, or medical staff for purposes of care and treatment. Correctional authorities should draft, promulgate, and enforce specific rules governing who may have access to such information and who is responsible for the release of the information.

5. A prisoner should not be denied parole or temporary release, or barred from participating in other community release programs, solely because of the prisoner's known or perceived HIV status.

(a) Where discretionary, temporary release is permitted by law, authorities may require pre-release disclose of HIV positive test results to spouses and similarly situated persons as a condition of release.

(b) Although parole or discharge should not be conditioned upon disclosure of HIV test results, prisoners scheduled for discharge should be encouraged to disclose their HIV status to their spouses or any similarly situated persons. Where a prisoner fails to do so, correctional authorities may notify appropriate public health authorities.
A. CRIMINAL SANCTIONS

Introduction

The primary public service the legal system can serve in combating the spread of the Human Immunodeficiency Virus (HIV) is to deter inherently dangerous practices which may spread the virus by penalizing those acts. However, state officials seeking to control the HIV epidemic should recognize that the criminal justice system is not the best, or only, means of controlling risky conduct on the part of people who carry HIV. Mass education campaigns about HIV, coupled with explicit counselling on safe alternatives to risky conduct, must precede any program of criminal prosecution or quarantine. Where offered, such education has proven highly effective in deterring dangerous practices.\(^1\)

Use of the legal system to deter the spread of HIV poses great potential for abuse by a public which is inflamed with hysteria over the epidemic and often callously indifferent or overtly hostile to persons infected with HIV. Accordingly, the legal system should not permit itself to be used as a tool to further prosecute, stigmatize or harass members of unpopular groups perceived by the public as the primary carriers of HIV, but must respect and enforce the constitutional barriers which protect individuals against unwarranted invasions of their privacy and liberty.

Several years ago, the American Bar Association endorsed the Uniform Health-Care Information Act. 9 Uniform Laws Ann. § 1-101 et seq. (Supp. 1987). The purpose of this act, which was drafted by the National Conference of Commissioners on Uniform State Laws, is to ensure the uniform and consistent protection of the confidentiality of sensitive medical information. Because of the importance of maintaining the confidentiality of sensitive medical information, including information on HIV status, any disclosure of such information should comport with the provisions of the Uniform Act. Consequently, we are recommending the American Bar Association should weigh what additional steps might be taken to ensure passage by the states and federal government of model confidentiality statutes that conform with the provisions of the Uniform Health-Care Information Act. The ABA might, for example, consider a cooperative endeavor with the American Medical Association, one of whose reports on AIDS recently urged the adoption of Model confidentiality laws to promote the uniform protection of confidential medical information. Board of Trustees of the American Medical Association, "Prevention and Control of AIDS-- An Interim Report," 15 (1987).
Role of Criminal Sanctions

Because existing civil and criminal remedies are available to prosecute the instances in which specific criminal sanctions might apply, it is felt that HIV-specific criminal sanctions will play a limited role in combatting the HIV epidemic because:

a) such measures do little to deter high risk behavior;
b) such measures pose a grave risk of invasion of personal privacy;
c) such measures may present practical problems in proof;
d) such laws may stigmatize groups perceived as principally at risk of carrying HIV, such as homosexuals and intravenous drug users, despite the fact that the HIV epidemic poses a danger to the general population.

HIV-specific criminal sanctions have been proposed for two reasons -- deterrence and punishment. Although proponents of such statutes believe that criminal penalties are effective to deter acts which pose a risk of transmission of the AIDS virus, the deterrent effect of such sanctions tends to be overstated. Because AIDS is spread through intimate sexual contact involving the exchange of body fluids or through blood to blood contact, criminal statutes proscribe acts which in and of themselves are harmless -- such as sex or blood donation -- but are deemed to present a risk of harm to others when engaged in by an HIV carrier. Thus, most instances of HIV transmission result from conduct which is consensual in nature. Explicit public education aimed at changing behavior will have a greater deterrent impact on such activity.

Where statutes are enacted which criminalize behaviors which pose a risk of transmitting HIV, however, such statutes should promote the duty of infected persons to disclose their antibody status to their partners and to use practices and precautions deemed safe by public health authorities. Accordingly, such statutes should recognize certain affirmative defenses, including but not limited to the securing of informed consent, use of reasonable preventive measures, and good-faith reliance on apparently valid medical advice that the actor is not infected or that a particular practice poses no demonstrable risk of transmission. No matter what type of HIV-specific criminal sanction is enacted, moreover, the state of mind requirement should be limited to purposeful, knowing or reckless conduct. Given the current state of medical knowledge
concerning HIV and the difficulties in testing for its presence, it is inappropriate to impose criminal liability on the basis of theories of negligence or strict liability.

Sanctions Outside the Criminal Law

Many states have public health laws which permit authorities to impose restrictions on persons with contagious diseases. These laws, which were enacted to permit quarantines during epidemics which occurred in the early part of this century, generally have not been utilized in recent years. Instead, due to advances in medical science, inoculations and antibiotics have replaced "pesthouses" as the primary weapons against highly contagious diseases.

Because there is no evidence that HIV can be casually transmitted, the utilization of quarantine laws to isolate persons with HIV infections necessarily raises fundamental constitutional issues. Moreover, given the large number of persons infected with HIV, the obvious expense of status-based quarantines severely limits the practicability of that approach.

Despite these considerations, quarantine laws remain on the books and are at least theoretically available to public health officials as a potential weapon against the HIV epidemic. To date, however, quarantine has been imposed in only a few rare instances in which HIV carriers have been characterized as unable or unwilling to forego activities which pose a substantial risk of viral transmission. Nonetheless, even these narrow, behavior-based quarantines may be constitutionally questionable in those states in which the law grants public health officials an unfettered discretion to identify, detain, and isolate quarantine targets.

A few states have amended their quarantine laws to afford constitutional protections prior to the imposition of any quarantine. Even in those jurisdictions, however, behavior-based quarantines would raise numerous issues. First, it is difficult to predict whether a quarantine target will act in a manner that endangers others. Moreover, in the event that such a prediction is incorrect, quarantined individuals will have been subjected to confinement which, given the nature of HIV infection, may last a lifetime. Furthermore, a danger would exist that unpopular groups, such as street prostitutes, would be singled out for quarantine (as in previous epidemics), while the possibly more dangerous conduct of others would be ignored.

Despite these problems, if the goal is to incapacitate
HIV carriers who refuse to desist from risky behavior, the use of behavior-based quarantines has at least one theoretical advantage over reliance on criminal sanctions. Because such quarantines would be permissible only so long as the subjects were unwilling to change their behavior, health officials could be required to provide individualized counselling and education, and to release individuals if and when such efforts were successful.

Alternatives to criminal sanctions also can be found in tort law, which might further the goal of deterrence by imposing liability, under negligence or battery theories, upon HIV carriers who fail either to disclose their status to sex partners, or to take appropriate precautions to safeguard partners against transmission of the virus.\(^5\)

Utilization of tort law has certain advantages over criminal sanctions. People who engage in high risk behavior could be held responsible for their own contributory or comparative negligence. Additionally, tort damages might provide financial relief to plaintiffs who face abbreviated life spans, reduced earnings, and staggering medical bills.

The tort law alternative, however, is not without its own difficulties. First, the availability of a cause of action may be meaningless, as a practical matter, because the potential defendant may be impoverished or dead, and his or her estate may be depleted by medical bills. Second, many actions may be barred by statutes of limitations because of the lengthy period that HIV may lie dormant before it produces detectable antibodies, and because of the additional latency period between infection and the onset of symptoms. Third, the latency aspects of HIV infection also complicate proof of causation and damages. Finally, like criminal sanctions, the tort law alternative poses privacy issues, particularly in cases alleging sexual transmission. To establish that HIV was acquired from a particular defendant, it will be necessary for a plaintiff to prove that he or she was not infected prior to contact with the defendant, and that he or she did not contract HIV in any subsequent encounter. Similarly, a defendant who carries the virus might try to prove that he or she was exposed to it only after contact with the plaintiff. Thus, such litigation may well involve the privacy of numerous third parties.

The Application of Traditional Criminal Laws

Although a number of commentators have concluded that traditional criminal sanctions have limited value in containing the spread of the HIV virus,\(^6\) these laws theoretically could be used to punish certain behavior risking HIV infection. Under the Model Penal Code, for example, such conduct might be subject to punishment as
homicide (murder, manslaughter or negligent homicide), attempted murder, assault, or reckless endangerment.

These offenses require proof that the defendant committed an act with a specific state of mind, and, with the exception of attempted murder and reckless endangerment, that the act caused a specific result. Proof of the conduct element for these offenses poses no special problems, but the remaining two elements -- state of mind and causation -- do pose substantial proof problems.

Under Model Penal Code § 210.2, the requisite state of mind for proving murder is purposeful, knowing or reckless. To act purposefully in the context of transmitting the HIV virus, the actor must believe that he or she carries the HIV virus, can transmit it, and desire to cause, by his or her behavior, another person to die. To act knowingly, the actor must know that he or she carries the virus and it is "practically certain that his [or her] conduct will cause" the death of another. To act recklessly, the actor must "consciously disregard[] a substantial and unjustifiable risk" that he or she carries HIV and can transmit it, and that his or her conduct will do so. That risk must be a "gross deviation from the standard of conduct that a law-abiding person would observe in the actor's situation." Moreover, the actor must act with "extreme indifference to the value of human life." In the context of HIV transmissions, instances in which an individual acts with one of these states of mind probably will be rare.

The states of mind required to prove manslaughter and negligent manslaughter are significantly less stringent, however, and probably could be established in some instances. To commit manslaughter, the actor must act "recklessly," but he or she need not act with "extreme indifference to the value of human life." Thus, to act recklessly, the actor must be aware of a substantial risk that he or she does or might carry the HIV virus, and that his or her conduct might transmit it. On the other hand, to commit negligent manslaughter, the actor must have a negligent state of mind, defined as disregarding a "substantial and unjustifiable risk," where that lack of regard "involves a gross deviation from the standard of care that a reasonable person would observe in the actor's situation."

Thus, for these two offenses, a fact finder might well conclude that an actor was reckless or negligent if he or she had failed either: (1) to submit to tests to determine his or her HIV status; (2) to use precautions when engaged in risky conduct; or (3) to abstain totally from risky conduct. It should be noted, however, that application of this standard in the present context might create a
potential for overreaction by jurors unguided by adequate legislative standards.

Even where the required state of mind does exist, proof of caution still may be an obstacle in an HIV-related prosecution for murder, manslaughter, or negligent manslaughter. As a general matter, identifying the person from whom the deceased contracted HIV will be difficult. Moreover, this problem is exacerbated by the delay between exposure to HIV and the production of detectable antibodies, and the further delay or uncertain relationship between exposure and death.

Prosecutions for the crimes of attempted murder, assault, and reckless endangerment obviously do not present the same caution problems because proof of death is not required. Indeed, proof of a result is not necessary for either attempted murder or reckless endangerment. However, attempted murder (like murder) requires proof of the state of mind most difficult to establish -- purposeful or knowing conduct -- and thus will not be a viable charge in most situations. 15

Proof of assault requires that the actor attempt to cause bodily injury or another or cause that bodily injury purposely, knowingly, or recklessly. 16 The charge becomes aggravated assault if the attempt is to cause serious physical injury, or if the victim suffers that injury when the actor behaves purposely, knowingly, or recklessly and with extreme indifference to the value of human life. 17

When serious bodily harm results from an assault, the Model Penal Code does not follow the common law rule that consent is a defense to an otherwise illegal touching. 18 In the context of an HIV-related prosecution, however, informed consent arguably might be allowed as a defense, except, perhaps, when minors are involved. Thus, the HIV carrier who participates in a sexual act is probably guilty of assault only when he or she fails to first advise a sex partner deemed competent under state law of his or her HIV status.

Finally, prosecutions for the offense of reckless endangerment may not encounter the same limitations imposed on other crimes. Reckless endangerment occurs when a person "recklessly engages in conduct which places or may place another person in danger of death or serious bodily injury." 19 Thus, the prosecutor is not required to prove that the defendant's conduct actually harmed the victim, and consent is not a defense. Guilt turns upon the fact finder's evaluation of how a person should act. For this reason, reckless endangerment -- like manslaughter -- may be susceptible to jury overreaction concerning risk-creating
behavior, particularly if the victim has not actually suffered any harm. These problems are moderated to some extent, however, by the fact that reckless endangerment is treated as a misdemeanor under the Model Penal Code.

Sexually Transmitted Disease Statutes

Twenty-four states have statutes which criminalize the exposure of others to sexually transmitted diseases. It appears, however, that these statutes are rarely enforced.

In most states, the offense is treated as a misdemeanor, although it is classified as an infraction in North Dakota and as a felony in Oklahoma. While most states punish the act of exposing another person to the disease (and thus would apparently entertain defenses such as the taking of reasonable precautions), some impose broad bans which prohibit infected persons from marrying or engaging in sexual intercourse. Several states impose strict liability; the actor need not know that he or she is infected.

Application of these statutes raises several problems in the HIV context. States which treat the offense as a misdemeanor may find the punishment too lax. On the other hand, laws which impose an absolute ban on marriage or sexual intercourse without regard to the taking of precautions may be unreasonable for persons who carry the HIV virus, because, given the nature of HIV infection, the ban could last a lifetime. Similarly, measures which impose strict liability may be subject to criticism on fairness grounds, particularly in view of the sometimes unreliable nature of existing HIV tests, and the fact that asymptomatic carriers of the virus often have no reason to suspect that they are infected.

HIV-Specific Statutes

Although education aimed at changing behavior is critical to halting the spread of HIV, some commentators suggest that criminal sanctions also could deter and appropriately punish HIV infected people from engaging in behavior that risks transmission. The Presidential Commission, recognizing the difficulties in applying traditional criminal law, has recommended that the states adopt criminal statutes "directed to those HIV-infected individuals who know of their status and engage in behaviors which they know are, according to scientific research, likely to result in transmission of HIV," and that such statutes should "clearly set[] forth those specific behaviors subject to criminal sanctions."

Several major arguments have been raised against the
enactment of HIV-specific criminal sanctions. First, as demonstrated by historical experience with sodomy statutes, criminal statutes outlawing private consensual sexual activity are not particularly effective from the standpoint of deterrence. Similarly, HIV-specific statutes may be of little practical use in halting the spread of the virus, and could divert the attention of legislatures and other officials from implementing more effective measures, such as individual counselling and mass public education. In addition, HIV-specific statutes may actually prove counterproductive, if they deter high-risk people from voluntarily coming forward for testing and counselling.

Second, such statutes would have detrimental and invasive impact on privacy rights, which would extend not only to HIV carriers, but also to their sexual partners.

Third, as we have noted, prosecutions under traditional criminal laws pose extraordinary proof problems. These obstacles will not disappear if HIV-specific statutes are enacted.

Fourth, in view of the possibility that morals laws may be selectively enforced to harass persons based on their sexual orientation, commentators have expressed concern that such statutes might be selectively applied against gay men and other unpopular groups. Moreover, selective application of such laws could mislead the public into ignoring the danger which the epidemic poses to all individuals who engage in high risk behavior.

State Statutes

In 1987 alone, 29 bills containing criminal sanctions specifically addressed to transmission of HIV. To date, five states have enacted statutes which criminalized certain behavior when engaged in by persons who have tested positive for HIV or who actually have AIDS or AIDS-related Complex (ARC).

Thus far, three types of criminal measures have been enacted by state legislatures: (1) statutes mandating disclosure of HIV status; (2) statutes proscribing particular activities; and (3) statutes enhancing penalties for acts that are already illegal -- such as prostitution -- when committed by an HIV carrier.

The first type of statute, which imposes an affirmative duty upon HIV carriers to disclose their HIV status, has been enacted in Louisiana and Florida. This type of statute appears to be the most closely aligned with community-based HIV education programs and the Presidential Commission's recommendations.
The second type of statute, which criminalizes certain otherwise legal acts when performed by HIV carriers, has been enacted in Alabama and Idaho. This type of statute proscribes the purposeful, willful, or knowing exposure of another person to the HIV virus. It is not clear whether these statutes permit a defendant to raise defenses such as use of precautions against viral transmission or disclosure of HIV status to a potential sexual contact. Sound legal reasoning would seem to favor recognition of such defenses, however, and it would seem inappropriate to apply these statutes to conduct which is not considered, under prevailing medical views, to pose a realistic risk of transmitting the virus.

The third type of statute imposes enhanced sentences upon prostitutes who continue to engage in sexual activity after being informed that they carry HIV. The policy rationale of such statutes may be questioned, to the extent that they fail to take into account the actor's use of precautionary measures or good faith reliance on apparently valid medical advice that particular conduct poses no risk of transmission. Such laws also pose a risk of selective punishment on one class of defendants, while ignoring the equally dangerous conduct of others, such as the patronizing of a prostitute by a person who knows that he or she carries HIV.

Finally, it might be argued that a sound HIV-specific criminal statute would limit the state of mind element to purposeful, knowing, or reckless conduct. Given the current state of medical evidence concerning HIV, and the difficulties encountered in testing for its presence, it might be questioned whether criminal liability should be imposed on the basis of negligence or strict liability.

B. CRIMINAL PROCEDURE AND COURTROOM PROCEDURE

Education

Mandatory education of all criminal justice personnel about the medical and legal aspects of HIV is essential to reduce tension and anxiety, protect the health and safety of all participants, eliminate the potential for discrimination, and insure the dignity of the criminal process.

Because of the fear of contagion, caused in large part by misinformation about the Human Immunodeficiency Virus (HIV) and modes of transmission, the potential for bias and discrimination occurs at every step in the criminal process. Many of the obvious problems -- access to counsel, access to the courtroom, and a speedy trial by a fair and impartial jury -- are dealt with in the committee's various
recommendations. Because many forms of discrimination and violations of due process are subtle, the committee recommends training programs that will promote the development of fair and consistent policies throughout the criminal justice system, from arrest to the termination of sentence.

The medical facts about the full course of HIV infection should include scientific explanations about transmission, the circumstances under which precautions are appropriate, definitions of terms such as seropositivity. The nature, reliability and significance of the HIV antibody test should also be discussed. Only after thorough education and training can the bench and bar develop and carry out non-discriminatory, rational policies concerning persons who are known or perceived to be infected with HIV.

Victims

Individuals who are the victims of assaults or sexual assaults where there is reason to believe that the victim may have been exposed to the virus should be counselled in a supportive setting and tested periodically. With respect to the victims of bites and spitting see the discussion below in the fifth paragraph of "Access to the Courtroom and Courtroom Proceedings."

An Attorney's Obligation To Represent

Attorneys, as officers of the court, should be vigilant in guarding against all forms of discrimination. The Section is convinced that once attorneys are educated about the medical facts concerning HIV, they will not hesitate to represent defendants known or perceived to be infected with HIV. The virus which causes AIDS, HIV, is transmitted by infusion or inoculation of blood, sexual contact and perinatal events.\textsuperscript{32} There is nothing in the attorney-client relationship which would expose an attorney to the risk of infection.

HIV Defendant's Access to Counsel

The Section is concerned that a person known or perceived to be infected with HIV may be denied access to counsel. The concern is particularly acute where the person is in some form of custody. A person should always have free and unrestricted access to counsel, and once the right to counsel has attached, the court itself should monitor the situation and be prepared to intervene.

Routine Processing of HIV Cases

Many defendants infected with HIV are totally
asymptomatic and, particularly where a defendant is at liberty, no one may learn of the defendant's HIV status. This is as it should be. Such information is normally irrelevant. Defendants with HIV infection may be fully able to participate in a trial or proceeding; and defendants, in most instances, want their cases resolved. The Section is concerned with cases being delayed by the prosecutor, the attorney or even the court where difficult issues arise. Court personnel, either uneducated about or unconvinced of the medical facts about HIV, may not want to deal with a defendant known or perceived to be infected with HIV, particularly if he or she is incarcerated. While cases are understandably difficult to document, the Section has heard of matters where the lawyers wished the case would "go away." Also, the court may be reluctant to sentence a severely ill defendant, particularly where mandatory sentencing provisions apply. The Section is convinced that these cases must be adjudicated, and unless there is a determination to the contrary, the cases involving HIV defendants must proceed in due course.

Access to the Courtroom and Courtroom Procedures

Persons with HIV infection may be completely asymptomatic or may have clinical symptoms and conditions indicative of opportunistic infections associated with immunodeficiency. However, even persons in advanced stages of HIV infection are often able to work and carry on normal daily activities. In this recommendation, the Section seeks to stress that it is a defendant's actual physical condition that should govern court attendance, not the fear of contagion of court personnel.

Lawyers, judges and court personnel are not at risk in the normal courtroom setting. In a November 1985 letter to a Florida judge, a Center for Disease Control epidemiologist stressed that the HIV virus can only "be transmitted through sexual contact or through blood products or blood. We have no evidence that it can be transmitted through air, food, water, inanimate objects, or casual contact. We [the CDC] have not recommended special precautions for courtroom proceedings where one or more of the participants had AIDS. I know of no usual courtroom proceedings that would result in the transmission of" the HIV virus.

Fear of contagion has resulted in failure to produce defendants from pre-trial jails or lock-ups, segregated transportation and identifying (often incorrectly) defendants as infected with the HIV virus.

Jail and courtroom security personnel must be educated so as to prevent restrictions on a defendant's access to the
courtroom and to prevent discriminatory actions towards defendants known or perceived to be infected with HIV.

Victims of bites or spitting by defendants known or perceived to be infected with HIV should have the medical facts explained to them in a supportive setting. The Section's review of the medical literature and consultations with leading authorities have not uncovered one case of such transmission.35

The Section has become aware of a number of incidents where unusual and unnecessary precautions were taken with respect to defendants with HIV or where they were perceived to be infected with the HIV virus. Security personnel have worn "protective" clothing (masks, gowns, gloves, etc.), and defendants have been forced to wear the same. The potential for humiliation and discrimination is obvious.

The only result of these precautions has been to create tension and anxiety and to increase the chance of an accident and blood spill. The Section recommends that by focusing on real, verified concerns, everyone's health and safety will be enhanced, and HIV defendants will not be discriminated against.

Where there is a danger of violence or escape, security should be increased accordingly. Persons infected with HIV are often debilitated, either from the disease or a course of treatment, so the real risk is often considerably less than with an uninfected defendant.

The Section has elsewhere recommended against mass antibody testing of incarcerated defendants. The arguments against testing are even stronger where defendants are at liberty. Even if everyone were tested, antibodies do not develop for weeks or months, and, therefore, a negative test would not guarantee safety from infection. Thus, court and security personnel must assume that all defendants are infected with the HIV virus. Where there is a blood spill or danger of blood contact, surgical gloves and proper clean-up procedures must be utilized in all cases. Universal precautions protect personnel from exposure and eliminate discrimination from the defendant's perspective.

Court clerical and security personnel must be educated as to the medical facts about HIV to prevent attempts by them to dissuade HIV defendants from attending court and to prevent any other forms or discrimination against HIV defendants, whether at liberty or incarcerated. Defendants at liberty have an obligation to attend their duly-scheduled court appearances unless the court excuses them because of their medical condition.
Jury Trials

The defendant's HIV status may be a legitimate issue in a criminal case. For example, some jurisdictions have permitted prosecutions for knowing transmission of HIV. Where the court has determined that the defendant's status or diagnosis is a legitimate issue in the case and not merely an attempt to create bias or prejudice in the jury's mind, a full voir dire is appropriate. If the defendant's condition is not an issue in the case but his or her condition is known or has been publicized, the Section feels that it should be up to the defendant to determine whether discussion of the issue with the jury would help or exacerbate the possible prejudice.

Medical Information and Confidentiality

There are a number of instances where the court might determine that a defendant's antibody status is relevant. The defendant, of course, may put his or her condition at issue in making a motion to dismiss in the interests of justice or at sentencing. Also, a defendant may repeatedly fail to appear in court or the jail authorities may not produce a defendant from the lock-up. Where a defendant's condition is at issue, the court (and the jury, where appropriate) must be provided with the most current, accurate and objective medical information available.

Once there is a demonstrated need for the court and the lawyers to know of the defendant's condition, to avoid potential discrimination against a defendant, dissemination must be restricted. Criminal justice personnel who receive information about a defendant's condition must safeguard the confidentiality of such information. Only where a court determines that others (the press, the public) have a right to know should such information be released.

Dismissals In The Interests of Justice

The statutes and case law of a number of jurisdictions permit the dismissal of criminal charges on grounds other than the merits. The dismissals are limited to cases which raise special and compelling circumstances and where the use of judicial resources to prosecute such cases would be unwarranted. Jurisdictions which do not presently have such a provision may wish to consider this procedure as HIV cases increase.

HIV Status and Sentencing

The Section believes that the issue of HIV status at sentencing deserves further study and discussion. Clearly, a person's HIV status should not foreclose an alternative to
incarceration sentencing option. Nor should a sentence of incarceration be utilized to quarantine a defendant. However, the Section recommends further work be done on the issue of whether and to what extent sentences may be enhanced where a defendant is infected with HIV. Should the condition be directly related to the nature of the offense (i.e., prostitution, assault, etc.)?

**HIV Status and Bail**

The Section also believes that the issue of HIV status and bail deserves further study but offers the following comments to aid the discussion. The primary purpose of bail is to insure a defendant's return to court to face criminal charges. A defendant's HIV status would normally not be relevant to that determination. If a defendant puts his or her HIV status at issue, the court may consider the seriousness of the defendant's condition and the level of medical care available to the defendant in jail. Others have argued that where there are compelling health or public safety bases related to the charge, HIV status should be considered whether or not the defendant raises the issue.

Two extraneous issues have arisen in the bail context: quarantine and forced testing. There have been reports that judges, either at the urging of prosecutors or on their own initiative, have set high bail or refused bail as a way of quarantining a defendant suspected of spreading the HIV virus. While a few jurisdictions have civil quarantine procedures and several others are contemplating such measures, it is a procedure of questionable validity and effectiveness in the HIV context. In any event, a criminal bail hearing is not a proper substitute for an extensive civil proceeding that must be held before a last-resort quarantine is imposed.

Judges, either at the urging of prosecutors or on their own initiative, have ordered HIV-antibody tests unconditionally or as a condition of bail. Either courts have felt that HIV status is a relevant bail factor or have been motivated to "help" the victim in instances of sexual attacks or of biting or spitting incidents. On the issue of forced testing, unless blood is taken from a defendant for evidentiary purposes, there are questions as to whether such an intrusion is constitutionally valid.

**C. CORRECTIONAL FACILITIES**

**Training and Education**

Education and training about AIDS are considered critical to the management and control of the disease in correctional facilities. The transmission of accurate
information about AIDS based on up-to-date medical knowledge is necessary to achieve several essential objectives:

1. to alter high-risk behaviors which foster the spread of AIDS;
2. to alleviate the fears of staff and inmates regarding their potential for exposure through casual contact;
3. to reduce medical care costs;
4. to limit potential liability exposure; and
5. to ensure humane treatment of those who are suffering from AIDS, ARC, or HIV seropositivity.

Under this recommendation, the training and educational programs contemplated would include the following attributes:

1. training and education of all personnel in correctional facilities;
2. training and education of all inmates in correctional facilities;
3. programs that include clear and explicit information about AIDS, its modes of transmission, and the ways of preventing the spread of the disease;
4. programs that are based on the most current medical knowledge;
5. programs for inmates who do not speak or understand English;
6. regular updates of staff and inmates on AIDS;
7. programs which include small group presentations as well as written and audio-visual materials;
8. instruction of staff members about the need to strictly protect the confidentiality of HIV-related information about an inmate;
9. further training for inmates just prior to their release from custody; and
10. documentation of training.

A few of these programmatic features warrant further discussion. The recommendation for the inclusion of
small-group training sessions comports with the recommendation of the National Institute of Justice of live training sessions as the most effective mode of education if presented by persons knowledgeable about AIDS from both medical and correctional points of view. These live sessions should be conducted in small groups so that staff and inmates have the opportunity to ask questions and have their particular concerns about AIDS addressed. In addition, steps should be taken to educate inmates who do not speak or understand English about AIDS.

As mentioned above, part of the training of correctional staff about AIDS should also focus on the need to protect the confidentiality of information about a person's HIV status. Such training may diminish staff demands for information about inmates' HIV status and protect inmates from the discrimination and possible violence that may attend disclosure of HIV status.

Inmates preparing to leave a correctional facility to rejoin the community at large should in addition receive special training regarding AIDS. Upon release, they will have the freedom and opportunity to engage in a number of activities which pose a high risk of spreading the AIDS virus.

Because of the high turnover of staff and inmates in correctional facilities, documentation of inmates' and staff members' participation in an AIDS educational and training program is necessary. Such documentation will ensure that all staff and inmates have received the necessary instruction about AIDS.

The costs involved in providing the recommended broad and continuing AIDS education require that funding be given priority. AIDS training and education cannot be viewed as a "one time only" responsibility for correctional institutions. The rapidly expanding medical knowledge about AIDS requires that programs be scheduled at regular intervals and be constantly updated to ensure policies and practices based on accurate information. Continuing education is also necessary because of the fears generated by AIDS. As stated in the National Institute of Justice study, if training and education programs are permitted to lapse, fears and concerns are quick to resurface among staff and inmates." NIJ, AIDS in Correctional Facilities: Issues and Options 23 (2d ed. 1987).

Medical Care and Counseling Services

This recommendation is premised on the notion that inmates who are HIV-infected are entitled to adequate medical care commensurate with that afforded the general
public. To satisfy minimal standards of adequacy, a correctional facility's medical-care program would therefore have to include the following:

1. medical management which parallels that offered in the community at large;

2. availability of confidential HIV-antibody tests, with counseling, at medically justified intervals for those inmates who wish to be tested;

3. timely response to medical complaints of symptoms associated with AIDS, ARC, and HIV seropositivity;

4. regular follow-up of those with AIDS, ARC, and HIV seropositivity;

5. referrals to appropriate community facilities for those inmates with AIDS, ARC, and HIV seropositivity who are being released from custody;

6. reasonable access when medically appropriate to innovative drugs being developed to treat AIDS when an inmate has given informed consent to the administering of such drugs; and


Though most of the program features delineated above are self-explanatory, two warrant further explanation. The sixth recommendation is designed to ensure that inmates have reasonable access when medically appropriate to innovative drugs designed to treat AIDS, such as AZT. Before such a drug is administered to an inmate, however, he or she must have given informed consent to the administering of the drug. Care must be taken to ensure that inmates are not used in an unethical fashion as guinea pigs in medical experiments concerning AIDS.

The recommendation that drug rehabilitation treatment be readily available to inmates is prompted in part by the recognition that the sharing of needles by intravenous drug abusers is one of the primary modes of transmission of the AIDS virus. Since correctional facilities contain a disproportionately high number of drug abusers, affording inmates drug rehabilitation treatment should help to curtail the spread of AIDS.

In addition to special medical care needs, the problem of AIDS creates special counseling needs which should be met by correctional institutions. A minimally adequate counseling program should include at least the following features:
1. medical advice regarding maintenance of health, avoidance of high risk behaviors, and proper measures to prevent the spread of infection;

2. psychological support to help inmates handle the mental and emotional stresses caused by AIDS and the fear of AIDS;

3. if HIV-antibody tests are administered, pre- and post-test counseling, regardless of the test results. Inmates should always be counseled before they are even tested so that they understand the significance of testing positive or negative and understand the importance, regardless of the test results, of refraining from high-risk behaviors.

4. encouragement of inmates with AIDS, ARC, or HIV seropositivity to voluntarily contact sexual or drug partners to inform them of the inmate's condition. These inmates need to be encouraged to contact sexual and drug partners to or from whom they may have contracted the HIV so that those persons desist from further high-risk behavior likely to further spread the disease.

5. special counseling about the potential to infect unborn children; and

6. special counseling to inmates preparing for release. Through such special counseling, inmates may be dissuaded from engaging in the high-risk behaviors, such as the sharing of needles during intravenous drug use, through which the AIDS virus is spread.

Segregation and HIV-Antibody Testing

Because of the limited ways in which the AIDS virus is transmitted, the fact that a prisoner has tested positive for the HIV antibody would not by itself justify isolating the prisoner from the rest of the prison population or in a special prison. Such segregation in fact might unwittingly contribute to the spread of AIDS in correctional facilities. If a segregation policy was adopted, inmates who were carriers of the AIDS virus might remain in the general prison population because their bodies had not yet produced HIV-antibodies. These and other inmates in the general population unit, lured into a false sense of security by the segregation of inmates who had tested HIV positive, might then engage in activities presenting a high risk of transmitting the AIDS virus.

Although, under this recommendation, inmates could not
be segregated solely because of their HIV status, they could still be isolated if the requirements of standards already developed by correctional officials governing the placement of inmates in administrative segregation or protective custody are met. One such standard is Standard 2-4215 of the American Correctional Association's Standards for Adult Correctional Institutions. This standard provides in part that: "The warden/superintendent or shift supervisor can order immediate segregation when it is necessary to protect the inmate or others." Under this standard, a very assaultive inmate, whether HIV positive or not, could be placed in administrative segregation so as to protect other inmates and staff.

Another standard, Standard 2-4220, governs the placement of inmates in protective custody and provides: "Written policy and procedure provide that admission to the segregation unit for purposes of protective custody is made only when there is documentation that protective custody is warranted and no reasonable alternatives are available." Under this standard, an HIV positive inmate against whom death threats have been made might be placed in protective custody for his own protection, although normally other steps, such as segregating the inmates who pose a danger to the HIV positive inmate or making more intensive efforts to educate inmates about AIDS, would and should be taken.

This recommendation would not preclude the isolation for medical reasons of inmates with AIDS or ARC. Such isolation might be necessary to protect the inmates with AIDS or ARC, whose immune systems are malfunctioning, from contracting diseases from other inmates or staff that might prove lethal to an inmate with AIDS or ARC.

Since an inmate should not be segregated in special areas of a correctional facility or in special correctional facilities simply because the inmate is or is suspected of being HIV positive, the mass HIV-antibody testing of prisoners for segregation purposes should be prohibited. HIV-antibody testing of inmates would still be appropriate, for example, when done on an inmate upon his or her request, when done for diagnostic purposes, and when done to gather statistical data on the prevalence and transmission of HIV in a correctional facility. Any HIV-testing of inmates should conform with appropriate medical protocols which at this time require two ELISA tests and a confirmatory Western Blot Test.

Confidentiality: Limits on Persons to Whom Disclosure is Made

It is well-recognized that the disclosure of sensitive medical-record information should be confined to those with
a legitimate need to know such information. American Hospital Association, "AIDS-HIV Infection Policy: Ensuring a Safe Hospital Environment" 18-19 (1987); Personal Privacy in an Information Society, The Report of the Privacy Protection Study Commission 304 (1977). As the person responsible for the overall operation of a correctional facility and for such decisions as whether a prisoner should be released on furlough, the warden, if he or she feels it necessary, should have access to information about an inmate's HIV status. Similarly, key supervisory personnel with a legitimate need for information about an inmate's HIV status should have access to the information as long as they have a right to such access under clearly-defined institutional rules. Finally, medical staff involved in the care and treatment of an inmate might, for diagnostic and other reasons, have a legitimate need to know of the inmate's HIV status.

On the other hand, disclosure of an inmate's HIV status to correctional officers, prisoners, and other staff is unnecessary and ill-advised. The confirmed risk of adult transmission of HIV is limited to situations where certain bodily fluids of an infected person -- i.e. blood, semen, or vaginal secretions -- are introduced into the body of an uninfected person. Use of appropriate equipment, cleaning supplies, and suitable precautions whenever contact with such bodily fluids is likely will provide the necessary protection against infection to inmates and staff involved in routine activities.

The Centers for Disease Control, the American Hospital Association, and the Occupational Safety and Health Administration all advocate the use of universal precautions not predicated on a person's HIV status to prevent the spread of AIDS. American Hospital Association, "AIDS-HIV Infection Policy: Ensuring a Safe Hospital Environment" 5 (1987). The taking of only selective precautions based on the results of HIV-antibody tests is unwise and poses a health risk, since a person may be infected with the AIDS virus, but test negative because his or her body has not yet produced antibodies to the virus. In addition, the disclosure of an inmate's HIV status could lead to that inmate being ostracized, discriminated against, or even killed by inmate's afraid of contracting the disease.

To ensure that the disclosure of information about an inmate's HIV status is strictly limited, correctional officials should draft, promulgate, and enforce specific rules identifying who may have access to such information and who may disclose the information.

Parole and Other Community Release

Because of the limited ways in which the AIDS virus is
transmitted, the confinement of a prisoner who would otherwise be released into the community should not be continued simply because the inmate is HIV positive. Correctional officials could, however, refuse to permit an inmate to participate in a community release program involving temporary release from prison if the inmate's HIV test results were positive and the inmate refused to notify his or her spouse or any similarly situated person of the test results. This recommendation is prompted by the belief that government officials can take steps to limit the harm caused by temporarily releasing a prisoner into the community. Furlough programs, programs involving release to halfway houses, and other community release programs would fall within the scope of this recommendation.

The confinement, however, of an inmate who would otherwise be finally discharged from a correctional facility, through parole or otherwise, should not be continued simply because the inmate has refused to disclose his or her HIV status to a spouse or similarly situated person. Such a drastic sanction for refusal to disclose sensitive personal information seems unwarranted, particularly since such mandatory disclosure requirements are not imposed on the general public and since more effective means can be taken to protect the health of spouses and similarly situated persons. If attempts to persuade the inmate to voluntarily disclose his or her HIV status to these persons are unavailing, then correctional authorities can notify public health authorities who can take the steps necessary to protect persons with whom the inmate may have sexual contact. When an inmate is being discharged from a prison or jail, vesting the ultimate decision as to unauthorized notification in the hands of public health officials makes sense since those officials are responsible for maintaining the public's health, since they can more understandably explain the significance of HIV test results and how to avoid contracting the HIV, and since they must make similar decisions regarding the unauthorized disclosure of the HIV status of non-prisoners.

Respectfully submitted,

Terence F. MacCarthy
Chairperson

February, 1989
ENDNOTES


4. Id.


10. M.P.C. § 2.02(2)(c).

11. Id.

12. For example, a prostitute who knew that he or she carried the virus might satisfy the recklessness requirement by continuing to engage in sexual acts that involved transmission of his or her own bodily fluids.


15. Ironically, the necessary state of mind would actually exist in the rare situation in which the infected actor erroneously thought he or she could transmit the virus to another by a method not scientifically established as a mode of transmission — such as spitting or biting. An attempted murder charge in such situations could fuel public hysteria over HIV and confuse the public over what conduct is truly dangerous. On the other hand, lesser charges, such as assault, may be appropriate where the actor has bitten the victim.

17. M.P.C. § 211.1(2).
19. M.P.C. § 211.2.
24. Id. at 131.
25. See generally, Sullivan & Field, AIDS and the Coercive Power of the State, supra note 3.
26. See Sullivan & Field, supra note 6, at 51-52.
27. Intergovernmental Health Policy Project, George Washington University, A Symposium of AIDS-Related Legislation at 59-60 (July 1987).
28. Louisiana Act 663 (1987) forbids the intentional exposure of another to HIV "through sexual contact without the knowing and lawful consent" of the other person. Violation is a felony punishable by imprisonment for a maximum of 10 years and/or a maximum fine of $5,000. Florida Public Health Code 384.25 (1986) prohibits persons who know they are infected with a sexually transmitted disease or carry HIV and can transmit the disease or virus to others, from engaging in sexual intercourse unless the sex partner has been informed of the actor’s status. Fla. Stat. Ann. § 384.24 (West. Supp. 1988).

30. Alabama Act 87-575 (1987) makes it a Class C misdemeanor for anyone with a sexually transmitted disease to knowingly transmit, risk transmitting, or conduct himself or herself in a manner likely to transmit, the infection. Similarly, the Idaho Health and Safety Code, § 39-601, makes it unlawful to anyone with a communicable sexually transmitted disease to "knowingly or willfully expose another person to infection."

31. Nevada Assembly Bill 550 makes continued prostitution under these circumstances a felony, while Florida Criminal Code § 796.08(4) makes such conduct a misdemeanor. Fla. Stat. Ann. § 796.08(4) (West Supp. 1988).


35. See notes 32 and 33 supra.

GENERAL INFORMATION FORM

To Be Appended to Reports with Recommendations
(Please refer to instructions for completing this form.)

No. (Leave Blank)

Submitting Entity: Section of Criminal Justice

Submitted By: Terence F. MacCarthy, Section Chairperson

1. Summary of Recommendation(s).

Recommendations are made on issues pertaining to AIDS that relate to the criminal justice system. These recommendations address the following areas: (1) limiting criminal sanctions and increasing public education as method of combatting the AIDS epidemic, (2) procedures and policies to be followed by courts, attorneys and others administering the justice system, and (3) procedures and policies to be followed by correctional facilities and their personnel.

2. Approval by Submitting Entity.

These recommendations were approved by the ABA Criminal Justice Section Council at its November 5-6, 1988 meeting.

3. Previous submission to the House or relevant Association position.

The ABA approved a policy at its 1988 Midyear Meeting (See Report No. 115A) which supported federal legislation which would promote increase level of voluntary counselling and testing for AIDS. It provided testing and counselling may not be disclosed without consent of individual, except where it is authorized by state and federal law which provides protection of individual's identity. It also expressed support for prohibiting discrimination against persons with AIDS in employment, housing, public accommodations and governmental services.

4. Need for Action at This Meeting.

There is an increasing incidence of AIDS in the United States. Persons in the legal profession, and particularly those who participate in the criminal justice system, are daily encountering dilemmas pertaining to their dealings with persons with AIDS. These persons need general guidance on the proper response to these dilemmas. The precepts contained in this Recommendation will help provide guidance on some of the more perplexing issues facing the legal profession and those
administering the criminal justice system. Delay in approving this Recommendation may result in the ABA being preempted on this issue by some other organization who will seek to give guidance to members of the legal profession on how they should confront situations involving persons with AIDS.

5. Status of Legislation. (If applicable.)

The 100th Congress considered various bills related to AIDS. The Anti-Drug Abuse Act of 1988 (P.L. 100-690) contained provisions relevant to educational programs such as "outreach activities" (e.g., see Sec. 509G(a)(1)(B)). At the time this General Information report was written it was not possible to anticipate relevant legislation that might be considered by the 101st Congress.

6. Financial Information. (Estimate of funds required, if any.)

No financial impact is anticipated.

7. Disclosure of Interest. (If applicable.)

There is no conflict of interest that is known to exist.

8. Referrals.

Standing Committees
1. Bar Activities and Services
2. Dispute Resolution
3. Ethics and Professional Responsibility
4. Federal Judicial Improvements
5. Forum Committee on Health Law
6. Lawyers' Public Service Responsibility
7. Legal Aid and Indigent Defendants

Special Committees
1. Delivery of Legal Services
2. Coordinating Committee on AIDS

Sections and Divisions
1. Business Law
2. Family Law
3. General Practice
4. Individual Rights & Responsibilities
5. Judicial Administration Division
   National Conference of Federal Trial Judges
   National Conference of Special Court Judges
   National Conference of State Trial Judges
6. Labor Law and Employment
7. Law Student
8. Litigation
9. Senior Lawyers
10. Tort and Insurance Practice
11. Urban, State and Local Government Law
12. Young Lawyers
Affiliated Organizations

1. Conference of Chief Justices
2. Federal Bar Association
3. National Association of Attorneys General
5. National District Attorneys Association
6. National Legal Aid and Defender Association

9. Contact Person. (Prior to meeting.)
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212/374-4782

10. Contact Person. (Who will present the report to the House.)
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