NATIONAL COMMISSION ON AIDS

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HIV INFECTION AND AIDS
IN
CORRECTIONAL FACILITIES

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P R O C E E D I N G S

(9:15 a.m.)

DR. OSBORNE: We're still missing one of the Commissioners who should be here, but we thought we should proceed.

I want to welcome everybody, and in particular thank our guests for their flexibility in joining us here. We're very disappointed not to join you at Rikers Island, but I think it certainly was prudent and wise that we do things this way, so now, I'm going to need to ask for some help from the staff as to how we want to proceed.

Karen, could I get you perhaps to help me make some suggestions?

MS. PORTER: I understand Dr. Braslow knows how we're going to proceed for the beginning part of the morning.

DR. BRASLOW: I'm Charles Braslow, I'm program director for Montefiore Rikers Island program service, I'd like to introduce Margaret Grossi, who is the Deputy Commissioner for the Department of Health, and one of her many concerns and responsibilities is the prison health care in the city jails, and she would like to start off

with a few words.

DR. GROSSI: Okay, I thought maybe I'd just orient you to the role of the Health Department and then turn it back to the Montefiore staff.

The New York City Charter gives, assigns responsibility for health care in the prisons to the New York City Health Department, and the Health Department in turn contracts for services with Montefiore, and they are the longest and the largest contractee, and now in the last year with St. Vincent's. There are nineteen facilities currently, and between 18 and 20,000 inmates at any one period of time, and we say about 120,000 inmate admissions a year.

Now, these facilities break down into eight are serviced by Montefiore, they are all on Rikers and they are all, they all tend to be very large. St. Vincent's operates three, the Tombs in lower Manhattan and the two boats, as we call them, the maritime facilities in lower Manhattan.

The Health Department currently operates eight, the large borough houses, you might think of them as, and some smaller houses in the boroughs,

plus two small facilities on Rikers; the mental health center and the old Rikers Island hospital, RIH so-called, which is no longer either a hospital or an infirmary, it's a general population jail.

So the health policies are set in cooperation, obviously, with all three providers. When it comes down to the procedures, of course, the individual provider determines his own procedures for his own facilities.

HIV policies are developed there for that way, and the procedures that we set in place several years ago under then Commissioner Joseph were to offer medical confidential HIV counseling and testing to inmates who would want it. We secured funding for a large AIDS educational program which was both for inmates and for correctional and health staff, and still is; a program of condom distribution in the jails, particularly at special housing facilities, and units, and is now available in medical clinics when inmates request them, and I guess Charlie will be saying more about that, and discharge packages, which amounted to business size envelopes which have the AIDS hotline information and hotline

numbers for access to drug treatment, and some condoms.

HIV testing is done in the Health Department laboratory. The volume now is around 300 a month. Is that the figure you have in your head, Charlie? And that's up. Initially, it was very, very much less and I only stress that because initially and perhaps for the first year, year and a half, the positivity rate was around 50, 55 percent, every single month, so we were obviously testing only those who were at very high risk. Now it tends to hover around 25 percent every month as the volume has gone up.

We did the first sero prevalence study, randomizing proportionately, proportional on the basis of sex, and the types of inmates housed in each facility. Those bloods were drawn at the end of 1989, November of '89, and the overall rate was 18 percent and that broke down into males--18 percent positive; males, 16 percent positive and females 26 percent positive. This was no surprise. We had had a resident a few years before who did an estimate of seroprevalence based upon the history of IVDA usage and she got similar percentages with

that same relatively high percent in females.

I think the value of doing a sero-prevalence study will be once we can establish trends, so we are going to be repeating this in the fall of this year.

DR. ROGERS: Margaret, are you talking jail population or prison population?

DR. GROSSI: Both. Charlie, do you have that breakdown?

DR. BRASLOW: That number is for a population which is approximately 80 percent pretrial detainees, and 20 percent sentenced, but only year or less sentence, so it would not include people who are sentenced to an upstate--although the seroprevalence survey was done on all new admissions, so it really would include everybody coming in, which would also include those people who ended up with prison sentences, so it's jail admissions is what the rate is.

DR. ROGERS: Excuse me.

DR. GROSSI: No, I'm finished. Whatever you want to say. That's I think good enough for an open. Charlie?

DR. ROGERS: Did I scare you that much,

Margaret?

DR. GROSSI: No.

DR. OSBORNE: Just before you go, I'm curious about the dynamics of the seroprevalence study. Was that accepted reasonably?

DR. GROSSI: It was a blinded seroprevalence study that of course went through our IRB and it went through yours, Charlie?

DR. BRASLOW: Yes.

DR. OSBORNE: And in terms of repeating it so forth, having done it once, therefore, relatively few problems other than the cost of repeating?

DR. GROSSI: I'm not aware of any problems. You're closer to the jail than I am, Charlie.

DR. BRASLOW: I think that when the idea was first discussed of doing a seroprevalence, which was before the development of any real therapy for HIV disease, I had concerns about whether this was necessary at all, because I was concerned about the potential for stigmatization of an incarcerated group by widespread publicity that they had a very high seroprevalence rate, with no

concommitant gain from it.

However, with the development of therapies, and I think a more realistic ability to use the sorts of numbers to project resource needs as far as what was necessary to deliver these therapies, that there seemed to then be a medical justification for it.

I think the way that it was done was a blinded discard blood seroprevalence, so that no extra bloods were drawn. It was all from admission bloods that had been drawn for other purposes.

DR. OSBORNE: Which would routinely be done anyway.

COMMISSIONER AHRENS: I just have a structural question. I don't understand the system here. You operate both jails and a prison or prisons in New York City operated by New York City, is that what I understand you to say?

DR. GROSSI: A couple of the facilities are for sentenced inmates.

COMMISSIONER AHRENS: Up to--

DR. GROSSI: Up to one year.

COMMISSIONER AHRENS: Okay.

DR. GROSSI: And they are not all on

Rikers, as a matter of fact, because Forbel and the Brig, they are various other jails, too, not just Rikers.

DR. BRASLOW: They also include the two facilities that the City runs from the State in upstate New York which are used for City sentenced inmates for a year or less, but the City only has responsibility for a year sentence or less.

COMMISSIONER AHRENS: So those would encompass the 19 that you mentioned, all of these?

DR. GROSSI: No, because I wasn't counting the two upstate.

DR. BRASLOW: The total including all of them is about 20,000.

DR. GROSSI: But the total number of facilities would be 21.

COMMISSIONER AHRENS: Okay.

COMMISSIONER DALTON: I wasn't sure whether Dr. Braslow was also going to give a presentation?

DR. GROSSI: Oh, definitely.

COMMISSIONER DALTON: Maybe I should wait.

DR. BRASLOW: I'm going to expand a

little bit on some of the things that Margaret mentioned. What I'd like to do is give you a little bit of an overview of the issue of correctional health in general and how it's developed, then an expansion of what Margaret mentioned as far as the way we provide health services in the City, and then some of the particularly HIV related issues that we've been dealing with for the past several years, at which point I really would like and hope that it would be a very open discussion.

Correctional facilities are called correctional facilities now, and I think that the reason is because there's some perception that developed in the 20th century that somehow incarceration would correct behavior.

In the 19th century, when prisons first started being built, they were called penitentiaries, and that implied the philosophy at that time, which was that it was a place that allowed people to do pennance. Obviously, a lot of these ideas have changed and I don't think that pennance or correction are really effective functions of the correctional facilities that

currently exist.

Prior to the 19th century, really, corporal punishment and a much wider use of capital punishment and exile and those sorts of punishments were used, but the development of warehousing of people in facilities is a relatively modern concept.

Provision of medical care in these facilities has really been moderately primitive up until recently. Most correctional health care was provided by the departments of correction, which ran the security aspects of the facilities, and as such, was very much subsumed to those security concerns, and the courts were very unwilling to get into issues concerning correctional facilities until really the 1970's, and they felt that it was the province of the correctional administrators to decide what went on in their own facilities and didn't really take any sort of judicial interest.

But in the '70's, as a result of the civil rights movement and a lot of people being incarcerated from the Viet Nam war period, more interest was focused, there were riots at Attica, there were riots here in New York City jails, and

in the mid-'70's there was a development of a judicial standard for what was required constitutionally for health care in correctional facilities, and the decision in 1976, Estel v. Gamble, established a constitutional criterion based upon the 8th Amendment proscription of cruel and unusual punishment, which essentially declared that medical care in a correctional facility could not be deliberately indifferent to the serious medical needs of the inmate without violating the 8th Amendment.

So that's the standard that's been used since 1976 to develop a system of judicial monitoring which has actually had to be enforced in a lot of correctional facilities around the country in order to try to improve the level of medical care, and I've had the experience of knowing that in many places in this country the medical care is still quite abysmal.

Some of the gains that have occurred have been wiped out by the very recent large increase in the correctional population. The population over the past several years has dramatically increased.

I started working at Rikers Island in 1980. At that time, we had responsibility for about 5,000 inmates. Currently my program has responsibility for about 13,000, and most of that increase occurred since about 1986, and they have literally built, they've over doubled the capacity of the Rikers Island facilities by bringing modular housing units in on flatbed trucks which form 50 bed dormitories and they can attach these things in many, many locations to pre-existing buildings, and by doing that, keep more and more people on a fairly small physical area.

The program that I'm responsible for is a part of Montefiore Hospital, and as Dr. Grossi said, we are one of the two contractors with the City Department of Health to provide services. Our program developed in about 1973 when I think the City wisely realized that provision of health care was something that a medical center could perhaps do better than the City agencies that had been directly providing the care at that time could do.

The Department of Corrections really was not in the business of providing health care, and it was the Department of Health's mandate to do

that by City Charter, so the Department of Health took the course of contracting out to a medical center for these services, and at that time, we started one facility on Rikers and as the years have gone by sort of expanded into other facilities and currently run the eight facilities at Rikers Island now, which is an average daily population of around 13,000 inmates. About 12 to 1300 of those are women, about 80 percent of them are pretrial detainees. They are people being held either without bail or on bail that they cannot afford. Many of those bails are very low. There are also about, I think 2,000 or so who are sentenced prisoners who have a sentence of a year or less, so that's what the population is constituted of.

Because it is a group primarily of pretrial detainees who are not able to get out on bail, it's a population that is extremely overrepresented by the economically disadvantaged. Approximately 45 percent of the population is black, 45 percent Hispanic, and about 10 percent white, and it comes from a group of people who cannot afford the bail, who don't have the family support to make bail, and who don't frequently have

the access to medical services in the community that other people do.

As such, I think we are particularly at a crucial point to be able to make interventions with regard to the HIV epidemic, and I think that if I could make one point here, it would be that we are able to reach a group of people who are not being reached on the outside. It's a group of young, primarily male drug users who are the exact group of people who do not avail themselves frequently of the health care system on the outside, and where I think that things that we can do on the inside might have a real likelihood of having a good impact.

So that I think that there's a very important public health aspect to correctional medicine, particularly in New York, which goes far beyond the mandate to take care of the medical needs of the inmates, which is really our primary goal.

I think that's an important point, because obviously, it's not a popular issue that the man on the street I think is particularly concerned about, providing health care to inmates,

and I have heard the attitude expressed on many occasions that people should be thrown in jail and locked in and throw away the key and who cares if they get any medical care. That's a sort of a hard attitude to get over, and it doesn't help when I explain, well, they have been accused of something, they haven't been convicted of something.

The perception is that most of these people are those that are causing the crime problem in New York City, and therefore they deserve what they get. And in order to try to overcome that attitude, I think that it's helpful and important to emphasize that we can make a big impact upon the course of this epidemic in the city at large, and we can also make a big impact on the course of the subsidiary epidemics that are occurring in other infectious diseases, partially as a result of HIV infection, that are also occurring in the city at large.

Such as every case of tuberculosis that we pick up in people who are incarcerated is a person who is not transmitting tuberculosis while they are on the outside. Every case of syphilis that we can detect and treat is a break in the

chain of transmission of syphilis. Both tuberculosis and syphilis are increasingly problematic in New York, and our ability to do something in the jails I think could make a big impact.

We're currently treating over 100 people on any day for active tuberculosis, whereas three years ago, perhaps, it was less than a quarter of that.

We also can show increased rates of syphilis, and these are related to some extent to HIV infection, to some extent to homelessness, to some extent to the concurrent crack epidemic, but they're all problems that I think that we can make an impact in.

That's really what I have to say about the constitution of our system. I'd be willing to talk, if you want to have a clearer idea of what the city jail system is at this point before we go into some of the specific issues that we've been dealing with.

Did that clarify things?

I remember first hearing about HIV, I think, in 1981 or '82, and it was the medical

director who was at Rikers at that point talking about the initial reports of the disease, and I think, as did everyone, we were caught somewhat by surprise by what's happened, although I clearly remember thinking when the first reports came out of the way the number of cases were increasing, and doing some multiplication in my own head and saying this isn't possible, within a few years there are going to be hundreds of thousands of people dead, and I also--I couldn't accept that, and I also couldn't accept or even project what the impact was going to be in the jail system, because at that time it was not perceived as being a problem that was associated with intravenous drug use.

But obviously, as things have developed, I think that there's been a shift in the epidemic and a lot of issues of HIV infection which are currently concerning us are very well represented by the issues that we're having to deal with, and I think one of the first ones and the one that I think we've probably spent the greatest amount of time on, and the greatest amount of effort on, is to demonstrate something that we are very aware of on a daily basis, which is the very dramatic change

in the nature of illness, the level of morbidity among the inmates in the correctional facilities.

Five years ago, ten years ago, my medical staff would see people with colds and would take care of them as a cold and give them a cold protocol. They would give people with headaches aspirin.

It's not that way any more, and we now have to be very attuned to all of the HIV-related conditions that may be responsible for a lot of common complaints that we see, so that the very level of medical care that we're having to provide has really been dramatically impacted, and we are seeing people with very early pneumocystic pneumonia, we are seeing people with very early CNS infections.

We've made diagnoses of people very early in the stages of cryptococcus meningitis, and we feel that it's very important for us to be attuned to that and to be able to give the time to our medical encounters that is necessary to be able to do that sort of thorough diagnostic evaluation.

That requires more medical staff, and we have been fighting and we have been fighting with

the assistance of the Health Department over the past several years to demonstrate that this increased morbidity requires increased resources for health care in the correctional facilities. I think to some extent we've been successful, but we're going to have to continue to fight this battle over the next several years to make sure that we do have the resources that are necessary to do that.

That's a fairly obvious need. We've coupled the concerns of that sort with development of an HIV-related program under the direction of Dr. Bellin, who is our infectious disease doctor, and he essentially has been calling the shots as far as program development with regard to treatment of HIV-related conditions, and I think that we've been able to maintain a very up to date and successful program which allows us to provide community level medical care within the correctional facilities. It's a very difficult battle, but it's one that I think has been to a large part successful.

With regard to how other correctional systems could use what we've learned, I think that

it's very important to have someone who is a specialist in infectious diseases accessible and I think it's important to have that person available to the entire medical staff of correctional facilities, and not to try to segregate out people who are HIV infected or who have HIV-related conditions, to provide specific medical staff for just treating that kind of a person, and I think that's one of the trends in a lot of correctional facilities, which is to try to train two or three health staff who can take care of these problems, and then everyone else really doesn't know a lot about it.

What we've tried to do is to teach everybody about it and to have one person who is responsible for letting everybody know how to take care of that and having program wide policies about taking care of HIV-related conditions, rather than have it be a specialized area.

Tied into the impact upon routine medical care has been the whole issue of HIV-related education, and obviously I think that education is still one of the mainstays of attacking the problems of transmission, and with

the Department of Health's AIDS education program, which was developed to bring people into the facilities to teach the inmates about HIV transmission, we have developed some of our own educational programs into an attempt to do that. We've gotten grants from here and there, from AMFAR and the State AIDS Institute to bring in additional personnel to develop programs to provide HIV educational efforts to the inmates, to the staff and also to the correctional staff, although we haven't really been directly related to that education among correctional staff.

Increased knowledge among correctional staff, however, has greatly reduced, I think, the initial atmosphere of fear that was present during the early days of the epidemic. I don't sense that there's nearly the fear and potential for recrimination from the correctional staff that existed in the early years. I hope that I'm right about that.

The next issue that we've been grappling with has been the whole issue of HIV testing, and Dr. Grossi mentioned that we do have testing available. It was developed, the policy was

developed for the entire system, the Department of Health with our input developed a policy of confidential self-initiated, voluntary HIV testing. That was at the very beginning when there was really nothing that could be offered to people who are positive, but we felt that it was important that people would have access to this information if they wanted to make their own decisions about risk behavior and so forth.

As therapies have developed, we've expanded the program and now are able to offer it to people who self-initiate it. If our medical staff feel that it might be an important piece of medical information, we will suggest it and if the person wants to have the test, then it is available to them. It's done with pretest counseling and post test counseling, and we have recently added some specific members of our staff who are specifically devoted to pre and post test HIV counseling.

The issue of confidentiality, though, is a big one here, and as much of a problem as that is on the outside, it's much more significant in a correctional facility, where it's really my opinion

that confidentiality cannot be assured. As you may be aware from the events of the last few days, it's an unsettled type of environment, there are multiple facilities where people are transferred from facility to facility and their medical records need to follow them from place to place. It's a situation where to maintain that sort of information in a confidential way is extremely difficult, and there are opportunities for breaching that confidentiality which do occur.

That I think is counterweighed by the necessity of having this information for providing a good level of medical care for the patient, so I think that it's worth accepting the risk that confidentiality may be problematic, especially given the fact that we really don't have any significant evidence of problems with people who have let other people know their HIV status. We have not been made aware of one group of inmates victimizing another group because they're positive, or of significant instances of correctional officers producing that sort of result.

It's certainly a concern, and we do everything that we can to maintain confidentiality

at the very highest level, but it's an important issue that we have to constantly fight about.

As Dr. Grossi mentioned, the number of tests that we have done have increased significantly recently, and we're making every effort to test people as necessary and to provide the appropriate medical services after we receive the results.

The issue of testing ties in directly, though, to the issue of housing and segregation and this is something that certainly has been an important issue in correctional facilities around the country. We do not have segregation based on HIV status, although some correctional health systems do. I know that California, for example, if someone is tested and found to be HIV positive, they're placed in a housing area or a group of housing areas which is solely for HIV positive patients. We don't do that in this system.

I don't think that there's a medical necessity to do it, and I think that it's not something that should be considered for any reason. I do feel, however, that some people with HIV disease require a higher level of medical care than

what we provided in general population, so that to house people based upon their medical needs in an infirmary setting I think is totally appropriate, and we do have a housing area on Rikers Island which is an infirmary where we have people with HIV-related conditions and are able to provide a higher level of nursing and medical care for people who require it, and I think in my opinion, that's the model that makes the most sense, and is least likely to produce difficulties with confidentiality, since obviously if there's an HIV housing area, everyone knows that everyone in this housing area is HIV positive and there's not even a pretense to confidentiality, and that's sort of a situation.

DR. OSBORNE: What do you do about active TB under those situations?

DR. BRASLOW: When we suspect active tuberculosis, we refer them to a municipal hospital for diagnosis, and initiation of treatment until they're not infectious. We do have a different infirmary, however, on Rikers, an infectious disease infirmary, which has currently been outfitted with the capability of housing people in

respiratory isolation and one of our other infirmaries also has a respiratory isolation facility with good air turnover and so forth where we warehouse suspicious cases.

In general, we feel that because of the setting of dormitories and ventilation problems within the jails, we would prefer, if we're suspicious of TB, to get them out of the jail until they're being treated.

The issue of provision of experimental and new therapies is one that we've grappled with as well. This is one that the inmate patients themselves are very interested in, and have initiated a lot of discussion about making new and experimental HIV-related therapies available to them.

As is frequently the case, the issue for us is somewhat complex, because there's a long history of abuse of correctional inmates as experimental subjects. In fact, there were drug companies who built special facilities inside of prisons around the country and used inmates as experimental subjects, which resulted in the development of federal guidelines restricting

fairly significantly the use of prison inmates as experimental subjects, and there's a prison in Michigan that has a building called the Upjohn building and Upjohn built it and they had drug trials there, it was a very nice facility, they provided better food than the general prison and there were big concerns about whether a situation like that could really result in the inmate giving his truly informed consent, because there was a real coersive element by the very nature of the services that would be provided for them if they did, quote, volunteer for these drug trials.

So there is a significant restriction on what you can do, and anything that you can do in a correctional facility has to really be shown to have a fairly good likelihood of directly benefitting patient or directly benefitting the class of incarcerated people, and depending on how you read the wording, it may or may not prohibit use of placebo based trials where there's a chance that some of the inmates may not be getting the drug, whereas other people are.

DR. ROGERS: Charlie, a suggestion. You're covering all the ground we want to know about. We

read a fair amount about it. I suggest you finish up fairly fast so the Commissioners can pop questions at all of you.

DR. BRASLOW: Certainly.

I'd like to say a few words about HIV transmission within correctional facilities. I hope that that does not play a large part in people's deliberations, because I think the general perception is that that's a major problem. I would just like to make the point that the same types of activities that transmit HIV infection occur in correctional facilities as they do outside of correctional facilities and I think our job should be to try to do what we can to prevent that. Toward that end, we do have a condom distribution program in our city jails. The inmates are allowed to carry up to three condoms.

This has been going on for about two years now and we have no evidence of any sort of security problem, which was the original correctional concern, and it's been a successful program as far as not causing problems, and I hope that it's been successful too in some instances of possibly reducing transmission.

We have a compassionate release program, where we can recommend to the Department of Corrections legal division the names of people who, with their consent, may have a limitation of their life expectancy based upon their HIV status, and we feel that that should be used in the deliberations of their case if the inmate wants that to happen, so we leave that up to the courts and we bring the medical information to their attention.

Specifically with relation to women inmates, we do have a lot of women. They are more highly infected than the men. Eight percent of them, approximately, are pregnant when they are admitted to the correctional facilities, so we do prenatal services where they are offered HIV testing if they would like it, and then there is the availability for them to make reproductive choices based upon that status.

We have mental health services, obviously, to adjunct our other services and provide a fairly thorough mental health evaluation for people who have difficulty dealing with their HIV-related problems or status while they're incarcerated.

And finally the whole issue of aftercare I think is a particularly problematic one. We have a very dynamic population with an average stay of only 45 days and as detainees we don't know when they're leaving the facility, so they'll go to court one day and never come back, leaving the system, so the ability to plug into aftercare services is very difficult. We're currently working on that, but I think it's one of the problems of 1990 in New York City where the entire medical system has been strained, and it's difficult to plug in people for care in general, and specifically for inmates it may be even more difficult, but I think that we recognize that as one of our problems and it's one that we're currently working on, because continuity of care when they're discharged I think is an important issue.

Those are what I consider to be the main issues that we've been dealing with. I haven't gone into any depth into the actual types of things that we do for HIV infected inmates. They're more or less what would be available on the outside.

We have about 150 people on AZT now. We

have about 40 people, 46 people I think currently on aerosolized Pentamidine. We do have respiratory isolation for people who might have respiratory disease, and I think are providing a good level of services in our facility. It's a shame that you didn't get a chance to come and see it on-site.

COMMISSIONER DALTON: Dr. Braslow, I was interested in the way you began your remarks by commenting on the nomenclature, penitentiary versus correctional facility.

My involvement first began in 1971 with the Attica Commission and that was shortly after there had been a change to correctional facility as nomenclature. The inmates naturally have a large number of terms for facilities, for guards, but for the deputy warden, the deputy superintendent of the facility, the inmates continue to call that person the "official keeper" which was the official language for the deputy warden in the 1970's and that to me captures a lot of language of what the institution is about.

I have a series of questions. The first has to do with testing.

Dr. Grossi, where do tests take place,

assuming an inmate self selects or is recommended for testing?

DR. GROSSI: Well, they take place in the medical clinic setting where the physician draws blood following precounseling, and the bloods are then sent to the Department of Health laboratories on First Avenue where they are run and results come back to the individual institutions.

COMMISSIONER DALTON: So when later Dr. Braslow characterized that as confidential, it certainly couldn't be anonymous, given that structure. It's confidential, meaning that the record of the HIV test is segregated from other medical records?

DR. GROSSI: It is handled in a confidential way, in that the last slip that is made out for that test that accompanies that blood specimen is just numbered, it does not have the name of the individual, of the individual inmate.

Also, I must say in terms of anonymous testing, part of the precounseling includes, particularly for detainees who might be going out in a very short period of time, the availability of anonymous testing on the outside and how they can

get it.

COMMISSIONER DALTON: I was going to ask you indeed if there was an option to Corrections Department testing. The option is once they're released, they're advised of the availability of anonymous testing.

DR. GROSSI: Right.

COMMISSIONER DALTON: The numbered lab slip, does that go into the inmate's medical file?

DR. GROSSI: Yes the number goes there, it goes to the last slip, and Charlie, does it then go on your log? I think each jail has a slightly different system of handling this.

DR. BRASLOW: When the blood is drawn initially we put the number in the chart, in the progress notes. When it comes back, we don't--we have not been putting the slip itself in the chart, but have maintained a central group of the slips with only the numbers on them, where the practitioners who have been prescreened as appropriate people for obtaining these results, they've undergone the appropriate training, can call and get those results.

It's an attempt to try to keep as little

in the chart as possible. It's something that we've talked about a lot. In fact, I've just been asked to reissue what our guidelines are as far as charting. We have to balance the necessity for medical practitioners to know the HIV status in order to manage the case with the desire to maintain as much confidentiality as possible.

COMMISSIONER DALTON: I take it, though, as a minimum the chart reflects the inmate has been tested, it may not reflect the test results?

DR. BRASLOW: That's correct.

DR. GROSSI: However, at some other facilities it might be done differently.

I just want to introduce Dr. Wallace Rooney, who is the medical director for prison health services and, Dr. Rooney, maybe you would want to say how it is handled in the borough houses?

DR. ROONEY: Yes, good morning. My name is Dr. Rooney, I'm medical director of prison health, Bureau of Prison Health, Department of Health, and in December of 1987, we began what we called a medically confidential voluntary HIV antibody testing system. As Dr. Grossi mentioned,

the actual test is done in the Bureau of Labs here on First Avenue.

We've progressed really very slowly with this. There was a question of confidentiality in pre and post test counseling in our individual clinics with the inmates, so that other people weren't hearing what was going on, namely, officers, and initially, we began with a selected list of M.D.'s who were privy to the test results, and the inmate who was tested was given the test number. He would then return to the clinic some one to two weeks later, if he was still with us; he would present that number; one of our selected physicians would phone the lab, would get the numbered result back and communicate it orally to that individual.

Should the individual have been released from the correctional system, he was to go to a very specific health clinic here in lower Manhattan where he would present that number and go through that process.

We met considerable difficulty and delay with this, as the number of tests increased. Where it was all right when there were two or three

tests, but when we started getting five, ten, fifteen, twenty tests a day, in conjunction with which, no matter how you phrase it, somewhere that physician has to pretty much mention in that chart what the test result was, and there was also a strong feeling on the part of practicing physicians, look, I need to know the test result when I look at this chart as to how will I treat this positive PPD, how will I treat this sore throat?

So we have finally come to the stage now where we no longer have the test results being transmitted by phone, but we get an actual hard copy of the test result without the inmate's name on it, just his number, from the Bureau of Labs sent in a sealed package addressed to the physician in charge of each facility.

At this point now, that lab test result, that written copy, actually goes into the patient's chart, and we consider the entire medical record as a medically confidential document, and we do all in our power to keep persons who are not authorized to view the entire document from getting access to it.

One of the difficulties, of course, is

that in our system we have some 20 different facilities, inmates are constantly being transferred from one to another. Each time the inmate is transferred, he's accompanied by this medical chart. Corrections Department takes the charts with the inmates when they move them from one facility to another.

There are various methods of sealing that medical document right now to know whether someone has gotten in there and looked at it, and frankly, that doesn't occur very much.

So to answer your question very briefly, yes, we have a hard copy of the lab report in the chart, we consider the entire chart a medically confidential document, we do all in our power to keep that entire chart confidential. We feel that it's necessary to mention the test result in that chart so that the next practitioner will be privy to that information.

COMMISSIONER DALTON: Thank you.

Dr. Grossi, in addition to the appearance in the medical chart of either the fact of testing or the test results, does that information appear anywhere else in the inmate's

files? Is it sent to the parole--I guess it wouldn't be parole, but in the case of somebody sentenced--well, I guess to probation, would it be sent to probation authorities? Would it be anywhere other than the medical records?

DR. GROSSI: I guess that comes down to the discharge summary when inmates, for example, are being sent upstate, Charlie. Do you want to address that?

DR. BRASLOW: They are not sent to anyone other than medical providers. We do a discharge summary from one medical provider to another. If they are subpoenaed, then the medical records can be subpoenaed, as can all medical records, but we have not been requested to send them to the parole board and that sort of thing.

COMMISSIONER DALTON: Dr. Braslow, you mentioned that in addition to self initiator testing, there is also a practice of essentially recommended testing by medical personnel, is that correct?

DR. BRASLOW: If we saw somebody who medically, this might be an important piece of medical information, we would ask--we would suggest

that the patient have the test. We would say that this was information that we thought was medically helpful, and then the person would receive the same sort of counseling that he would receive otherwise.

COMMISSIONER DALTON: You indicated that you thought it was worth taking the risk that confidentiality would be breached because of the availability of therapies.

DR. BRASLOW: Yes.

COMMISSIONER DALTON: But I take it that's still the inmate's choice to decide?

DR. BRASLOW: Absolutely, and they have to sign consent and so forth.

COMMISSIONER DALTON: When you say the availability of therapies, you also indicated that there's a difficulty in the prison system in terms of making experimental therapies available to inmates, given the problems with the code of federal regulations, et cetera, et cetera, so when you say that available therapies in some ways alters the balance, the desirability of testing or the appropriateness of taking the risk of confidentiality being breached, what therapies are you talking about?

DR. BRASLOW: I'm saying AZT, we wouldn't want to start somebody on AZT unless they were positive.

DR. BELLIN: It goes beyond that, if I could go on. When a person comes back HIV positive he's immediately given a pneumovax vaccination to prevent pneumococcal pneumonia. He's also instructed about influenza in the appropriate season and given vaccination as well. We've been offering for a good deal of time now, for T cells less than 500, AZT to prevent the progression of disease, and we follow the patient very closely on a three month interval. If T cell counts continue to drop, we decide on prophylaxis.

It's part of an educational effort that begins from the moment of HIV positivity. So the therapies that are available, even conventional therapies, which I think are being alluded to here, are significant and we have a very proactive program in place right now.

COMMISSIONER DALTON: That's helpful.

One final question, and I'll let David get in.

Dr. Grossi, you mentioned with respect

to the seroprevalence program, you said "of course it went to our IRB," the "our" being the Department of Corrections or being Montefiore? Who sits on this IRB?

DR. GROSSI: The Health Department has its own IRB as does Montefiore. A study like this would have to go through our IRB because we were doing the study, our laboratories and our AIDS bureau people.

I want to correct what I think happened to that one, also. I believe it also went through Montefiore's IRB, the seroprevalence study.

DR. BRASLOW: I'm not sure whether it did or not.

DR. GROSSI: I think it did, but we're not sure, is where we're going to leave it.

COMMISSIONER DALTON: Who sits on your IRB?

DR. GROSSI: I chair it. However, at that time, that was a few years ago, it happened to be a combined medical health research association of New York, MHRA/Department of Health IRB. The Department of Health now has it's own IRB, and a number of people in the department sit on it. I'm

designated as the chairperson, and there are a number of outside people who sit on it as well.

DR. BRASLOW: There are people who have, as Dr. Grossi does, interest in inmate concerns who are on the IRB, as the federal guidelines say it has to be passed by an IRB with either an inmate representative or somebody representing inmate interests.

DR. GROSSI: Yes, and that occurred at that time. If we currently had proposed any research, have any proposed research involving inmates, we would have to call somebody in who would have to fit into that category to fulfill the requirement of the guidelines.

COMMISSIONER DALTON: Who would be the inmate representative for that? Would it be, for example, the Prisoners' Rights Society?

DR. GROSSI: We would select somebody that was mutually agreeable to the members of the IRB or the Commissioner or both.

DR. BELLIN: At Montefiore Medical Center, Nancy Dubler serves that program, so any program we initiate we pass through to the IRB, and then pass it on to the Department of Health IRB.

DR. ROGERS: Let me preface my question by saying I much admired what Montefiore has done there, it's been an impressive program, but a couple of tough questions.

At least until recently you lived half as long if you had the misfortune of being a prisoner with AIDS vis a vis outside, and I've been startled and concerned by the 30 percent diagnosis only at autopsy, which suggested the system was missing a hell of a lot of people.

DR. BRASLOW: I think those numbers are from the State system. I'm not sure you have comparable numbers from the City system.

DR. ROGERS: Are you doing better?

DR. BRASLOW: We don't have as many people die, because we don't have nearly as long term a facility. I don't know the number, the comparable numbers for our system.

DR. BELLIN: I think there are two issues here: First of all, there's a larger question of are we adequately detecting HIV disease, and the answer to that is no, and that's absolutely true. We have a grossly inadequate number of people being tested, we have a grossly

inadequate resource for achieving that, but we have significantly increased that from before.

One has to recognize that there are competing interests here. One has to deliver care to the people you find, and you also have to be able to find new people, and it is unconscionable to just label people, to go out and test people for the purpose of stigmatizing them, as Dr. Braslow pointed out, unless you can deliver the care. So our efforts have been directed towards developing adequate care for the people we find and then expand our capacity to find new people in order to deliver the care.

To answer the specific question that you addressed earlier, the mortality studies that you referred to are much older data. We have our own experience with our own HIV patients, specifically the AIDS dormitory that we care for. We have kept people alive way beyond their life table, people who have had both pneumocystis, both cryptococcal meningitis, with total renal shutdown, and we were using at that time compassional release, experimental agents; Fluconazole, which is now a recognized treatment and aerosol Pentamidine, which

is a recognized treatment.

I was surprised when we did this, we kept people alive far longer than any of the literature said we could, and the only time they went on to die was when they were released on the compassionate program and stopped therapy.

So we are making ground in keeping patients alive, but you can only increase your capability to deliver patients if you have the infrastructure of care, and that's what the Department of Health has been working with us in terms of the ability to deliver care as well as to identify new people.

DR. GROSSI: I think there's something you should add, which I don't think you mentioned Charlie, and that was the Goldwater unit. Inmates who are in the infirmary and who are too ill for infirmary level care, but not sick enough to need acute patient care, it's quite often those who are ready to be dismissed from an HHC facility and are, quote, really ready to die with AIDS, and a SNF level of care unit is needed for in between, and about three years ago, Charlie, I believe, the unit at Goldwater was established.

That's Goldwater Memorial Hospital, under the auspices of the Health and Hospitals Corporation, and there is now a six bed unit there, and it's at most times filled partly by inmates that will transfer from the infirmary and partly--with AIDS of course, all with AIDS, and partly inmates who will be transferred from the HHC facilities.

DR. BRASLOW: Right, I think it's been an important place for people who have significantly advanced disease who are not considered to be eligible for acute admission to a hospital, but who if they remained in our facility are extremely disturbing to the other inmates, and that's been a valuable resource.

DR. OSBORNE: Eunice Diaz.

COMMISSIONER DIAZ: Maybe I missed it, but I don't know if any of the speakers mentioned if there were conjugal visits at any of the facilities permitted?

DR. BRASLOW: Not in the city jails.

COMMISSIONER DIAZ: Is there any kind of educational program or outreach for the families of HIV impacted prisoners that are going to be

released, so that the families or extended others within the settings that they go back to really know how to deal with this within their environment?

DR. BRASLOW: We do not have any programs that extend beyond discharge. We have tried to set up some pilot programs that have involved families and have found it to be not related to HIV in particular, but in terms of other sorts, mental health type problems, which has been extremely difficult to set up and we really haven't been successful.

What I'd really like to do is give Nick Freudenberg, who has been involved in several of our HIV educational initiatives to say a few words about what he's done with us at Hunter College.

MR. FREUDENBERG: Had you finished your questions?

I'd like to briefly talk from two different points of view. First, I'd like to outline what I think some of the elements of a comprehensive AIDS prevention program in a correctional setting need to be and then describe briefly some of the--a particular project we've

been work on at Rikers Island, and I really want to echo Charlie's opening comment that I think the prison population presents extraordinary both opportunities and challenges for AIDS prevention work, that in New York City here are 120,000 people who are at highest risk of HIV infection, and to develop programs that could provide in population, which is not being reached by other programs with the knowledge and the skills and the support to begin to make changes in behavior could have a dramatic effect, not only on that population, but on the population of New York City as a whole.

And I think a really critical task for public health people, correctional people and AIDS organizations, is to work to define a standard of care and services in correctional settings, so that AIDS prevention and AIDS education becomes part of medical care, and I think the fact that there's a constitutional right to medical care, and the fact that AIDS education and AIDS prevention services are really the key element for preventing the spread of AIDS, means that we have to say that failure to provide comprehensive AIDS prevention constitutes deliberate indifference to the medical

needs of this population.

In outlining the elements for comprehensive AIDS program, I'm basing it both on the work that I do at Rikers Island and also I've served as an expert witness in court cases in Alabama and Connecticut and reviewed their AIDS prevention programs in their settings.

I think first of all a comprehensive AIDS program has to include a mandatory program for all inmates into the system where they get information about AIDS and orientation to the services available both in the correctional system and outside the correctional system. In most cases, I wouldn't support mandatory education, but I think in a prison setting it's particularly important because of the danger of stigmatization if people have to step forward for AIDS education. I think in a prison setting where the potential for discrimination of people who are identified as being gay or being drug users or being concerned about those things are so great that there has to be some common level that everyone is provided with.

Second, I think there needs to be

mandatory education for all correctional staff and all health staff working in correctional settings, and they can really make the difference between a program working and not working by either reinforcing or subverting the attitudes. In Alabama, for example, which has a segregation facility for people with HIV, the corrections guards would go in wearing masks and gloves, and that undercuts any educational program that tells people that it's not a casually contageous disease.

I think all inmates need to have the opportunity to request confidential counseling and testing, and that service needs to be accessible and confidential, and I think at Rikers they're moving in that direction. The addition of staff will make it in fact available to people who request it.

Inmates should have the opportunity to participate in ongoing groups that provide information and support about risk reduction. I think if we look at what we've learned from a decade of AIDS education experience we know that superficial interventions in general don't work, information alone doesn't work and I think that's

particularly true in the prison setting, and I think it's even more an issue in the jail setting where there's a short-term stay, so I think our interventions need to be much more intensive than they generally have been and there need to be ongoing opportunities for people to participate.

I think that peer educators can play a very important role in prison programs. That's difficult in a jail setting where people usually aren't there enough, but not impossible and recently released inmates I think could play a strong role.

I think prison officials need to create a social environment that supports prevention and I think this is both very difficult but very important. Drug treatment needs to be available to those who want it. For someone to come into prison with a drug problem and want to get help and not be able to have it just doesn't make sense and it seems to me that this is a setting where we really need to be putting efforts to expand the capacity and I think the effort makes a difference in terms of recidivism and so forth, so it's a good place to put drug treatment resources.

Condoms need to be available. There need to be affirmative programs to prevent sexual violence within the prison system, and as Charlie has described, I think determined efforts to treat syphilis, tuberculosis and other infectious diseases will make sure by the time anyone leaves prison and had risk factors that something could be done about that it's taken care of.

Inmates need to learn skills that will protect them against infection both inside and outside the system. The condom distribution is a controversial one and New York City is sort of in the middle of places that have developed other policies. In the system in New York City, inmates need to request, as I understand it, a visit to the medical service in order to get a condom. That's a big obstacle. Better than they can get them and from our discussion with inmates, there's an ilicit market for Saran Wrap, baggies and so forth, and I think that's an indication that people want to protect themselves, but don't always want to identify themselves and tell the guards and identify themselves as someone who engages in same sex behavior.

Prevention needs to be linked with social services with regard to inmates and AIDS. Nowhere is it clearer that the links between prevention and treatment than in a correctional system. Unless you educate people in the general population of inmates about how HIV is and is not transmitted, you will not be able to put HIV infected inmates in the general population and have them be able to talk about it. If you have an atmosphere, and again, I agree with Charlie there's been good progress in Rikers in reducing fear and hysteria, if you have an atmosphere where people know about how the disease is transmitted, then you don't need to segregate inmates.

If you don't have that, and again as in Alabama, you have guards going in with gloves and masks, you have a situation where you have to do what you say is done.

I think prisoners and inmates need to be included in planning and implementing AIDS prevention programs and they can play a critical role. I don't know how much you've done other work in looking at correctional AIDS programs, but I would strongly encourage you if you haven't to talk

to some inmates who are involved. There's a program at Bedford Hills women's prison and there are other programs and I found inmates who spent some time working in AIDS prevention programs are extraordinarily knowledgeable and skilled in understanding the obstacles.

AIDS prevention programs need to be developed for all institutions within the correctional system, particularly jails and police lockups which reach a large number of people who aren't reached by other programs and move out quickly. But in addition, probation programs, halfway houses, parole programs, and only I think by having a comprehensive system where each inmate at several points in the system gets information and knowledge and support can we hope that by the time people get out, they'll have what they need.

I think a prerelease counseling session is a critical component of comprehensive program.

And, finally, I think there needs to be much more effort on the part of AIDS organizations, prison health officials, correctional departments to work together. I think there are limits to what a correctional system or even a prison health

service can do, and I think Rikers has a lot of people, a lot of organizations working there, and I think that really adds to the programs.

I think there are then problems of coordination, but I think having advocacy groups and AIDS organizations come in, that they have a credibility and a level of experience working with AIDS which is not always the case for people who work inside the system. And I've outlined some of these things and will make them available with people.

I want to just spend a couple of minutes talking about a problem we've spent the last year working on, which we call the AIDS empowerment program. This is a program we've developed a curriculum for women in the House of Detention. It's a program designed to have women feel more confident about their ability to take action to protect themselves against HIV, and we've attempted to address some of the particular obstacles in this setting.

From our pre-intervention interviews, we found that 44 percent of these women report they rarely or never use condoms, 38 percent report that

they've shared needles, 28 percent report having sex when they don't want to, 77 percent report using drugs often or sometimes to get away from their problems. Interestingly, and I think this is in general a problem in New York City, but particularly in prison, 70 percent believe that crack use is not a risk factor for AIDS HIV, and I think we need to do a much better job talking about the link between crack and HIV to have people understand.

A lot of people feel that unless they shoot drugs, they don't need to worry. And 28 percent of the women we talked to say that they often or sometimes feel there's not much they can do to protect themselves against AIDS, and it's really that feeling we've tried to address.

We've put together an intervention in which there are five sessions, each on key topics that came up in our interviews. They include coping with life at Rikers, drugs and your health, drugs and addiction, sex, sexuality and relationships and self esteem and negotiation skills. Each session is two hours long. We spend ten hours with a group of eight to ten women.

We've had very good cooperation with the Department of Corrections in getting the same group together and we do one session a day for a week, so even people who are there for only a week or two were able to reach women over that time period. We've just finished this about a nine month cycle of groups and are in the process of evaluating changes in knowledge, attitudes and intended behavior, and we'll be producing a curriculum that we then hope to train other staff at Rikers, including people on the corrections side and people who work in volunteer programs at Rikers to use with other populations and in other settings.

DR. OSBORNE: Thanks. Don? Larry, did you have a question before?

COMMISSIONER KESSLER: Yes, I had a couple of questions around the condom issue.

Dr. Braslow said that inmates can ask for up to three condoms at a time. Do you have any figures on how many ask, how many carry them, for what period of time and how many are actually using them and for what purposes?

DR. BRASLOW: Well, we really don't feel that it's productive to do a lot of asking about

that, so I really don't have the answer to those questions.

As Nick mentioned, the system for giving out condoms requires a visit to the medical provider. You don't have to tell the guard you want a condom. I don't want what you said to leave that impression. You have to sign up for the sick hall procedure and you go and see a medical practitioner and in the privacy of a medical transaction you can ask for a condom, so there really should be no reason why the correctional staff should know that.

As a result, though, of having to access them through the medical care system, I think that we have given out many fewer than if they were more widely available, if they were available in the commissary or through other non-medical ways.

Getting the condoms at all was a compromise on the part of the Department of Corrections. There is a great deal of resistance to the idea, because it seems in their minds to sanction the idea of sexual activity, which is supposed to be prohibited, and I think it was a victory of Dr. Joseph that he was able to negotiate

the system that we currently have with the Correctional Commissioner at that time, but it had to be done under a medical model, because that gave it the imprimatur of being a medical situation, which made it more palatable.

In the future, I think we should continue to make efforts to expand the availability to non-medical settings, but at current times, that's not the case.

COMMISSIONER KESSLER: Do you have any anecdotal evidence that it increases sexual activity?

DR. BRASLOW: None.

COMMISSIONER KESSLER: What about women? Is there any availability of dental dams?

DR. BRASLOW: There is not currently. It's been brought to us as an issue, and I think that it's something we need to work on, but it's not currently available.

COMMISSIONER KESSLER: And the final question, in terms of the guards' anxiety about condoms being used as ways to smuggle in drugs or as a weapon to choke someone, so on, has that anxiety died down because over time they simply

haven't been used for that purpose?

DR. BRASLOW: Well, I think that--I think the answer to that is yes. We don't hear those sorts of concerns expressed any more. They were expressed prior to instituting the availability of condoms at all.

Since they were available, I have not heard of any incident of the sort that you're describing, and therefore I think that there is less of an argument to resist expansion of the condom availabilities beyond what the current situation is, so that I think that we've got a program now that seems to have worked and I think allayed some fears, and I would hope that in the future that this would result in an increased availability.

DR. GROSSI: Could I just add something to that?

Charlie, as I recall when we originally designed the program to address the fears of Corrections, that maybe they would be used for contraband, et cetera, one of the requirements was that it would be a unique condom, which turned out--they were initially striped and now are pink?

DR. BRASLOW: Yes. They wanted to be able to distinguish between condoms that we have given out from from ones that might be used to smuggle drugs in from visitors and so forth, and they wanted them to be identifiable.

DR. GROSSI: And we do not know of any incident in which the unique condom has been found?

DR. ROONEY: Yes, may I add some background to this? Only a few weeks ago, I met with the new chief of operations for our corrections department, the head of their uniformed division, the group of people who would most look into this situation to try to keep condoms out of the facilities.

The ostensible purpose of the meeting was to expand the distribution of condoms to our mental health unit. Up to now we've only been distributing condoms to people in general population, plus a particular section that I won't go into, a homosexual housing area out at C95. That was the first place we began to distribute condoms.

But to go back a little bit, what we did was to prove to Corrections that sexual intercourse

did take place in a correctional setting by proving to them a substantial number of cases of acquired gonnorhea, oral, urethral and rectal. We proved that this activity does take place in a correctional setting. They recognized it grudgingly.

There's tremendous fear that it would increase the number of attacks and harrassment that would go on. None of that has shown up as late as the conversations I had two weeks ago with their operations division, and I asked them very specifically, were there any increased episodes of sexual attacks, fights, illicit use of condoms for other purposes, and Corrections could cite no increase whatsoever.

No, what we do, quite frankly, in distributing the condoms, which are by our correctional department ordered not uniquely identifiable, when you go back and look at the order, we can distribute any color condom we want--

DR. GROSSI: But the agreement I think was--

DR. ROONEY: The oral agreement, but the written order specifies that it needs to be in a

sealed container. The order reads that no inmate may have more than three condoms in his possession at any one time and they must be in their original sealed container.

Now, the inmate may come to any of our medical clinics, and in most of our medical clinics what we have is a bowl on the doctor's desk with a number of condoms in them. If the inmate wants some condoms, he may take one, two, three, he may take, frankly, as many as he wants, because how much he has in his possession is between himself and the Correction Department. So we keep no running account of how many condoms we distribute to any particular inmate or group of inmates, but I'll say over all, through our supply disposition, that we have--I wouldn't say--we're dealing now in almost thousands in our system.

COMMISSIONER AHRENS: Per what?

DR. ROONEY: I think thus far this year as many as 2,000. Now, a number of these I think find their way into the hands of the corrections officers themselves. In addition to which we put three condoms into a discharge packet of information that we give to each prisoner, so when

he goes for his property, he also gets a sealed envelope which gives him certain written material in Spanish and English about AIDS, about condoms, common use and three condoms, so I include that number.

But it's really a very simple, low key process. Bowl of condoms on a desk. At this point they really don't have to be uniquely identifiable. Inmate comes in, he wants them, he takes them.

COMMISSIONER KESSLER: I assume that there is not a supply of proper water based lubricant available?

DR. ROONEY: Now we have somewhat of a technical question. Let me go back to the uniquely identifiable condom, and the many subcommittees that developed on the size, shape, color of condoms, and where we were going to purchase them.

To my recollection, there is one firm in the south that produces two types of condoms. The first one we purchased turned out to be not that satisfactory, it didn't pass certain tests, but the condom we're purchasing now is not oil based, but there is a lubricant. I don't know the technical details, but I do know that according to consumer

report, it's one of the first or second best ones in the country being manufactured, safest.

COMMISSIONER KESSLER: Is there also literature available in terms of the proper use of condoms?

DR. ROONEY: Well, yes. What we are pushing for, really, in each of our facilities, we have a cap program of AIDS educators that go in on a scheduled basis, and have educational programs, sessions with inmates, at which time they go into how to use a condom, purpose of the condom and distribute material.

We are pushing for having those AIDS educators also being able to dispense the condoms the way we do in a medical clinic now, but again I must harken upon the fact that the fears the corrections staff had, that it would increase fights, increase assaults, that they would be jammed into locks and so on. None of that has happened, and believe me, the correction department was looking for it, and they haven't found it in about two years.

COMMISSIONER KESSLER: I congratulate you all, because it seems that just watching you,

you can even talk about condoms without squirming. In some parts of this country, people won't even say the "C" word.

DR. BRASLOW: We're bored at this point.

COMMISSIONER DeJARLAIS: I've also been struck by the in depth discussion of drug use in prison. There are certainly certain studies from other cities indicating that prisons are wonderful places for transmitting the virus among drug injectors, across geographic subdivisions within a city.

What's happening on this issue in Rikers? Is there anything being done? Is it not discussable? What really is the current situation?

DR. BRASLOW: We have specific programs related to drug problems. We have methadone detoxification to people who are addicted to opiates when they're admitted and we also have a State Department of Substance Abuse services funded program called the KEEP program, which allows us to maintain people on methadone while they're incarcerated and then directly refer them to an evaluation point in the community to determine the appropriate long-term treatment for their drug

addiction, which I think is able to circumvent some of the delays in getting people drug treatment which has occurred in the city.

As far as anything specifically related to reducing transmission within the facilities from that route, perhaps Dr. Grossi--there is nothing currently. I would certainly think that the availability of solutions that could clean apparatus infected with blood would be something that could potentially do that.

DR. BELLIN: I think this also harks to the whole issue of education. There are manners of spread of disease within a prison that is not the usual routes. Obviously, sexual activity, IV drug use is one way.

Other ways include spitback methadone, which is a way of gaining currency within a prison facility where a person basically regurgitates the methadone they've taken in and therefore effectively transmits hepatitis and other such things that day. There's also tatooing that goes on in the prison, which during my attending rounds at the communicable disease unit the inmates are very ingenious at finding ways of finding pigment

and of tatooing each other.

There are many different issues here that really need significant education within the prison with people who are sensitive to the issues that are unique to this environment, and some of the issues that Nick was dealing with are very important and have to be worked on.

COMMISSIONER S. ALLEN: I'm not sure if I heard you correctly, Charlie, if the education of the guards is not part of your shop? Is that correct?

DR. BRASLOW: That's correct. The Department of Corrections provides their own educational efforts for the correction officers and I think Margaret may have said--do your Department of Health educators also do that?

DR. GROSSI: Yes.

DR. BRASLOW: Our services are primarily inmate related.

COMMISSIONER S. ALLEN: Is that effective? Has it alleviated the fears and so forth?

DR. GROSSI: It's been consistent and ongoing for a number of years. I think we have to

say it's effective, although there haven't been any measures of that, but I think the Grossi measurement is things that Charlie referred to in terms of attitude on the part of correctional officers. They definitely have calmed down over what I heard what, say, three years ago, Charlie, when they were all very, very uptight about HIV. I don't hear that any more.

DR. BRASLOW: At one point there was separate transportation of inmates who were known to have HIV infected status, they were using special types of handcuffs that could be disposable and all that has gone beside the board.

DR. GROSSI: They were even suiting up on both sides, both corrections and in the HHC facilities, when a so-called AIDS patient was brought in for a specialty clinic visit or an inpatient admission to the hospital, all of that has long since passed.

COMMISSIONER S. ALLEN: What happens if a guard is exposed to blood? How do you proceed there? Blood to blood, I mean, not--

DR. BRASLOW: The Department of Correction has its own health management division

which is responsible for the health of the correctional employees. So that if they were exposed to blood, they would have to get their advice from that division, and I really don't know what their policy is.

For our purposes, we have Montefiore employee health policies related to our staff who have exposures to blood, and that's obviously a constantly evolving situation, and also gets into a lot of issues of what you can do as far as obtaining HIV-related information about the source of the blood exposure, and it's our feeling that that should be something that the source controls, whether access to that information is obtainable.

COMMISSIONER S. ALLEN: One more question on the families. Eunice brought it up about the HIV positive, I was concerned about confidentiality to families, but do you have any basic education to the families that come to visit? Is there some type of information there for all individuals in the process of--that's a wonderful target.

DR. BRASLOW: We really don't have any programs specifically devoted to the families.

They do come in and visit, and it would probably be a good place to provide handouts and so forth. I will give that some thought.

What we have had to do when we've had outbreaks of viral exanthems, we've had measles and rubella outbreaks where we've had to provide information to the families to make sure pregnant women weren't being exposed, which was done in the visiting area, but as yet we haven't done anything in the way of HIV materials for those people.

COMMISSIONER S. ALLEN: And there's a potential, as Harlan just mentioned, of a video for people waiting to utilize, hopefully different languages and so forth.

DR. BELLIN: I think your question is really right on the money. You're beginning to see the prison as being a real public health asset, you're talking about educating families, outreach for tuberculosis and syphilis and the rest, those are excellent questions that are really right on the money.

But as you also can see, there's really no functional provision for that in terms of the institution. We have institutional care for the

inmates, we have the corrections officers covered as well, but there has never been this proactive public health view of the prison as you're describing it. That may be one of the major contributions that you can give to redefine the prison that sees 120,000 admissions that touches so many lives of so many poor people of being the entry point of so many other interventions.

MS. WISHART: I'd like to add something here in terms of doing something for visitors. I think it's important to remember that by the time people get there, it's taken them a long time, hours of waiting for the buses, waiting in the heat, a long ride, so anything you need to present needs to be really good, not some home made video, because they're used to very sophisticated level on television and they're certainly not going to look at them unless they're really great.

MR. FREUDENBERG: Just an anecdote. There's a bus that goes from Rikers to Manhattan, Q101 and I've had students go out to do AIDS education projects on the bus, going out with family members and they've been warmly received, and it illustrates the potential for reaching

people.

COMMISSIONER DALTON: I must say when you mentioned home made video, it makes it quite apparent you do need a professional production.

I think I'm going to switch to first names here, since my first name was mentioned, and Nick, I appreciate you laying out the elements of a comprehensive AIDS program, I think that will be very useful for us, we may need to debate it, but I wouldn't mind taking word-for-word what you laid out.

I would also like to say thanks to Eran for his remarks. Earlier in response to the question of what kinds of therapy do you in fact make available, I thought you gave a very good primer on what ought to be available and what I take it Montefiore makes available, and if you could--that's in the record, but if you have something you want to add to that, that would be really very helpful.

DR. BELLIN: You mean add in general care? One thing I didn't mention was in addition to the direct delivery of blood tests and immunizations that are initially done, we also

review the record. As you know, the standard for positive skin tests in tuberculosis is 5 millimeters in someone who's HIV positive. The standard for prophylaxis is obviously much more aggressive in people, so we also ask our practitioners to review the chart to see whether the reaction to TB was 5 millimeters or not, and to go over the history.

If they had a history of positive skin test, we will treat. With syphilis, we go over that history, because as physicians, we realize at this point the disease progresses more aggressively and you have to proceed more aggressively as well. That's a basic level of care that we would expect.

One of the issues that Charlie brought up is that there are a number of questions we don't know what to do with right now. We have a large Hispanic population, I use the term advisedly, I don't know exactly what it means, but it seems to serve in conversations. There's a very high toxo titer, for example, toxoplasmosis is a common infection and no one has the foggiest notion of what to do with these people; whether we should be prophylaxising them against toxoplasmosis or not.

I think we're fortunate today because it seems to indicate you will not until the T cell counts fall blow 100, and although we perceive ourselves being in the AIDS epidemic forever, it's really not forever and I think we're going to begin to see this population mature over this lower range over the next two or three years. We need to actively find solutions to public health interventions for this population that is not generally dealt with in the other environments.

Another classic issue that we've been agonizing over is the whole issue of immunizing full blown AIDS patients. Clearly, the CDC has recommended that HIV positive children can be immunized but full blown AIDS; should you or should you not. We have done our best not to immunize full blown AIDS patients and try to isolate them when we've had these outbreaks, but there are very specific clinical questions that we don't have the answers to that unfortunately we also happen to be in the best position to answer if we could get around the--that's a bad term, I don't want to use that, the inhibitions that have legitimately been placed in the past.

There are ranges of opinion on this, but I'm a strong believer that in situations where there is no therapy known, legitimately known therapy known, that a placebo based trial might actually be reasonable and in something like a prophylaxis for toxoplasmosis where we have this large population of high reactors and we don't know what to do with them, we process so many people, this might in fact be the environment to treat half with the a prophylaxis and half with not and give them followup care.

That may be a radical notion. These are people who are not going to be seen otherwise, be completely uncounted, and I'm convinced we're going to see real morbidity here. I'm not talking about things that are not proven, but there are lots of areas where things are not known and these are not people who come to the clinical trials. That's just another issue.

COMMISSIONER DALTON: That latter issue we're going to get into tomorrow afternoon, and I agree it's important.

DR. BELLIN: It's not just of the sexy drugs, we're talking about the non-sexy preventable

drug approach which needs large scale involvement which I don't think the large scale academic medical centers are set up to produce. I think areas such as we are might be more ready to do that.

COMMISSIONER DALTON: Charlie, I heard your caution that we not get hung up thinking and talking about how HIV is transmitted in prisons, you indicated it's transmitted the same way as elsewhere, although there are additional ways to think about focusing on the reasons.

I think we have to focus on this, because the general public impression that sex in prison is largely forcible rape. Even when there's that perception, you get peculiar notions, like you shouldn't distribute condoms because that would encourage rape. That's bizarre, because I take it a rapist wouldn't stop to put on a condom, nor primarily be at risk, being the inserter rather than--so I think there's some advantage to be gained about talking about sex within prisons, giving out accurate information, being able to talk about it comfortably.

I want to ask you whether you're--I

assume you're familiar with Cathy Potler's report which indicates that most prison sex is consentual, assuming that has any meaning in the context of a prison, and I was curious about what your understanding is in the jails that you administer.

DR. BRASLOW: Well, I think that we have very limited knowledge of this issue, because we really only see the results of sexual activity in terms of sexually transmitted diseases, whereas Dr. Rooney mentioned we have been able to show transmission of gonorrhea within a correctional facility, which is evidence that something occurred.

The only thing we would see would be a forcible incident which required medical care where the person was willing to come forward and talk about it. That happens extremely rarely. It's very rare that an inmate will come to the clinic and say, "I've been raped." I think it's too weak, though, to say that most sex is totally consentual. I think a lot of it is coersive, but not physically violent, so that even coersive sex, which is based upon a power relationship where one partner may not want to be involved, still might be a setting where

a condom could be used and where it could be, the availability of condoms could be helpful.

I think it's something about which we don't know a great deal and some sort of better studies going on looking for that sort of thing might be very helpful. It's something that the correctional hierarchy I think is very resistant to.

MR. FREUDENBERG: I think we also assume that it's only inmate-inmate sex we're talking about, but there's a commerce in everything at Rikers, as in other prisons, and I think we need to talk about correctional staff and inmate, both male-male and male-female. From our discussions with women at Rikers, that's a problem, and our comments, it might not be the traditional definition of forcible rape, but when there's a trade of some kind there's a level of coersion there.

COMMISSIONER DALTON: I have another question. There was a vague reference in Dr. Grossi's opening remarks to a special unit. I take it that's the gay unit that Dr. Rooney mentioned.

Are condoms freely available in that

unit? Is that because there's an assumption that gay inmates have sex, but people who are essentially straight on the outside don't? What's the logic for having condoms available in the gay dorm but not elsewhere?

DR. BRASLOW: Number one, there is a housing area that is called the homosexual housing area. It is only, it only houses people who request to be housed there, so it's not something that the person is forced to be housed there against their will. They know its exists and they ask to go into it when they come in, and they ask to go there, because I think that the inmates feel more secure there, and feel less likely to have predatory activity occur.

The answer to your second question, I think that condoms are more available there, because we make rounds in that area on a daily basis, and dispense condoms to people in the housing area who ask for it, which makes it easier for them to get it than if they came to the clinic, and I think that the presumption behind that would be that they were more likely to have sexual activity than other people.

DR. ROONEY: May I interrupt for a minute to give some historical background to it?

Quite frankly, it was a means of getting the door open. We went to Corrections with the problem, they denied it. They did grudgingly admit that it did exist. We asked to begin somewhere and we focused upon the homosexual housing area as the easiest area to convince Corrections to begin any program and it was a small, self contained unit with a maximum capacity of about 180 and Corrections kept a very close eye on it to see if there were any increased fights, incidents.

When the program ran well there, we used it as a means of getting through the doorway, so that we look upon it not that they would be handled in any unique fashion, but that we would use it as a small laboratory and expand past that, so today it's just one of many areas that we dispense condoms.

DR. BRASLOW: I think, I really want to clarify that, because it really, I don't want to leave the wrong impression. Many of the people in that housing area are there for criminal charges related to sale of sex, and I think that there

might not be--there might be a not unjustified feeling that some of these inmates were engaging in sexual relations with a larger number of other people, so while I would certainly not want to imply that that was making a comment related to sexual orientation, I think that perhaps there is something to the actual, to that concern which is really based in fact.

MR. FREUDENBERG: And they're at extraordinarily high risk of infection for the reasons you just gave.

DR. ROGERS: Could I just add a comment on that? Because, I'm sorry we haven't seen Rikers, but having seen this board, I would emphasize that it is a very different population than, say, the Gay Men's Health Crisis or what have you. This is a group who, as Charlie has said, have been largely female-behaving prostitutes; they have breasts, they wear lipstick, they have plucked eyebrows. It looks like a female ward, at least it did when I visited it. It was quite a difference.

So I think they have selected, they have asked to be on this ward for their own protection from the rest because they are quite evidently

different than most of those going in, as you can see.

DR. BRASLOW: I would, my final word on this subject is that I think that condoms should be as freely available to everyone as it is to this group currently.

DR. OSBORNE: Jim Allen, Diane and Larry, and I think we probably need to move along because we're running out of time and we would love to spend all day with you, but let me ask the people who have been patient about questions to also be brief, if they don't mind.

DR. J. ALLEN: This has been an extraordinarily rewarding day and I want to thank you all for the information that you provided and congratulate you all on the programs recognizing given resources you could do and would do much more than you are able to.

My question, really, goes back to a point that Dr. Braslow made fairly early in his presentation and it's a question that I had even before you mentioned it. You've provided some of the information in regards to continuity of care. I think the impression of most people in the

general public is that you're dealing with inmates and I think you have very clearly presented the fact that most of your people are fairly short-term, many of them have not, they're pretrial detainees, and for--in actual fact, we really need to consider them as part of the general population, who for a very short period of time are in a unique circumstance, and I think that's an impression that we've got to get across to our legislators and to others.

Because if we fail to provide for continuity of care here, the problem really is coming from the general public, you're identifying it, it's going right back out to the general public.

The issues of confidentiality were discussed, the problems of the sudden breaks, the fact that the inmates, and I use that as a general term, it may not be the most appropriate, are often transferred from one facility to another, they may go off for the date at court and never come back and the very clear problems of even trying to arrange for continuity of care. It would be helpful for me to address the problem of what

recommendations need to be made, what can we do to correct this problem, because I think it's an incredibly important area.

DR. BELLIN: I think that's really an astute observation and it cuts to the heart of our problem. The short-term stay on average is 45 days, but it's bi-modal, most are gone in three days.

I think a good example of what can work is an effort we've done with the Department of Health TB bureau, in which we've set up a supervised therapy program, twice weekly TB therapy on Rikers Island in a pilot way at two of our facilities and we have coordinated that we send records to the local community TB centers where people get their health care in the community for TB and we forward their medical records to those places so that our patients know they're going to be going back to their community, they're going to a specific spot and their records are available there and in fact they get there and get treated.

Unfortunately, there is no parallel available in the general community for AIDS care. At the turn of the century, when there was a lot of

TB, the response was to built build up TB health centers and you would deliver whatever medication was available locally. We don't have that available. There are budgetary constraints, but one of the things you might consider on that is setting up HIV care centers where within the local center you could get Pentamidine, Bactrin AZT and we could get the records there just as easily.

We have as part of our general care, flow sheets, three pages; one with all the major medical events on it, one with laboratory values, one with the medications. That completely summarizes the medical care. If that is able to be forwarded to a local community system, then they could get ongoing continuity and followup on these things.

We've already done it with TB, we're very actively working on expanding that program with TB, and it's been very successful, but there has to be a commitment to developing the local infrastructure for people in the community which just doesn't exist right now, and the hospitals cannot take the place of that local infrastructure.

DR. BRASLOW: I think, too, I think the

development of that sort of system has to be considered in terms of the entire public health needs of the population of the city as a whole, so that I think a good system of community health provision centers is a great idea.

I would differ somewhat with the idea of having specifically HIV-related ones, because I can see problems from the communities and confidentiality and so forth. If we had, however, an effective network of community health provision services that could provide care of all sorts, then that would be an appropriate way to go, with the addition of a liaison between the inside of the jail and the outside of the jail, which currently really doesn't exist. It's something that we are trying to effect, but really have not done so as yet.

There needs to be some centralized person that once a person gets out, that they can call and talk to, to have their medical records forwarded to the appropriate place, to intercede to try to make appointments at various facilities. That's a sort of a link that has not been developed at the present time, and we have a very fragmented

type of system. We have multiple agencies involved, Department of Health, Department of Corrections, Montefiore, HRA, HHC, I mean, there are just so many different possibilities for care being received from different places, that it just, it has produced incredible logistic problems as far as being able to coordinate it, and we need somebody in a centralized location to I think try to do that task, and that would be what I would think would be very helpful.

MS. WISHART: I would also like to talk about continuity of the care within the jail after the first encounter, because that's one of our major problems. We talked about our programs, medical programs, our educational programs, but one of our most outstanding problems is getting people for followup. The most effective way to do that is to have adequate custodial staff to bring those people, you give them a list and say we want to see those. The cutbacks in New York City and the unrest on Rikers this week, much of that is related to cutbacks and we have already felt the impact of those cutbacks on our medical services; lack of custodial coverage not only in our clinics, but

almost total lack of any officers available to bring people for followup. You can identify a problem as a result of the intake lab tests, but if you cannot find that person, you cannot treat them.

You may have a marvellous educational program, but if you call for 25 inmates and and five come, you have lost a major opportunity. So that's an area that I think needs major resources.

MR. FREUDENBERG: And if you can't find the people in the jail, imagine how much harder it is to find them in the community, and I think that illustrates the need not only for the institutional city wide system to set up a system for integration, but also a bottom up community level system for managing individuals of case management and of tracking down people.

A significant proportion of the population at Rikers has recently been homeless or is discharged and is homeless and so the difficulty of actually finding people, getting them into care and then continuing that care is extraordinarily difficult and I don't think it can be done with health professionals alone, but needs a level of worker who can be working in the community and can

really bring people in and work with them on an ongoing basis.

DR. BELLIN: I don't want to get into a large political discussion about whether we should have HIV specific centers or not, but there are specific skills that HIV people need, and that I do not know that we can use a medical model that we've used to date when we train infectious disease people to go out and make ponderous statements of what to do.

We have very dedicated nurses and PA's who particularly demonstrated over the last 48 hours their professionalism, I want to acknowledge them and they deliver a good deal of our medical care and they can deliver adequate HIV level care so we can make it affordable, make it deliverable, but you have to limit the spectrum of knowledge that has to be transmitted. You cannot expect a physician to cover everything. You could expect a well trained physician assistant or a well trained nurse to be really sophisticated in this care and I just mention that as an aside. You can decide how to politically work it out.

DR. OSBORNE: Thank you. Diane?

COMMISSIONER AHRENS: I wanted to hear a little bit more about women in your facilities, and first of all, talk a little bit more about what you're doing with women, how does that differ from what you're doing with men, how are women responding to this, and how does that differ from the male response, and then, finally, you mentioned that eight percent of the women that I assume when they come are pregnant, and if there are 1300 in, that would be about 100 in any one day would be pregnant.

If they choose an abortion how do they get it and who pays for it?

DR. BRASLOW: I would say that our overall HIV-related services are the same for the men and the women. They all have access to HIV testing and they have access to the same sort of levels of medical care. The only, the difference is the reproductive issue. They have access to OB-GYN services at a Health and Hospital Corporation Hospital in the city, Elmhurst General Hospital, and they do have access to abortions. If they request it, we refer it to Elmhurst and they perform it there, or if at a later stage of

pregnancy, they do it at a different HHC facility.

COMMISSIONER AHRENS: And paid for how?

DR. BRASLOW: It's paid for by--the inpatient portion of health care is paid for through the Health and Hospitals Corporation system. They absorb the cost of inpatient inmates who require care at those facilities, and also specialty clinic services that they provide.

Other funding is to our contracted services through the Department of Health and then Department of Health's budget itself pays for their own direct patient care activity. HHC just absorbs that, I assume, and we have our own OB-GYN consultant who comes into the facility to provide on-site service and that's part of our contract.

COMMISSIONER AHRENS: What are the response of women to the kind of education that you provide, and does that differ from the male response?

DR. BRASLOW: I think that the women in general are extremely concerned about their health status, and are very interested in participating in programs developed for their health status. I think Nick's program has been specifically aimed at

the women, and has been extremely successful in reaching a group of women in an educational effort. I think both the men and the women are interested in hearing this information, and as I said at the very beginning, it's a group that have not been amenable to educational efforts on the outside, and I think a lot of them are very scared and are very desirous of hearing what they can hear.

I don't know of major differences between the men and the women. Nick, do you have any feeling about that?

MR. FREUDENBERG: I think in general women have been more responsive to AIDS prevention programs for a host of reasons that you're probably familiar with, such as feeling more responsible for health and so on. I think there's not, especially when it's provided in a way that gives women an opportunity to voice some of their concerns and fears and ask questions. So we found more women wanting to participate in our sessions than we have the resources to provide.

COMMISSIONER AHRENS: Just to follow up on that. What percentage of the women that come through this system would you say are there for

prostitution charges, which would impact on this whole discussion?

DR. BRASLOW: There's a large number of people with prostitution charges. As health care providers, we generally are not interested why people are there, and it's not part of their medical records, so I really don't pay a lot of attention to that. What I do know is that they do have a higher incidence of HIV infection, which I think is to some extent due to the fact that there's a high prevalence of sexually related charges against them and also they have an extremely high rate of syphilis infection, which I think for the same reason.

COMMISSIONER AHRENS: But that gives you a different population of women than the reason the men are in there. I think that really is a dynamic.

MR. FREUDENBERG: The women are there for drugs or prostitution, that's the majority, and both charges put them at risk.

DR. BRASLOW: Much less incidence of violent type crimes on the women.

MS. WISHART: I would also like to add

on a practical level, because I was the administrator in the women's clinic when I first went to Rikers, that periodically there are great sweeps of the street, maybe because the President is coming to town or before an election and perhaps 50 prostitutes will be brought in overnight and 50 of them will be bailed out by their pimps the next morning, so as a group in general, they do not stay very long in the jail.

DR. BELLIN: But, again, it's a bimodal distribution. You have 21 percent gone in three days, but then you have a good percentage that hang around for a month or month and a half, about 50 percent of them, so you can make an intervention even at that side.

DR. OSBORNE: We're running out of time. Actually, we ran out of time, but I'd like Larry to get his last chance at a question. Larry, go ahead.

COMMISSIONER KESSLER: Mine was more of a comment, maybe Dr. Rogers can help me.

I think the Harvard researchers at the Deacon and Mass. General have done some research on the immunization issue for full blown AIDS cases

and have found it not to be a major hassle. I'm not sure if there's data on that.

DR. BELLIN: No data on live vaccine. There is data on killed vaccine, which shows early in the stage of HIV infection you have better response than later, but the actual safety of using a live biological in full blown immuno incompetent hosts, there is little data available.

It has been policy to immunize HIV infected patients, but no one has done a large cohort of full blown AIDS patients. I have had two opportunities now to do that very interesting study, but frankly I would like to avoid it as long as possible. It may become more and more necessary as the patient population gets sicker, because we do have to immunize anybody who is full blown AIDS who might be in general population if they're in a building where there is a measles outbreak, so we will get that experience over time.

COMMISSIONER KESSLER: And your reason for wanting to avoid it is the history of using inmates--

DR. BELLIN: That's not the reason. The reason is the fear that an attenuated virus, while

attenuated in the light of an immunocompetent host, might not be so attenuated in an immunoincompetent host. Smallpox vaccination historically was not given to people immunoincompetent, because that would become a major disease for someone immunoincompetent.

DR. OSBORNE: There were a few cases in the epedemics of military personnel who were given the smallpox vaccine, and it became a way of diagnosing their AIDS, because it just took off.

David?

DR. ROGERS: I guess this is a social comment I wanted to have the opportunity to say before you people left.

What an irrational society we are. Here we are cramming the institutions full of other problems. We're fortunate to have people like you; badly underfunded, hampered by all kinds of restraints and yet doing the kind of job you are. I feel very privileged to have listened to all of you this morning. That prison population is very lucky to have all of you there.

DR. BRASLOW: Well, I would like to thank the Commission for inviting us, and would

like to invite you again if you can possibly do it, to come back at a time when you can visit Rikers Island, because I think you would be impressed by the physical nature of it, and we'd really like to have the opportunity to show you what we're doing on-site, because I think it's good.

Thank you.

DR. OSBORNE: Thanks so much. Some of us will want to take you up on that.

(Time noted: 11:15 a.m.)

A U T H E N T I C A T I O N

This is to certify that the attached proceedings before the NATIONAL COMMISSION ON AIDS

IN THE MATTER OF: HIV INFECTION AND AIDS IN CORRECTIONAL FACILITIES

DATE: AUGUST 16, 1990

DOCKET No.:

PLACE: 5 PENN PLAZA NEW YORK, NEW YORK

Were held as herein appears, and that this is the original transcript thereof for the file of the Department or Commission.

Linda Fisher

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