Alabama Bound

AIDS quarantines are alive and well in Southern prisons, where HIVers die a slow death. Is this effective HIV prevention or cruel and unusual punishment?

September 1, 2000 By Tim Murphy

I write to you from Unit 28, the housing facility designated for those of us who have tested HIV positive. Unit 28 is a segregated facility. We are not permitted to attend the school or vocational rehabilitation programs afforded to other prisoners.

—Martin Groot, #44534

At present, I still witness what appears to be negligence of medical care for some of the HIV positive inmates, especially when proper care is too expensive. Two fellow inmates, who both died recently, were not, by any means, given proper help when their very lives depended on it.

—Robert White, #33746

I've got a story to tell and I've been praying to God for a way to tell the truth about the way life is here.

—Willie Gaines, #28009

These recent dispatches from the state penitentiary in Parchman, Mississippi, grimly confirmed what the 150 advocates gathered on June 17 in Washington, DC, had long heard secondhand from lawyers, doctors and family members who'd had a glimpse "inside": In Mississippi state prisons, inmates with HIV are segregated from other prisoners, denied participation in prison programs and subjected to dangerously substandard medical treatment.

But the letters were not without flashes of hope; after all, they were to be read at a conference kicking off a national movement for the rights of inmates with HIV. "No Lost Causes," sponsored by the National Prison Project of the American Civil Liberties Union (ACLU), focused special attention on positive inmates in Alabama and Mississippi, two states with longstanding policies of HIV segregation, whose prisons are "the absolute bottom of the barrel for PWAs," according to Rachel Maddow, one of the conference planners. "There has been scattered advocacy for inmates with HIV since the beginning of AIDS," Maddow says, "but there's never been a coordinated national initiative, which is what we need to change things."

Some state systems segregate living and eating quarters for HIV positive inmates or, as in Texas

and California, move them to an HIV-only treatment facility once they're diagnosed with AIDS. But Mississippi, Alabama and, more recently, South Carolina are the only states that exclude HIVers from vocational training, religious services and work release—which prepare inmates for life after prison or offer them a chance to earn early parole. None of these state systems provide "separate but equal" HIV versions of those programs, a policy that a lawyer for the Alabama Department of Corrections (DOC) has said is due to a lack of funding.

In Alabama, legal wrangling over the matter dates back nearly 15 years, when inmates with HIV first filed suit through the ACLU. Since then, the case has gone through several rounds of appeals, in which judges repeatedly upheld the segregation policy. Margaret Winter, the inmate's current ACLU lawyer, recalls one federal judge, Robert Varner, saying that death by AIDS was as horrific as being mauled by a lion and that inmates with HIV were too irresponsible to be integrated into the general prison population. She calls this "the clearest example I've ever seen of a case being decided by hatred and terror." Winter had high hopes for a Supreme Court appeal, but last year the Clinton administration advised the Court not to hear the case, allowing the segregation to continue.

A legal challenge in Mississippi, initiated in 1990, foundered for a time after the inmates' local private attorney, sixth-generation Mississippian Ron Welch, signed a 1995 settlement that guaranteed his clients an appropriate diet and weekly sick calls, but left the state's segregation policy intact. (Welch, in a 1999 National Law Journal article, called his clients "spoiled kids.")

In 1997, 110 inmates from Unit 28, Mississippi's HIV segregation unit at Parchman, abandoned Welch for the ACLU. The new lawyers commissioned two independent reviews of Unit 28 medical records. One report, authored by a New York City HIV doctor, said that treatment for inmates in Unit 28 "threatened the survival of these men," moving a federal judge, in July 1999, to order Parchman to bring its medical care for HIVers up to federal standards (including triple-combination therapy and viral load testing). Then the judge allowed Welch to remain as inmate counsel and barred ACLU lawyers from discussing case-related matters with inmates.

This June, however, only a few days after the DC conference, a federal appeals court lifted the gag order, and Winter immediately set out for Parchman. She was stunned by the inmates' reports: Treatment had rapidly deteriorated after the imposition of the gag order, they said, with some inmates denied drugs for opportunistic infections and others required to demonstrate compliance to a medically substandard two-drug combination before prison staff would add a standard-of-care protease inhibitor. Leonard Vincent, general counsel for the Mississippi DOC, insists that health care in Unit 28 is now "optimum," provided by the University of Mississippi Medical Center under the supervision of Stanley Chapman, MD, an infectious-disease specialist who treated many of the inmates before they were incarcerated. (Chapman did not respond to faxed questions from *POZ*.)

But Carla Shaw, of Jackson, Mississippi, backs up Winter's version. Her son, Robert, 30 and HIV positive, is serving an eight-year sentence for armed robbery in Unit 28. Robert went into Parchman on triple-combo therapy with an undetectable viral load, Carla says, but he was immediately, and without consultation with his outside doctor, deprived of all meds for 30 days

and then put on a two-drug combo. She says that even after he was put back on triple-drug therapy, Robert's viral load has continued to climb.

Rick Perritt, released from Unit 28 last January after serving a short sentence for forgery, recalls men passing out during hot Mississippi summers (Unit 28 lacks air conditioning) and enduring very long waits for ambulances, even when seriously ill. "No one in my time ever actually died in the unit," he says, "but one guy—I can only remember his drag name, Vanessa—died two days after leaving for the hospital." In Unit 28, Perritt says, "No matter if you killed 20 people or just wrote one bad check, you're out of luck."

Like their counterparts in Unit 28, several inmates in the segregated HIV unit at the Julia Tutwiler Prison for Women in Wetumpka, Alabama, sent letters to be read at the June conference. One from Paulette Nicholas echoes the concerns of the men in Mississippi: "Illness goes untreated or misdiagnosed. I have heard correctional staff state, 'It's your fault you have the virus, you're going to die anyway, so why complain?' Every day [conditions] get worse and our lives are getting shortened." For Connie Stratton, the worst aspect of segregation is being cut off from early-parole programs: "Women in the general population with a 10-year sentence are usually gone within eight to 10 weeks. I've been in prison six months with a 10-year sentence for possession of cocaine, not offered any foundation of recovery to live drug-free. Why send someone to prison if there is no rehabilitation offered?"

Though the Alabama DOC refused to comment for this article, officials have justified the HIV segregation by saying that if positive inmates were integrated, a bloody fight or sexual activity could lead to HIV transmission. Alabama told a court of appeals that over eight years, only two of 30,000 HIV negative inmates seroconverted, based on mandatory exit tests.

Ted Hammett, vice president of ABT Associates in Cambridge, Massachusetts, a policy research firm, prepares a regular report on HIV in U.S. prisons for the Department of Justice. He says that the study officials in Mississippi and Alabama most frequently cite to defend their segregation policies, which found annual HIV transmission rates in Florida prisons to be an alarming 21 percent, was based on a self-selected sample of inmates who volunteered for HIV tests, most likely because they believed themselves to be at risk. Studies of other integrated systems have yielded annual seroconversion rates of less than 1 percent, he says, while the single controlled study to date, tracking male inmates in Illinois from 1988 to 1990, yielded an annual incidence rate of 0.3 percent. "Even if it's true that Mississippi and Alabama have lower transmission rates than nonsegregated systems, that doesn't justify the segregation policy," Hammett says. "I've argued for years that there are better ways to prevent in-facility transmission, like education and prevention."

Sharing that conviction, Maddow says the new coalition will hold meetings in Montgomery, Alabama and Jackson, Mississippi, in early September in order to "bring the movement to its site of crisis" and to engage local advocates, especially churches, in forcing change.

The June conference was marked by the presence of representatives from several high-profile national AIDS organizations, such as the American Foundation for AIDS Research and the National Association of People With AIDS, who are new to this issue. Maddow says she hopes this signals their readiness to play a larger role in advocacy for inmates with HIV.

“The event in DC was an opportunity for national AIDS organizations to find out about prison issues and get involved,” says Ellen Bentz, program manager for HIV and Corrections at the National Minority AIDS Council. “We need to frame this as a national AIDS scandal, not a prison issue. A prison official once told me, ‘One letter of protest we file and don’t notice. Two letters we file and don’t notice. But when the file starts getting fat, then we start noticing.’ We may not be the constituencies of these states, but we can still bring that pressure.”

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