IN THE DISTRICT COURT OF THE UNITED STATES FOR THE MIDDLE DISTRICT OF ALABAMA, NORTHERN DIVISION

LOUIS HENDERSON, DANA HARLEY, DWIGHT SMITH, ALBERT KNOX, JAMES DOUGLAS, ALQADEER HAMLET, and JEFFREY BEYER, on behalf of themselves and of those similarly situated,	)	
Plaintiffs,	)	
v.	)	CIVIL ACTION NO. 2:11cv224-MHT (WO)
KIM THOMAS, Commissioner, Alabama Department of Corrections; BILLY MITCHEM, Warden, Limestone Correctional Facility; FRANK ALBRIGHT, Warden, Julia Tutwiler Prison for Women; BETTINA CARTER, Warden, Decatur Work Release/ Community Work Center; EDWARD ELLINGTON, Warden, Montgomery Women's Facility, in their official capacities,	)	
Defendants.	)	

OPINION

The seven plaintiffs (Louis Henderson, Dana Harley, Dwight Smith, Albert Knox, James Douglas, Alqadeer

Hamlet, and Jeffery Beyer) bring this lawsuit on behalf of themselves and a class of all current and future HIV-positive prisoners incarcerated in Alabama Department of Corrections (ADOC) facilities. They challenge the ADOC's policy of categorically segregating HIV-positive prisoners from the general prison population, arguing, among other things, that, despite the dramatic advances in the treatment of HIV and despite the plaintiffs' differing individual circumstances, the plaintiffs are being denied the opportunity to be even considered for various rehabilitative services and programs offered to other prisoners. They have named as defendants ADOC Commissioner Kim Thomas and the wardens of the four ADOC facilities that house HIV-positive prisoners.

The plaintiffs claim that the HIV-segregation policy discriminates against them on the basis of a disability (HIV status) in violation of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 et seq., and § 504 of the Rehabilitation Act, 29 U.S.C. § 794.

as the "window period," generally lasts for a few weeks, but can extend as long as three months, and the people experiencing it represent the most infectious group of individuals with HIV.

Acute HIV gives way to chronic-HIV infection. During this stage, the viral load lowers. The final stage, advanced-HIV infection, occurs when the body's CD4 T-cells, which play a critical role in the immune system, drop to low levels and the viral load rises.[1] More commonly, this final stage is known as acquired immunodeficiency virus, or AIDS.

HIV emerged in the United States in the early 1980s and soon grew into an epidemic. HIV inevitably progressed to AIDS. Virtually everyone infected died. Meanwhile, no one, including the medical community, understood how HIV was transmitted. Fearing that even casual contact could spread it, doctors treating patients

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1. As the facts will show, not everyone with HIV will enter this final stage.

with HIV wore protective gear so extensive it was nicknamed a “space suit.” The profound consequences of the disease, combined with lack of knowledge about how it could spread, created an era of hysteria in the epidemic’s early days.

The tide began to turn in the decade that followed. In 1996, the first protease inhibitors were approved to treat HIV. Highly active antiretroviral therapy (HAART), emerged as an effective weapon against the disease. These treatments did not eliminate the virus, but they did restrict its ability to progress and could stave off

Today, advances in HIV treatment have profoundly changed the disease. There is still no cure for HIV: indeed, there is only one known case in which a person was completely cured of it. However, modern treatment regimes have rendered it manageable. The vast majority of HIV patients can be treated by one pill once a day; side effects are less severe, and, where they do occur, multiple treatment options allow patients to try different medications until they find one that works; and, most importantly, although people with HIV will require treatment for their entire lives, HIV is no longer invariably fatal. People who receive treatment for HIV can expect to enjoy near-normal lifespans.

HIV can be transmitted through contaminated blood and bodily secretions, commonly during unprotected sex (between a man and a woman or between men) and needle sharing (for drug use or tattooing, for example). It is not transmitted through casual contact or through the

food supply.[2] A person would have to drink a 55-gallon drum of saliva in order for it to potentially result in a transmission. There is no documented case of HIV being sexually transmitted between women.

Moreover, simply because HIV can be transmitted in certain contexts does not mean that it will be, or even that it is likely to be, transmitted by that means. Advances in antiretroviral treatment have not only ameliorated the effects of HIV, but have also powerfully reduced (and in some contexts, even vitiated) the possibility of transmission, even when individuals engage in high-risk behavior. This is true because transmission typically occurs only when a person's viral load is at a certain minimum threshold. Modern treatments, however, if successful (which they generally are), result in "viral suppression," a state in which the person's viral

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2. The U.S. Centers for Disease Control and Prevention excludes HIV from its list of diseases that can be transmitted through the food supply.

load is so low that the likelihood of HIV transmission is, generally speaking, virtually non-existent.

Because modern treatment is effective as prevention, the medical community now recommends that antiretroviral treatment be offered to everyone living with HIV who is ready and willing to take it. This approach represents a sea change that has revolutionized the public-health strategy for preventing transmissions.

While in 2012, outcomes are better, treatment simpler, and prevention possible, social perceptions of HIV have yet to catch up with the modern realities of the illness. Undoubtedly exacerbated by the terror that accompanied the disease in its early history, a relentless stigma adheres to HIV. This stigma has at least two plausible sources. First, HIV is most frequently found among historically marginalized populations: particularly, gay men. Prejudice against homosexuals intensifies prejudice against HIV, and prejudice against HIV becomes a proxy for prejudice

against members of the gay community. Because HIV is also more common among minorities and the poor, the stigma attached to HIV deeply implicates race and class prejudice, as well as homophobia.

A second source of stigma stems from the means of HIV transmission. The plaintiffs' expert, Dr. Frederick Altice, an international authority on HIV and the Director of the HIV in Prisons Program at Yale University School of Medicine, explained: "People make judgments just by the virtue of HIV that you must have done ... something dirty or something awful to have acquired HIV. Being gay. Being a prostitute. Being sexually promiscuous."[3] These impressions build upon negative stereotypes about the groups most commonly affected by HIV.

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3. Unfortunately, the transcript from the trial is not yet available, and the court is therefore unable to cite to it.

The progression of how HIV has been handled in American prisons somewhat mirrors its progression in the free world: initial (and understandable) terror about its spread gave rise to drastic prevention measures, which subsided as both treatment and understanding of HIV improved.

The first report of HIV in prisons was made in 1983. Soon after, a critical minority (but never a majority) of state-correctional systems began segregating HIV-positive prisoners from the general prison population. In the mid-1990s, as the fear surrounding HIV began to subside, most States that had enacted such policies reversed them. By 2006, only three States still segregated HIV-positive prisoners: South Carolina, Mississippi, and Alabama. In 2010, Mississippi ended its segregation policy as well. Today, preeminent public-health organizations, including the U.S. Centers for Disease Control and the National Commission on Correctional Healthcare, uniformly recommend against segregating prisoners with HIV.

B. The ADOC's HIV-Segregation Policy

As in the rest of the nation, the advent of the AIDS epidemic generated panic within the ADOC. Billy Mitchem, the former warden of Limestone Correctional Facility, explained: "[E]verybody was ... afraid. The inmates were afraid. The staff was afraid. We didn't understand, really, how you could get AIDS. I mean, you used your imagination, and most of that was wrong.... And people were dying."

It was in this atmosphere that the ADOC established its original HIV-segregation policy. The initial policy was austere. HIV-positive prisoners were segregated in every aspect of their daily lives, from the dorms in which they were housed to the chapels in which they worshiped. They had no access to the myriad programs available to the general-population prisoners. At Limestone, the dorms where HIV-positive prisoners were housed were cordoned off from the rest of the prison by a fence with a locked-metal gate. Plaintiff Dana Harley

described the circumstances of HIV-positive women in a letter to the warden of Tutwiler:

> "We are in isolation from general population like we are contagious animals. Officers only come and see about us when they see fit.... Basketballs are flat and playing cards are beyond recognition. It's enough to be living every day with our virus and trying to cope. We are confined and can't even participate in everyday activities such as trade schools or state jobs to stay occupied.... It's like punishment three times over: Prison, the virus, then the denial of an education or trade. We are secluded from everyday life."

Pls.' Ex. 82.

During this time, a class of HIV-positive prisoners twice challenged the ADOC's segregation policy. In the first challenge, the plaintiffs alleged that the segregation of recreational, religious, and educational programs violated the Rehabilitation Act. The district court denied their claims, and, after a decade of litigation, the Eleventh Circuit Court of Appeals upheld that decision. See Onishea v. Hopper, 171 F. 3d 1289

(11th Cir. 1999) (en banc). Before the Onishea litigation had concluded on appeal, the same class of HIV-positive prisoners challenged the same policies, this time under the ADA and the Eighth Amendment. See Edwards v. Ala. Dep't of Corr., 81 F. Supp. 2d 1242 (M.D. Ala. 2000) (Thompson, J.). This court found that the plaintiffs' claims in Edwards were identical to those denied in Onishea and therefore barred under the doctrine of res judicata.

In 2007 and 2008, the ADOC relaxed its segregation policy. HIV-positive prisoners were integrated into trade schools, substance-abuse programs, and other activities, and, for the first time, they were permitted to participate in the work-release program.

At trial, the parties offered competing characterizations of the department's policy as it operates today. The court finds that the policy itself is best described as, in general, a series of categorical, non-individualized determinations that the

department makes with regard to HIV-positive prisoners. Simply put, in a number of aspects of institutional life, HIV results in automatic placement and automatic exclusion. Outcomes that depend on a complex web of factors for HIV-negative prisoners are determined based on a prisoner's HIV-positive diagnosis alone. Because the policy differs with respect to male and female prisoners, the respective practices are discussed separately below.

1. Men

Every male prisoner entering the ADOC first reports to Kilby Correctional Facility to undergo classification. There, each prisoner is given a physical and mental-health evaluation, is interviewed by a classification specialist, and his behavioral history (particularly his criminal history) is reviewed. As a result of this process, the prisoner is assigned a custody level. Custody levels for men include "close," "medium,"

abuse treatment, and certain mental-health programs. As Stephanie Atchison, Classification Assistant Director for the ADOC, explained, this impacts the department's placement decisions. If, for example, a prisoner "needed to participate in a substance abuse program," the classification team would "approve a group of institutions that offered substance abuse treatment, and whichever one had the space available, that's the one he would go to." Finally, each prisoner is subject to a medical and mental assessment, which can further limit the number of facilities for which he is eligible.

For the approximately 250 men within the ADOC who are HIV-positive, however, all of the factors normally considered in the classification process are overridden by an HIV-positive diagnosis.[5] Upon entering the system,

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5. Atchison explained that the automatic decision with regard to HIV is a "placement directive." Placement directives come from the commissioner rather than from the classification specialists and override normal classification considerations.

every prisoner is given an enzyme-linked immunosorbent assay (ELISA) test, which measures an antibody to HIV.[6]

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6. The diagnostic test upon entry is required by state law. See 1975 Ala. Code § 22-11A-17(a).

7. Testimony at trial demonstrated that, in addition to the stress of being confined in an isolation cell, this practice is harmful because it comes across as a punishment for being diagnosed with HIV. Plaintiff Albert Knox explaned: "I didn't feel like I deserved to be locked up in [a segregation cell] .... I always considered seg to be a place where you [go when you] screw up in prison or whatever ... that's a disciplinary that you get .... [F]or me to be locked up in there, and I didn't do anything wrong, I didn't think it was right. It was punishment."

8. The testing process cannot reliably diagnose all HIV-positive prisoners, however, because, as discussed above, individuals who have recently been infected and fall in the "window" period will not test positive for HIV, despite being very contagious.

condition listed on the ADOC's medical-classification chart for which diagnosis alone, without any consideration of actual treatment needs, limits the prisoner's placement possibilities to a single facility. This placement is also made without regard to security-classification procedures. Limestone is equipped to house only general-population prisoners who are medium and minimum custody; the only close-custody prisoners there are those who have HIV.

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Donaldson and instead placed at Limestone, which is only designed to house codes zero through two.

Program opportunities are also necessarily limited. For instance, the ADOC's sole 12-15 month therapeutic-community program for substance-abuse treatment is offered at St. Clair Correctional Facility. HIV-positive prisoners are never placed at St. Clair, no matter how dire their addictions. Further, while approximately 85 % of HIV infections in Alabama come from Mobile, Montgomery, and Birmingham, all of which are in central or southern Alabama, Limestone is located on the State's northern border, far from these cities (Mobile is an over five-hour drive from the prison). Therefore, while general-population prisoners are by no means guaranteed a placement near their homes and families, most HIV-positive prisoners are completely barred from this possibility. For many of them, this makes family visits difficult or impossible.

The segregation policy continues within Limestone. There, HIV-positive men are separated into two HIV-only dormitories: Dorms B and C. Together, these dorms are known as the "Special Unit." HIV-positive prisoners who are mentally ill, because they are barred from going to Bullock or another facility equipped to treat serious mental health needs, are housed in the Residential Treatment Unit, a set of nine cells in Dorm C cordoned off by a large metal cage, which juts out into the dorm's common area. If an HIV-positive prisoner is placed in administrative or disciplinary isolation (for example, as punishment for his conduct), he is placed in the same isolation dormitory as the HIV-negative prisoners, Dorm E. Although that dormitory includes only individual isolation cells that are locked closed throughout the day, which completely prevents any physical contact among prisoners, the HIV-positive prisoners are placed together in a row, separated from cells occupied by HIV-negative prisoners by a floating metal gate.

Because HIV-positive men are uniformly housed in Limestone's Special Unit, they are necessarily excluded from any benefits that stem from being housed in other dorms. Limestone has, for instance, a Senior Dorm, which provides a safer and calmer environment. There is also a Faith-Based Honor Dorm, whose prisoners enjoy

often "extremely effective" because the "minute-by-minute interaction in the bathroom, in the dorms or in their housing units, [and] at meals" creates an "ongoing dialogue about the sort of issues that are taught" in the program.

HIV and substance abuse are frequently comorbid: currently, around 41 prisoners with HIV are enrolled in some component of SAP. However, while HIV-positive prisoners can participate in SAP classes, they are not permitted to live in the SAP dorm, and must return to the Special Unit for meals and when classes end each day. As a result, they are deprived of one of the fundamental qualities that makes SAP effective.[9]

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9. At trial, the ADOC downplayed the importance of the residential aspect from which HIV-positive prisoners are excluded. However, this representation is belied by the department's own description of SAP's objectives: "The goals of the program are to: (1) offer a stable, quiet and residential environment wherein recovering inmates can live together as a family, reinforcing each others[']sobriety." Pls.' Ex. 51, at 15 (emphasis added). The very existence of a SAP dorm could be viewed as communicating the ADOC's belief that substance-abuse programming benefits from a residential component.

In addition to the housing-segregation policy, prisoners with HIV at Limestone are required to wear white armbands. The ADOC attests that all prisoners are required to wear armbands of various colors and that each color simply designates the dorm to which each prisoner belongs.[10] Commissioner Thomas explained that the armbands "help control the flow of inmates throughout a facility": they prevent violence and unauthorized activity because correctional staff can better monitor whether the prisoners are in their proper dorms. However, while no other two dorms share the same armband color, both of the Special Unit dormitories, Dorm B and Dorm C, are assigned white armbands. A correctional officer stated that this makes it difficult to tell whether the HIV-positive prisoners are in their correct

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10. There was conflicting testimony at trial about when the armbands policy was initiated. Testimony from the plaintiffs' witnesses suggested that, originally, only HIV-positive prisoners had armbands and that other dorms were given armbands only after the onset of this litigation. The ADOC disputes this chronology. Currently, every dorm except for the pre-release dorm uses armbands.

dorms, hollowing out the purported security purpose of the armbands.

There is one circumstance in which HIV-positive prisoners may be housed outside of Limestone: when they

programs. However, also like the men at Limestone, they cannot reside in any specialized dorms, including Tutwiler's SAP dorm and Honor Dorm. HIV-positive women who are mentally ill, instead of being placed in the

they may not work for food-service employers in the work-release program.

4. Work-Release Eligibility Criteria

When HIV-positive prisoners are considered for the work-release program, they must meet a number of criteria

Site Medical Director or an HIV Specialist, who has the option to waive them at her discretion.

Although the ADOC manages populations with a number of illnesses that are equally as serious and as infectious as HIV, HIV is the only disease with a separate subset of criteria dedicated solely to it. It is also the only disease whose criteria are based on rigid numerical thresholds rather than treatment needs or functional abilities. A prisoner who does not have HIV is instead evaluated based on her medical code and the seriousness of her treatment needs. For instance, prisoners who are receiving dialysis, hepatitis chemotherapy treatments, and cancer treatments are not "clear" for work release (but the criteria do not categorically require people with these illnesses to satisfy any numerical criteria divorced from actual treatment or capabilities). Joint Ex. 35.

II. DISCUSSION

A. Justiciability

Before reaching the merits of the plaintiffs' claims, the court must decide whether

As this case a class action, "each claim

12. The plaintiffs assert a challenge both to the ADOC's HIV-segregation practice as a whole and to various aspects of the policy. They also presented significant evidence about the discriminatory effects of the policy, at times making it difficult for the court to discern what the plaintiffs considered to be true aspects of the policy and what were merely its deleterious effects. As previously explained, the court considers the heart of the challenged policy to be a series of automatic determinations made with regard to HIV-positive prisoners. However, the challenged conduct is the determination itself, and not its many effects.

adjudication of several distinct claims for relief. See Harris v. Thigpen, 941 F.2d 1495, 1526 (11th Cir. 1991) (requiring the district court to evaluate the risk of HIV transmission occurring "with regard to each program from which [HIV-positive prisoners] have been automatically excluded," rather than with respect to prison in general); see also Miller v. King, 449 F.3d 1149, 1150-51 (11th Cir. 2006) (stating that "it is important for lower courts to determine on a claim-by-claim basis ... which aspects of the State's alleged conduct violate[s] Title II"). The court understands the plaintiffs' claims against the HIV-segregation policies and practices at ADOC prisons to encompass challenges to the following discrete policies: (1) the policy that HIV-positive men are segregated within Limestone from the general-population prisoners; (2) the policy that HIV-positive men are permitted housing only at Limestone and Decatur Work Release, and excluded from all other ADOC men's facilities; (3) the policy that HIV-positive women are

segregated within Tutwiler from the general-population prisoners; (4) the policy that women are allowed work-release housing at Montgomery Women's Facility, but not the ADOC's other work-release facility for women; (5) the exclusion of HIV-positive prisoners, male and female, from food-service jobs within the prison and at work release; (6) the eligibility criteria applied to HIV-positive prisoners, male and female, who apply to participate in the work-release program; and (7) the requirement that male HIV-positive prisoners wear white armbands.

As for the first two claims (segregation within Limestone and exclusion from other ADOC facilities for men), plaintiffs Louis Henderson, Jeffrey Beyer, and James Douglas have standing to challenge these policies. All three reside in the Special Unit at Limestone and wish to be integrated into the general population at Limestone and to be eligible for housing at other facilities. Plaintiffs Dwight Smith and Alqadeer Hamlet,

who are currently placed at Decatur Work Release, would like to be eligible for other work-release facilities; they therefore have standing to challenge the ADOC's policy of housing HIV-positive prisoners exclusively at Decatur.

As for the third and fourth claims (segregation within Tutwiler and eligibility for only one women's work-release facility), plaintiff Dana Harley has standing. At the time this case began, Harley was housed in Tutwiler's segregation dormitory and wished to be integrated. She also wanted to be eligible for all women's work-release facilities (rather than only for Montgomery Women's Facility). All plaintiffs have standing to raise the fifth (exclusion from food-service jobs) and sixth (HIV-related eligibility requirements for work release) claims, as all desire the opportunity to work in food-service jobs and to apply for work release without being subjected to eligibility criteria that they argue are discriminatory and unnecessary. In particular,

plaintiff Douglas has been excluded from work release because of the eligibility requirements. Lastly, all male plaintiffs have standing to raise the seventh claim, as they all are required to wear white armbands.

The ADOC devoted ample time at trial to the argument that class representatives who were denied certain benefits because of the policy lack standing because they would not have been guaranteed those benefits even if they were not HIV-positive. For instance, the department argues that the male plaintiffs lack standing to challenge their ineligibility for transferring to facilities other than Limestone because no prisoner has a right to transfer to the facility of his choosing. Therefore, the ADOC argues, even if this court were to order relief, the plaintiffs' injuries could not be redressed. However, this argument misses the point. The plaintiffs are not challenging the outcome of the department's decisions, but rather, the fact that they are entirely barred from consideration because they have

HIV. Therefore, the plaintiffs' standing hinges on the fact that they have not been considered even though they wish to be, not on whether this consideration would result in a particular outcome. It has long been understood that governmental policies of exclusion and segregation create actual, concrete injuries that are redressable by the courts. See, e.g., Jackson v. Okaloosa Cnty., 21 F.3d 1531, 1537 (11th Cir. 1994) (holding that a claim of "exclusion ... and, as a result of this exclusion, imminent segregation," alleges a "redressable injury"); cf. Ne. Fla Chapter of Assoc. Gen. Contractors of Am. v. City of Jacksonville, 508 U.S. 656, 666 (1993) ("When the government erects a barrier that makes it more difficult for members of one group to obtain a benefit than it is for members of another group, a member of the former group seeking to challenge the barrier need not allege that he would have obtained the benefit but for the barrier in order to establish standing. The 'injury in fact' in an equal protection

case of this variety is the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit.").

The ADOC also contends that, because Harley was transferred out of Tutwiler and into Montgomery Women's Facility after the complaint in this case was filed, her challenge to segregation within Tutwiler is now moot. Further, towards the end of trial, the ADOC conceded certain aspects of the plaintiffs' claims and assured the court that its practices "would change" in certain respects.[13] Now, the ADOC urges the court to disregard those claims, arguing that they have been mooted.

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13. The policies and practices that the ADOC committed to changing include: (1) the exclusion of HIV-positive prisoners from food-service jobs in prison and in the work-release program; (2) the requirement that all HIV-positive men wear white armbands; and (3) the policy that HIV-positive men are placed together in Dorm E (administrative and disciplinary isolation). The ADOC also committed to evaluating options for removing the fence that currently surrounds the Special Unit at Limestone.

"[T]he voluntary cessation of challenged conduct will moot a claim only when there is no 'reasonable expectation' that the accused litigant will resume the conduct after the lawsuit is dismissed." Nat'l Ass'n of

original). This court must conduct the mootness inquiry with attention to three relevant factors: (1) "whether the termination of the offending conduct was 'unambiguous'"; (2) "whether the change in government policy or conduct appears to be the result of substantial deliberation, or is simply an attempt to manipulate jurisdiction"; and (3) "whether the government has 'consistently applied' a new policy or adhered to a new course of conduct." Nat'l Ass'n of Bds. of Pharmacy, 633 F.3d at 1310 (citations omitted).

The mootness issue with regard to Harley can be dispensed with easily. The HIV segregation that Harley challenges at Tutwiler never ended: the ADOC simply removed her from the location of the challenged conduct. The only question, then, is whether Harley can expect to be subjected to the ADOC's practices at Tutwiler in the future. Transfers between Tutwiler and Montgomery Women's Facility are common (indeed, Harley has previously been moved back and forth between the

facilities), and as such, there is a more than reasonable basis to believe that she will be subjected to segregation in Tutwiler again.

Nor is this court deprived of its power to decide the plaintiff's claims challenging policies that the ADOC now agrees to change. The ADOC has provided no information about the department's deliberation process and has provided only vagueries about the basis for its decision to alter its policies. Therefore, its policy changes are far from unambiguous. See Harrell v. The Fla. Bar, 608 F.3d 1241, 1267 (11th Cir. 2010) ("[T]he Board acted in secrecy, meeting behind closed doors and ... failing to provide any basis for its decision [to change its challenged practices]. As a result, [the court has] no idea whether the Board's decision was well-reasoned and therefore likely to endure.") (quotations and citations omitted). In addition, while "a defendant's cessation before receiving notice of a legal challenge weighs in favor of mootness ... cessation that occurs late in the

game will make a court more skeptical of the voluntary changes that have been made." Harrell, 608 F.3d at 1266 (quotation marks and citations omitted). In this case, the department committed to policy changes at the close of trial, despite the fact that this litigation has been ongoing for over a year-and-a-half. The concessions therefore seem more likely an attempt to avoid an unfavorable result in this litigation than "the result of substantial deliberation." Nat'l Ass'n of Bds. of Pharmacy, 633 F.3d at 1310.

As to the third factor, the court has not received any concrete evidence as to whether and how any changes have, in fact, been made, nor has it received any evidentiary details about when and how future changes to the current policy might occur. Therefore, the court cannot be sure whether the ADOC truly has mooted these claims. All three factors thus counsel against a finding of mootness on the conceded issues.

In sum, all of the plaintiffs' claims present justiciable controversies. Neither the standing nor mootness doctrines preclude the court from reaching the merits of these claims.

B. Title II of the Americans With Disabilities Act and § 504 of the Rehabilitation Act

The plaintiffs assert claims under Title II of the ADA and under § 504 of the Rehabilitation Act. Title II provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity." 42 U.S.C. § 12132. Section 504 provides that, "No otherwise qualified individual with a disability ... shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial

assistance." 29 U.S.C. § 794(a).[14] Claims under both statutes are governed by the same standards. See, e.g., Cash v. Smith, 231 F.3d 1301, 1305 (11th Cir. 2000); see also Everett v. Cobb County Sch. Dist., 138 F.3d 1407, 1409 (11th Cir. 1999). To state a claim under either statute, the plaintiffs must show: "(1) that [they are] qualified individual[s] with a disability; (2) that [they were] either excluded from participation in or denied the benefits of a public entity's services, programs, or activities, or [were] otherwise discriminated against by the public entity; and (3) that the exclusion, denial of benefit, or discrimination was by reason of the plaintiff[s'] disability." Bircoll v. Miami-Dade Cnty., 480 F.3d 1072, 1083 (11th Cir. 2007) (citation omitted);

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14. Both statutes clearly apply to Alabama state prisons. See Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206 (1998)(holding that state prisons and jails are considered public entities for the purposes of the ADA); Pretrial Order (Doc. No. 177) at 12 (Stip. 1) (stating that the ADOC receives federal financial assistance, therefore subjecting the ADOC to the requirements of the Rehabilitation Act).

see also Harris, 941 F.2d at 1522 (applying those elements in the prison context). Because the same standards govern claims under both statutes, in the interest of brevity, the court will refer to both as "the ADA."

The plaintiffs correctly assert (and the ADOC concedes) that HIV is a disability under the ADA.[15] Therefore, the court's analysis addresses the other elements of a claim under the ADA.

15. The ADA and the Rehabilitation Act define disability as (among other things) "a physical or mental impairment that substantially limits one or more major life activities of such individual." 42 U.S.C. § 12102(1)(A) (ADA); 29 U.S.C. § 705(20)(B) (Rehabilitation Act). The ADA Amendments Act of 2008 clarifies that "major life activities" includes "the operation of a major bodily function, including ... functions of the immune system." 42 U.S.C. § 12102(2)(B). As HIV critically impacts the immune system, it is within the ambit of the statute.

1. Segregation

Among the regulations promulgated under Title II of the ADA is the "integration regulation," which provides that, "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (emphasis added). "[T]he most integrated setting appropriate" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. Pt. 35, App. B (2011). Consonant with the integration mandate, the Supreme Court has concluded that, "Unjustified isolation ... is properly regarded as discrimination based on disability." Olmstead v. L.C. ex rel Zimring, 527 U.S. 581, 597 (1999).

At trial, the ADOC insisted that its policies do not amount to segregation.[16] The department argued, in essence, that, because HIV-positive prisoners can participate in certain integrated programs, they are not truly "segregated."[17] The ADOC enmeshed these arguments

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16. The ADOC made this argument despite the fact that, even during the trial, the department's own website described the policy as segregation.

17. The ADOC downplayed the significance of separate dorms for HIV-positive prisoners by referring to them as simply "where the prisoners sleep." See, e.g., Defs.' Pretrial Br. (Doc. No. 211) at 65 ("Class Representatives simply cannot sleep in the dorms ... with the rest of the general population); id. at 67 (referring to the plaintiffs' claim as a "sleeping arrangement request"). The ADOC's expert, Dr. George Lyrene, was particularly dismissive, stating that, "The argument about the importance of sleeping together seems petty and spurious to me." Defs.' Ex. 336, at 12. However, the facts show that the dorm is more than where the prisoners sleep. Prisoners spend much of the day in their dorms. (Plaintiff Beyer reported spending an average of 7-8 waking hours in his dorm during the summer months, and 10 hours a day in the winter. Plaintiff Knox testified that he spends around 6-8 hours each day in his dorm.) Residents of the Special Unit (and many other dorms at Limestone) also eat all of their meals there. Beyer said of his dorm, "It's the place ... where I sleep, I eat, I read, I watch TV. It's just the place where I live. ... [I]t's not just where I sleep." Plaintiff Henderson

(continued...)

with an emphasis on the adequacy of medical care in the Special Unit and an account of various programs to which HIV-positive prisoners have access. Thus, the department's true meaning appears to be that, because the prisoners are not denied health care and because they have access to many programs, they have no right to complain about the fact that they are segregated. The court agrees that "segregation" is an uncomfortable term, loaded with implications of prejudice.[18] The court also finds that it is an appropriate way to describe the policy at issue here. Mandatory separate housing in a separate dorm (which is, for male prisoners, itself

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17. (...continued)
echoed Beyer's comments, saying of his dorm, "That's where I live."

18. "Segregation" is defined as "the separation or isolation of individuals or groups from a larger group or from society," but it can also refer to "the separation or isolation of a race, class, or ethnic group by enforced or voluntary residence in a restricted area, barriers to social intercourse, divided educational facilities, or other discriminatory means." Webster's Third New International Dictionary 2057 (2002).

within a separate facility) would doubtlessly violate the ADA if unjustified. The same can be said for the practice of excluding HIV-positive prisoners from food-service jobs.[19]

However, the ADA extends its protections to only individuals claiming discrimination with respect to, or exclusion from, a public entity's services who were "otherwise qualified" for those services. Onishea, 171 F.3d at 1300. "'An otherwise qualified person is one who is able to meet all of a program's requirements in spite of his handicap.'" Id. (quoting Southeastern Community College v. Davis, 442 U.S. 397, 406 (1979)).

The "otherwise qualified" analysis entails a two-part inquiry. First, the court must determine whether the plaintiffs are qualified for integration where they are currently segregated. Second, if the plaintiffs are not

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19. The ADOC's work-release policy and its policy requiring male prisoners with HIV to wear white armbands are analyzed under different legal frameworks under the umbrella of the ADA.

qualified as an initial matter, "the court must nevertheless evaluate ... whether reasonable accommodations would[, if made by the ADOC,] make [plaintiffs] otherwise qualified." Harris, 941 F.2d at 1525; see also Martinez v. Sch. Bd. of Hillsborough Cnty., 861 F.2d 1502, 1505 (11th Cir. 1988). The plaintiffs carry the burden of making a prima-facie showing that they are otherwise qualified or would be if the ADOC made reasonable accommodations. Onishea, 126 F.3d at 1329-30. If the plaintiffs make a prima-facie showing, the burden then shifts to the ADOC to establish that the proposed accommodations are not "reasonable" because implementation would impose "undue financial and administrative burdens" or require "a fundamental alteration in the nature of [the] program" at issue. Harris, 941 F.2d at 1572 n.48 (citations omitted); see also Henrietta D. v. Bloomberg, 331 F.3d 261, 280 (2d Cir. 2003) ("[I]t is enough for the plaintiff to suggest the existence of a plausible accommodation, the costs of

which, facially, do not clearly exceed its benefits, and ... [o]nce the plaintiff has done this, she has made out a prima facie showing that a reasonable accommodation is available, and the risk of nonpersuasion falls on the defendant.") (quotation marks and citation omitted).

Courts have prescribed a particular analytical approach where the disability is a contagious illness. If a person with a contag[redacted]ness poses a direct threat to the health and s[redacted]fety of others, then she is not "qualified" within the meaning of the statute. See Onishea, 171 F.3d 1296-97. To make this determination, courts apply the factors identified by the Supreme Court in School Board of Nassau C[redacted]ty, Florida v. Arline, 480 U.S. 273 (1987); see [redacted]

Arline factors to a challenge of the ADOC HIV-segregation policy). The factors include: "(a) the nature of the risk (how the disease is transmitted), (b) the duration fo the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degress of harm." Onishea, 126 F.3d at 1297 (quoting Arline, 480 U.S. at 288). In applying these factors, the court must take into account the basic principle that "the significance of a risk is a product of the odds that transmission will occur and the severity of the consequences." Id.

Arline emphasized that these factors must be applied on an individualized basis: only by doing so can the court honor Congress's "goal of protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fear, while giving appropriate weight to such legitimate concerns ... as avoiding exposing others to significant health and safety risks."

Arline, 480 U.S. at 287; see also id. (stating that "the district court will need to conduct an individualized inquiry" in applying the factors). It follows that, in the context of a class action challenging the treatment of persons with a disability as a group, the court must not make a finding of significant risk as to the entire group unless it can be sure that no individual within the group would not pose such a risk.

When the Eleventh Circuit previously considered whether the ADOC's segregation policy violated the ADA, that court found that the seriousness of HIV, then a death sentence for everyone who contracted it, rendered unacceptable even a small (though plausible) risk of transmission. See Onishea, 171 F.3d at 1293 ("HIV infection inevitably progressed to AIDS. AIDS always led to death, often after lengthy suffering."). The court held that, "when transmitting a disease inevitably entails death, the evidence supports a finding of 'significant risk' if it shows both (1) that a certain

standard that the Eleventh Circuit applied in Onishea for fatal illnesses no longer applies to HIV. Instead, this court must apply the "significant risk" test the the Supreme Court outlined in Arline.

The court may not simply conduct this analysis with respect to HIV in prison in general, however. Instead, the court must consider the risk of transmission with respect to each specific aspect of institutional life in which the plaintiffs claim exclusion. See Harris, 941 F.2d at 1526 (reversing the district court because it "should have determined the risk of transmission not merely with regard to prison in general, but with regard to each program from which appellants have been automatically excluded"). Because the plaintiffs have not provided clear guidance on how the court should parse their claims, the court will do so according to the different contexts in which the transmission risk may differ. Assessment of the risk with regard to men must be separate from that with regard to women, since the

21. The court notes the obvious fact that this is not a case in which the plaintiffs are unqualified because of legitimate eligibility requirements unrelated to their HIV status. See, e.g., Pottgen v. Mo. State High Sch. Activities Ass'n, 40 F.3d 926, 928 (8th Cir. 1994) (addressing argument that student was excluded from interscholastic sports because of legitimate maximum-age-eligibility requirement, not because he had learning disabilities). On the contrary, here, because housing is a necessary component of institutional life that is

21. (...continued)
individuals" and that threat could not be eliminated with reasonable accommodations. Id. at 1296-97 (citations

107, at 6. As the viral load drops, so does the risk of transmission, and, once full viral suppression is obtained, the risk is essentially non-existent.

The level of scientific certainly for this general principle, however, differs in different contexts. The best data available come from randomized controlled trials. In 2011, Science magazine reported the results of one such trial showing that, among heterosexual couples, the use of antiretroviral therapy dramatically reduces transmission of the disease. Science deemed these results its "Breakthough of the Year." The randomized control trial studying the effect of antiretroviral therapy on transmissions between men who have sex with men is still underway. However, "community viral load data among men who have sex with men" suggest "a markedly reduced level of transmission" for that group as well. It was clear to the court that both the plaintiffs and the ADOC had adopted the general principle that virally suppressed individuals are highly unlikely

to transmit HIV sexually, whether the sexual act is between people of different sexes or of the same sex. None of the ADOC's experts disputed the proposition that viral suppression dramatically reduces a person's ability to transmit HIV through sexual activity: The ADOC's expert witness, Dr. Steven Scheibel, stated that: "[S]omeone's not infectious in terms of sex if they have an undetectable viral load .... If ... people ... are on antiretroviral medication and the virus level is OC'herhaitylso bopleno com. aat:

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antiretrovirals, the virus will be only have a minimal presence in the blood and body fluids. Based on the current state of medical knowledge, Dr. Altice found it probable that viral suppression reduces risk of transmission via needle sharing: "[C]ohort studies and community types of studies ... suggest[] that this treatment as prevention paradigm works for all groups. However, he conceded that "the jury's not in 100 percent" in that regard. Dr. Scheibel was more skeptical: "[T]he bottom line is that we do not know how transmission may occur when people are sharing needles and when people are tattooing in terms of HIV transmission." Despite Dr. Altice's optimism and indicators showing that virally-suppressed HIV-positive persons pose a drastically reduced risk of transmission when sharing needles, "'[l]aw lags science; it does not lead it.'" McClain v. Metabolife Int'l, Inc., 401 F.3d 1233, 1247 (11th Cir. 2005) (quoting Rosen v. Ciba-Geigy Corp., 78 F.3d 316, 319 (7th Cir. 1996)). Therefore, at this time, the court

cannot conclusively find that virally suppressed HIV-positive individuals who share needles pose no, or only a nominal, risk of transmission.

In addition to individuals who obtain viral suppression through medication, there is another very small group called "elite suppressors" who often have undetectable viral loads without the aid any HIV medications. The risk of elite suppressors spreading the virus is similar to that of persons who have obtained viral suppression throughout treatment. Dr. Scheibel's chart review of HIV-positive prisoners at Limestone reveals that the vast majority of prisoners on antiretroviral medications have acheived viral suppression. He also identified one elite suppressor among those who are not on HIV medication.

Based on this evidence, it is clear that at least some, if not a majority, of HIV-positive prisoners at Limestone present a very low risk of transmitting the

virus.[22] Prisoners who have achieved viral suppression pose an infintesimal risk if they abstain from sharing needles, regardless of whether they have sexual intercourse with other prisoners.

The understanding that some people with HIV are very unlikely to transmit the disease is shared by ADOC Commissioner Thomas. In the context of addressing the criteria the department uses to determine whether HIV-positive prisoners are eligible for work release, he explained that "the medical criteria allows ... a person [for] who[m] the risk of transmission is almost zero to have access to a work-release program." Implicit in that testimony is that Commissioner Thomas not only believes that individuals exist within the system who are not

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22. Despite the power of antiretrovirals to reduce the odds of transmission, adherence is key to the medications' success. People infected with HIV who are virally suppressed can quickly become infectious again if they cease to take their medicines.

infectious, but he also that believes that the ADOC is able to identify those individuals.[23]

The level of risk is somewhat different for prisoners who were not previously diagnosed with HIV (but had been unknowingly living with the disease) before entering the ADOC's custody. This group is, generally speaking, very infectious until medication takes effect. As the medication takes effect and the viral load lowers, the risk of transmission decreases accordingly. Thus, for these prisoners, the probability of transmission will depend on the length of time over which they are adherent to medication and their behavior. Should they engage in high-risk behavior (including both sex and needle-sharing) before achieving viral suppression, the risk of transmission is high. On the other hand, if these

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23. Since HIV-positive prisoners are not segregated at work release, but are housed alongside HIV-negative prisoners, Commissioner Thomas's statement also relates confidence that the department can safely house at least some HIV-positive individuals with prisoners who are HIV-negative.

prisoners abstain from voluntarily participating in behavior that risks transmission, the risk is minimal. However, even in the absence of high-risk behavior, involuntary occurrences (such as rape) create some risk. Nevertheless, on balance, the probability of transmission posed by even a quite infectious person who does not voluntarily engage in high-risk behavior is generally low, and it will reduce drastically as treatment takes effect.

There may exist a small minority of prisoners who, for various reasons, will never achieve viral suppression (barring further advances in science or changes in behavior). For example, some people with HIV who have poorly adhered to antiretroviral medications develop strains of the virus that are resistant to treatment. Others may, for various reasons, be unwilling to take medications altogether. For these prisoners, the risk and probability of transmission are largely a function of

behavior (though this risk will be higher than that posed by prisoners who have achieved viral suppression), and the duration of the risk is indefinite. Essentially, the risk posed by this group is the same as that posed by all HIV-positive prisoners before the advent of antiretroviral treatment.

The ADOC's argument that integrating HIV-positive prisoners would increase the number of transmissions stems from the indisputable fact that integration would increase opportunities for high-risk behavior. However, the picture is more complex than the department suggests. HIV-positive and HIV-negative prisoners at Limestone already have ample opportunity to interact with one another and engage in high-risk activity in areas of the prison other than their housing units. As Dr. James Austin, a nationally renowned expert in prison and jail classification and risk assessment, explained, "sexual contact between prisoners occurs in virtually all areas

24. The low transmission rate is particularly notable because in the earlier litigation challenging the more

instead appears that so long as integration is handled responsibly, it is unlikely to meaningfully increase transmissions, if at all.

Further still, it is possible that eliminating the segregation policy could deter high-risk behavior in some instances. Dr. Altice opined that, among HIV-negative prisoners prone to risky behavior, segregation could create a false sense of security. Believing that no one in their midst had HIV, they may be more willing to engage in high-risk behavior than they would otherwise. This could place them at risk for contracting HIV from highly infectious HIV-positive prisoners who were not segregated because they were tested during the "window period" (and for countless other sexually transmitted infections). Thus, perversely, it is at least, arguably, possible that the segregation policy could lead to

25. Deputy Commissioner Emmitt Sparkman of the

Regardess of the likelihood of transmissions, the significance of transmission for the person who becomes infected with the virus should not be understated. There is no cure for HIV at this time. Therefore, should a prisoner in the custody of the ADOC become HIV-positive while incarcerated, he will remain so for the rest of his life (barring scientific advances). Accordingly, he would be burdened with a lifelong responsibility to maintain access and adhere to antiretroviral treatment, a failure to do so likely resulting in a dramatically shortened lifespan. For the disproportionately poor prisoners in the ADOC, this responsibility (which is literally a matter of life or death) is no small thing. On the other hand, the consequences of being HIV-positive are not nearly as severe today as they were during an earlier time. As has been discussed, the vast majority of people with HIV enjoy near-normal lifespans. They can typically be treated with a simple one-pill-a-day regimen

free of crippling side-effects. And, because of antiretrovirals, they can also engage in ordinary sexual behavior without reasonable fear of transmitting HIV to their partners. With appropriate treatment, they can have lives nearly identical to those of people who do not have HIV (that is, aside from having to take medications).

Balancing these factors and weighing "the odds that transmission will occur" against "the severity of the consequences," Onishea, 126 F.3d at 1297, it is obvious that, given the life-changing advances in HIV treatment, ceasing the housing, categorically, of all HIV-positive prisoners exclusively in Limestone's Special Unit would not create "a direct threat to the health or safety of other individuals" within the meaning of the ADA. Onishea, 171 F.3d at 1296-97. A very low risk would be created if the ADOC integrated HIV-positive prisoners on an individual-by-individual basis, based, for example, on

whether their viral levels are suppressed and whether they have a demonstrated history of medication adherence and abstinence from high-risk behavior. That description could fit many prisoners currently incarcerated in the Special Unit; segregating them thus violates the ADA. On the other end of the spectrum, a threat could be created if the ADOC integrated (without imposing additional safeguards) HIV-positive prisoners with high viral loads who refuse to take medication and who have a history of risky behavior (for example, attempting to rape other prisoners).[26]

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26. Integrating such persons could, in certain circumstances, amount to a violation of the Eighth Amendment's prohibition of cruel and unusual punishment. See, e.g., Gates v. Collier, 501 F.2d 1291, 1300 (5th Cir. 1974) (finding an Eighth Amendment violation where inadequate medical care resulted in, among other things, "inmates with serious contagious diseases [being] allowed to mingle with the general prison population"); Clark v. James, 794 F.2d 595, 596 (11th Cir. 1986) (requiring "reconsideration of appellant's claim that by assigning him to prison duties requiring exposure to contagious diseases, prison officials violated his eighth ... amendment rights"); Billman v. Ind. Dept. of Corr., 56

(continued...)

What is critical here is that, despite this range of risk, the ADOC maintains a blanket policy of precluding all HIV-positive prisoners at Limestone from integrated housing, regardless of their individual circumstances. That policy denies plaintiffs the individualized determinations to which they are entitled under the ADA, see Arline, 480 U.S. at 287, and unjustifiably treats all HIV-positive prisoners identically, despite the fact that their circumstances are materially different, not identical. See Kapche v. City of San Antonio, 304 F.3d 493, 499 (5th Cir. 2002) (describing Supreme Court precedent interpreting the ADA as "consistently

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26. (...continued)
F.3d 785, 788 (7th Cir. 1995) (upholding Eighth Amendment claim alleging that "employees of the prison system, knowing that [a prisoner] had a history of raping his cellmates and was HIV-positive, nevertheless placed [the plaintiff] in the same cell without warning him of the danger he faced, and that they did nothing to interrupt the rape while it was in progress"). However, even with these prisoners, the court can discern no reason why the ADOC would need to treat them differently from other prisoners who have shown sexually predatory behavior and have serious infectious diseases other than HIV.

point[ing] to an individualized assessment mandated by [the act],” and “further not[ing] that [the court is] unaware of any decision from [its] sister Circuits abrogating the requirement of an individualized assessment in favor of a per se exclusion under the ADA.”). For this reason, the ADOC is currently violating the rights of the HIV-positive prisoners within its custody by categorically segregating them because of their HIV status and excluding them from the integrated housing for which they may be qualified.

The court witnessed the impact of the segregation policy when it toured Limestone and the Special Unit with both legal teams during the trial. The court recognizes that the prisoners in the Special Unit were locked down during the visit out of consideration for the court's safety. Even discounting the effect of the lockdown, the Special Unit evoked the feeling of a place abandoned. The prisoners there displayed a striking uniformity of

disposition. They peered, sullen, from their cells. The quiet, which the ADOC touted at trial as an asset of the unit, seemed instead to accent the dormitories' isolation from the lively general-population dorms, communicating these prisoners' exclusion. The imposing cage around the residential treatment unit, where mentally ill prisoners with HIV are kept, allows any observer to see the activity within. The effect of a severely mentally ill man isolated within the cage, which juts into the common area where the prisoners eat and watch television, would surely be disturbing to those both within it and without. It is evident that, while the ADOC's categorical segregation policy has been an unnecessary tool for

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housing at Limestone, the court need not draw such lines now, at the liability stage. This case is a class action including as plaintiffs all present and future HIV-positive prisoners within the custody of the ADOC. See Henderson v. Thomas, 2012 WL 3777146 (M.D. Ala. Aug. 30, 2012) (Thompson, J.) (certifying class). Consequently, for the ADOC to escape liability, there must be not a single HIV-positive prisoner who is or could be qualified for, and thus has the right to, integrated housing. That is clearly not the case. For now, it is sufficient to say that, pursuant to binding Supreme Court and Eleventh Circuit case law, the ADOC is in violation of the ADA with respect to the plaintiff class.

The only barrier to integrated housing for qualified prisoners at Limestone is the ADOC's medical classification system, which treats all HIV-positive prisoners identically and precludes them from being integrated. As such, the sole accommodation necessary

27. The ADOC asserts a fundamental-alteration defense to these accommodations. If accommodations amount to a fundamental alteration, the defendants need not make them. "[A] proposed accommodation amounts to a 'fundamental alteration' if it would eliminate an 'essential' aspect of the relevant activity." Schwarz v. City of Treasure Island, 544 F.3d 1201, 1220 (11th Cir. 2008) (citations omitted). For example, in PGA Tour,

For those prisoners who are not currently qualified (perhaps because they are highly infectious), the law requires the ADOC to make reasonable accommodations that would render them qualified. See Bircoll, 480 F.3d at 1081-82 (citing 28 C.F.R. § 35.130(b)(7), which requires that "[a] public entity ... make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on

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27. (...continued)
... give a disabled player ... an advantage over others," thus "fundamentally alter[ing] the character of the competition." Here, the ADOC contends that, because its current treatment of HIV-positive prisoners was shaped in part by prior litigation (in particular, the consent decree in, Leatherwood v. Campbell, No. CV–02–BE–2812–W (N.D. Ala. Apr. 24, 2004) (Bowdre, J.)), any change from the status quo would constitute a fundamental alteration. This contention is without merit. The fundamental-alteration defense is not intended to serve the purpose of foreclosing successive litigation on related (albeit not identical) issues. Moreover, despite what the ADOC may imply, the Leatherwood court did not order the ADOC to segregate HIV-positive prisoners from the general prison population; it merely addressed the unconstitutionally inadequate conditions of confinement that HIV-positive prisoners faced at Limestone at the time, namely, inadequate medical care. The court sees no tension between Leatherwood and its decision today.

the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.").

The plaintiffs have shown that reasonable accommodations exist that would reduce (and even eliminate) most of these individuals' odds of transmitting the disease. Principally, Dr. Altice explained that, "From a public health and clinical perspective, the rational way to reduce the risk of HIV transmission in prison is not through housing segregation but through effective HIV treatment." Altice Report, Pls.' Ex., at 6. Under this approach, antiretroviral medication is offered to every HIV-positive person who is ready and willing to take it so that it will suppress the virus and reduce or eliminate the chances of transmission. Taking this step could eliminate many prisoners' likelihood of transmitting HIV. Thorough

education would also play a preventative role. These methods are reasonable ways to reduce the risk of transmission.

The court emphasizes that, in affording HIV-positive prisoners the individualized determinations to which they are entitled, the ADA grants the ADOC discretion in choosing how best to do so. See, e.g., Frame v. City of Arlington, 657 F.3d 215, 246 (5th Cir. 2011) ("Indeed, a municipality is granted the discretion to choose how best to make its services accessible."), cert. denied, 132 S.

particular prisoners' qualifications for integration, the ADOC is entitled to rely on the reasonable judgments of its medical professionals. See Olmstead, 527 U.S. at 602 ("Consistent with [the ADA's prohibition of unnecessary segregation], the State generally may rely on the reasonable assessments of its own professionals in determining whether an individual 'meets the essential eligibility requirements' for habilitation in a community-based program."); Arline, 480 U.S. at 288 ("[C]ourts normally should defer to the reasonable medical judgments of public health officials.").

However, while the law grants the ADOC deference in choosing how to satisfy its responsibilities, the department is of course obligated to act in good faith as it works to ensure that no prisoner in its custody remains unnecessarily segregated because of his HIV status. Cf. Griffin v. United Parcel Serv., Inc., 661 F.3d 216, 224 (5th Cir. 2011) ("[W]hen an employer's

unwillingness to engage in a good faith interactive process leads to a failure to reasonably accommodate an employee, the employer violates [Title I of] the ADA.") (citation omitted).

A final aspect of the ADOC's housing policy at Limestone warrants brief discussion: the practices in Dorm E. That dormitory houses both HIV-positive and HIV-negative prisoners who have been placed in administrative or disciplinary isolation. As was noted above, before the end of trial, the ADOC conceded this aspect of the plaintiffs' challenge and assured the court that its practices would change. Now, the ADOC urges the court to disregard the issue, arguing that it has been mooted. The court, however, finds good cause for resolving the matter. For the reasons given earlier, the court has not been deprived of its power to determine the legality of this challenged conduct simply because the ADOC says it has voluntarily ceased that conduct during the course of

litigation. See Nat'l Ass'n of Bds. of Pharmacy, 633 F.3d at 1309. Moreover, the ADOC's conceded practices have evidentiary relevance; they speak to the credibility of the department with regard to other justifications, and they provide evidence of the department's intentional discrimination against individuals with HIV.

Unlike prisoners housed in other parts of Limestone, prisoners in Dorm E are restricted to their closed (and locked) cells (each of which holds only a single prisoner) for almost the entire day. They leave their cells only when handcuffed and escorted by ADOC staff. Because of this intensive monitoring, they have no physical contact with one another at any time, and consequently, transmission of HIV between an HIV-positive and HIV-negative prisoner in isolation is not remotely possible. Nevertheless, the HIV-positive and HIV-negative prisoners in Dorm E are segregated: HIV-positive prisoners are clustered together separately from the HIV-

negative prisoners. Because the size of each group will differ depending on isolation needs at the time, the dorm features a "floating gate" that the ADOC uses to demarcate the border where the HIV-positive cluster ends and the cells housing HIV-negative prisoners begin.

Because ending segregation in Dorm E would present absolutely no risk of harm, it is clear that the ADOC's policy of separating HIV-positive prisoners and HIV-negative prisoners in the dormitory and using the physical infrastructure of the building to indicate which prisoners have HIV, is, and has always been, wholly unnecessary and promotes no legitimate purpose. As such, it serves only to discriminate for the sake of discrimination. That is precisely the sort of "irrational disability discrimination" that the ADA "seeks to [prohibit]." Tennessee v. Lane, 541 U.S. 509, 522 (2004); see also Bledsoe v. Palm Beach Cnty. Soil and Water Conservation Dist., 133 F.3d 816 821-22 (1998)

(holding that the ADA prohibits "all discrimination by a public entity" regardless of the form it takes).

The ADOC's practices in Dorm E are most relevant in

Judicial Request (Doc. No. 240) at 1-2 (responding to a judicial inquiry about the purpose of the Dorm E practices by referencing unspecified prior "conflicting statements," but not attempting to put forth any actual purported purpose).

In addition to Dorm E, certain other unnecessary features remain in place at Limestone. One standard operating procedure, which remains on the books (though purportedly unenforced), warns that, "Routine physical contact with Special Unit inmates should be kept at a minimum at all times." Joint Ex. 7, at 3. "Any staff member who enters the cell of a Special Unit inmate may wear ... 1) plastic or latex gloves; 2) Face mask; 3) Goggles; 4) Protective Rainwear." Id. A barbed-wire fence surrounds the two Special Unit dorms. Originally, that fence separated HIV-positive prisoners from general-population prisoners in the common yard. The gate to the fence is kept open now, but the fence is no less

visible; it remains a stark reminder of the HIV-positive prisoners' separation.[28] These relics of the department's earlier policies, unaltered despite having no current purpose, suggest that other aspects of the policy are likewise relics of a different era, retained by the department due more to inertia than because they are truly needed today.

Moreover, these other unnecessary features matter in their own right, even if unused. They impress upon both the prisoners and ADOC staff that HIV-positive prisoners are different and dangerous. Despite the ADOC's

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28. The fence's purpose (enforcing segregation) is obvious in the layout of the prison. Much of Limestone's grounds are symmetrical. After entering the prison's front entrance, to the left is the "A-Side" of the facility, and to the right is the "B-Side." Each side is made up of five separate dormitories (all of which are identical) that are laid out in a circle with a common yard in the middle. Two of A-Side's dormitories, Dorms B and C, make up the Special Unit. A-Side and B-Side are completely identical in their physical appearance, except that for the large, barbed-wire fence that cuts through the middle of the common yard and around the two Special Unit dormitories. Of course, no such fence exists on B-Side (which is otherwise identical in all respects).

modifications to its policy in recent years, the symbolic power of the segregation policy has not been diluted. Like the fence with its unlocked gate, the barrier between the prisoners with HIV and the rest of the prison is more visible and more imposing than the narrow doorways that allow them access.

b. Exclusively Housing HIV-positive Men at Limestone and Decatur Work Release

The ADOC has neither argued nor given the court any reason to believe that the transmission risk posed by housing HIV-positive prisoners in general-population dorms at Limestone would differ in any meaningful way from housing HIV-postive prisoners in general-population dorms at other facilities throughout the State. Nor has the ADOC argued or presented evidence that housing HIV-positive prisoners at a work-release facility other than Decatur would pose any additional risk of transmission. Therefore, the court may answer the "otherwise qualified"

question with the same analysis under Arline articulated with respect to housing within Limestone. In terms of the Arline analysis, to the extent that HIV-positive prisoners are qualified for integrated housing within Limestone, they are, to the same extent, qualified for integrated housing at any other facility. Similarly, the same accommodations that the court has already found reasonable (modifying the ADOC's classification system and various prevention measures) would suffice to consider HIV-positive men for prisons other than Limestone. Since HIV-positive prisoners are already housed in an integrated setting at Decatur Work Release, the court finds that no concerns about transmission justify a blanket bar on housing HIV-positive prisoners at other work-release facilities.

The question, instead, is whether housing prisoners at facilities other than Limestone and Decatur would impose an undue burden on the State. In essence, the

29. (...continued)
substandard housing provided to HIV-positive prisoners. In the 2004 settlement, the ADOC agreed to significant changes to its housing and standard of medical care for prisoners with HIV. In 2006, the consent decree expired. However, the ADOC has continued to adhere to its terms. Experts on both sides agree that the current level of care is good, and the ADOC has shown that it may well exceed the level of care typically provided in the community.

30. The ADOC argues that the plaintiffs can find no relief here because the ADOC's prisoners, regardless of

The court first observes that care for HIV-positive individuals can be highly variable, ranging from profoundly complex care to a regime that is relatively simple. In assessing the ADOC's claims, the question is not whether every facility or even whether any additional facility could provide adequate care for the most ill prisoners, but rather whether any facility could provide HIV care for any of the system's HIV-positive prisoners.

One critical component of the ADOC's current system of care is the availability of an HIV specialist to meet with prisoners at Limestone. The parties dispute how often and to what extent a specialist must be involved in

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30. (...continued)
services and programs afforded to all inmates." Defs.' Pretrial Br. (Doc. No. 211) at 31. The ADOC misconstrues the plaintiffs' claim. The plaintiffs do not request a right to transfer to the facility of their choosing; the plaintiffs ask only not to be segregated on account of their HIV status. Cf. United States v. Jefferson Cnty. Bd. of Educ., 380 F.2d 385, 390 (5th Cir. 1967) (school children have the right to desegregated education despite the fact that "a schoolchild has no inalienable right to choose his school").

care. Dr. Altice opined that, while it is appropriate for HIV patients initially to be monitored quarterly by a specialist, patients who become stabilized and virally suppressed do not require such frequent consultation with a specialist: instead, they can be monitored by a specialist as little as twice a year. Dr. Altice found that, for a stable patient, a specialist may also evaluate laboratory results without even seeing the patient. The ADOC's experts contested Dr. Altice's view. Dr. Lyrene noted that some very sick patients must see a specialist every day. Dr. Schiebel stated that, while biannual appointments with a specialist may be appropriate for a stabilized and adherent patient, a more conservative approach is appropriate in the prison environment, where adherence to medication is a challenge. Dr. Scheibel also emphasized the value of a specialist's opinion in evaluating lab results, addressing drug interaction concerns, and treating comorbitities.

available that could make HIV specialty care available at multiple facilities. One means of doing so, much debated at trial, is telemedicine, whereby an HIV specialist would virtually consult with primary care providers in other locations.[31] The ADOC's primary argument against telemedicine is based on cost. To that end, the department presented Hal White, the director of an information technology consultancy. White conducted a thorough evaluation of the costs of implementing

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31. The court finds it clear the telemedicine is an adequate means of providing access to specialty care. However, the debate over its merits at trial warrants some discussion. Dr. Altice testified that telemedicine has been effectively used for the provision of HIV specialty care in a number of other prison systems. Dr. Scheibel suggested that telemedicine is less than ideal because the primary care physician may lack experience with HIV and may not report back to the specialist. However, he also reported that most patients he had consulted via telemedicine had good outcomes, although several experienced nonadherence problems, which he attributed to unknowledgable primary care physicians. Dr. Lyrene expressed concern about practical matters, such as the handling of patient files. The court finds that these concerns can be addressed through simple planning and training, particularly since telemedicine has been effectively implemented elsewhere. Further, while the ADOC's experts identified concerns about telemedicine, neither suggested that it is an inadequate means of providing HIV care.

telemedicine within the ADOC and visited various facilities to assess potential challenges. He estimated that the total cost of installing the necessary technological equipment for all ADOC prison sites for five years would be $ 2,026,619.53. While the ADOC emphasized this larger number at trial, the cost for each individual facility was estimated at $ 21,184 for equipment with an additional $ 8,217.53 to install special equipment at Limestone, from which it is presumed the HIV-specialist would operate. The facilities would then have highly variable maintenance costs, ranging from a total of $ 8,000 per facility over a five-year period to $ 49,250 per facility. The General Fund Appropriation for the ADOC for fiscal year 2012 is $ 377,900,000; the total cost of adding telemedicine at one facility for five years at even the most expensive facilities therefore amounts to .02 % of the ADOC's budget. At the least expensive facilities (of which there are 13, according to White's expert report), the cost would amount to less than .01 % of the budget. Given this,

while the court stops short of deciding whether telemedicine is the best or even a good option for the ADOC, the court concludes that it would not be prohibitively costly to install telemedicine in at least one additional facility (and, indeed, the plaintiffs do not insist that it should be installed at every facility in the system).

Even if telemedicine were not possible, however, the plaintiffs also make the plausible suggestion that an HIV specialist could travel to different locations within the system to see patients. Further, the plaintiffs presented evidence that in certain other states, HIV-positive prisoners travel to a designated prison for HIV specialty care. The court finds both of these options particularly feasible since stable HIV patients require care only quarterly or biannually. In sum, the court is not convinced that the ADOC could not find a reasonable, cost-effective way to provide HIV specialty care on an as-needed basis in at least one facility other than Limestone.

The ADOC similarly argues that the other members of its medical staff, from doctors to pharmacists, cannot provide adequate HIV care at any facility other than Limestone. The department contends that it cannot train staff at other facilities to provide adequate HIV care. Further still, the ADOC claims that its staff cannot adequately provide the routine monitoring necessary to track the progress of HIV.

However, even if the court takes the ADOC's experts at their word when they say that the department's medical staff is not currently equipped to handle even basic care for HIV-positive prisoners, the court does not find it credible that the ADOC cannot sufficiently train at least some medical staff enough that they could provide the most basic HIV care. The plaintiffs have shown that an abundance of resources exist in Alabama from organizations that specialize in the provision of HIV care and are ready and willing to train ADOC staff for free. For instance, Dr. James Raper, who directs the 1917 Clinic, a multispecialty HIV practice at the

University of Alabama at Birmingham with vast experience in the provision of HIV care (including to patients exiting the correctional system) testified that he would be open to having health care providers at his clinic assist with the delivery of health care to HIV-positive prisoners on a consulting basis. Madeleine LaMarre, a nurse practitioner who served as nursing director and clinical services manager for the Georgia Department of Corrections and participated in a committee to oversee that department's transition from a segregated to integrated system for HIV-positive prisoners, evaluated the resources available in Alabama for HIV treatment and concluded that these resources were adequate to train ADOC staff at multiple facilities. Given LaMarre's experience overseeing Georgia's transition from a segregated to integrated system and her personal outreach to HIV care professionals in Alabama, the court finds that her testimony merits substantial weight.

Dr. Altice also presented evidence that effective training has been possible in several state systems, many

of which he consulted during that process. In Florida, for instance, he helped create a mini-residency program to train correctional medical staff throughout the state in routine primary HIV care. On-site training helped to "create[] de-facto treating experts where there had previously been a complete void." Moreover, this was all achieved at a time when, unlike today, HIV care was "really, really complex" across the board.

It is readily apparent that, if the ADOC wishes to train medical staff at other facilities (at least enough to equip them to address the basic needs of stabilized, virally suppressed HIV-positive prisoners), it may do so. Further, it may do so at minimal or no cost.

free training for medical staff in HIV care. Further still, in making a determination that delivering HIV care at facilities other than Limestone would raise costs, she did not consult with a single community health-care organization in Alabama. This would have been fruitless, she assumed, because "community providers ... generally do not wish to come into the confines of the prison. So therefore, we would have to take our inmates out into the community to receive care." Based on the testimony of the plaintiffs' witnesses, her assumption was incorrect.

Dr. Scheibel testified that, even if training was

positive effect on adherence (or any therapeutic benefits whatsoever). Indeed, the plaintiffs in this case uniformly expressed only deep sadness at being segregated, and the ADOC presented no prisoner witnesses to contradict this testimony. Therefore, while the court finds that adherence is of tantamount concern for HIV patients, the court does not find that housing prisoners in a segregated environment makes adherence more likely. To the extent that the ADOC argues that adherence issues are better addressed by professionals who are knowledgable about HIV, the court finds that, given the resources available, this concern can be addressed through training. In any event, and perhaps most importantly, the ADOC has also not shown why it could not identify prisoners with an adherence problem and address those prisoners' behavior separately from adherent patients; indeed, Dr. Scheibel was able to identify such individuals in his chart review. In sum, adherence should be addressed on an individual-by-individual basis, as the ADA requires, rather than categorically.

The ADOC's arguments about medical care are also undermined by the wide variety of correctional systems that have successfully provided care in more than one facility. It is evident that there is no one-size-fits-all approach. Each system approaches this issue differently based on its needs. Dr. Altice provided several examples of systems in which he served as a consultant. In California, for example, the largest prison system in the country, facilities throughout the State can manage HIV, but the State also maintains a central unit where patients with complex medical needs can go on a purely voluntary basis. In Texas, routine HIV care is provided at prisons throughout the State, often supplemented by specialty care provided via telemedicine. Texas also maintains specialty centers for more intensive treatment. Florida maintains six to eight "centers of excellence" to manage complex HIV, but does not require HIV-positive prisoners to remain at these centers if their conditions are stable. In Massachusetts, HIV patients are monitored on-site

as the "window period," generally lasts for a few weeks, but can extend as long as three months, and the people experiencing it represent the most infectious group of individuals with HIV.

Acute HIV gives way to chronic-HIV infection. During this stage, the viral load lowers. The final stage, advanced-HIV infection, occurs when the body's CD4 T-cells, which play a critical role in the immune system, drop to low levels and the viral load rises.[1] More commonly, this final stage is known as acquired immunodeficiency virus, or AIDS.

HIV emerged in the United States in the early 1980s and soon grew into an epidemic. HIV inevitably progressed to AIDS. Virtually everyone infected died. Meanwhile, no one, including the medical community, understood how HIV was transmitted. Fearing that even casual contact could spread it, doctors treating patients

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1. As the facts will show, not everyone with HIV will enter this final stage.