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# Action on HIV/AIDS in Prisons: Too Little, Too Late

A Report Card

prepared by  
Rick Lines



Canadian  
Strategy on  
HIV/AIDS

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# Executive Summary

## Background

The issue of HIV/AIDS and prisons has been studied extensively in Canada and internationally. Since 1992, a number of reports have been released in Canada providing recommendations to the federal and provincial/territorial governments about how best to implement a comprehensive and compassionate response to the HIV/AIDS and hepatitis C (HCV) crisis in prisons.

In 1992, the Prisoners' HIV/AIDS Support Action Network (PASAN) released *HIV/AIDS in Prison Systems: A Comprehensive Strategy*. Shortly after the release of the PASAN report, the Correctional Service of Canada created the Expert Committee on AIDS and Prisons (ECAP) to assist the federal government in promoting and protecting the health of prisoners and of staff, and preventing the transmission of HIV and other infectious agents in federal correctional institutions. In 1994, ECAP released a report with 88 recommendations.

In 1996, *HIV/AIDS in Prisons: Final Report* was published by the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society. The Final Report reviewed the history of the response to HIV/AIDS in prisons since the release of ECAP's report, nationally and internationally; presented relevant new developments in the area; examined whether there is a legal and/or ethical obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV; and addressed the issue of the potential liability for not providing condoms, bleach, and sterile needles, and the resulting transmission of HIV in prisons. The goal was to assist the Correctional Service of Canada (CSC) and provincial/territorial prison systems in their efforts to reduce HIV transmission in prisons and to staff and the public. The Final Report contained a list of recommendations for action which updated some of the recommendations made by ECAP. It concluded that "unless CSC and provincial[/territorial] prison systems now act quickly and decisively, they may be held morally and legally responsible for the consequences of their inaction for prisoners, staff, and the public." The Report was submitted to both the federal and the provincial/territorial governments for response and action.

## HIV/AIDS in Prisons: 2002 Report Card

In 2002, over five years after the release of the 1996 Final Report, and 10 years after CSC created ECAP, it is time to assess whether the call for action made in the Final Report has been heard, and to document what progress, if any, has been made in Canada in responding to HIV/AIDS in prisons.

A questionnaire was developed and sent to the federal and provincial/territorial ministers of health and ministers responsible for corrections in September 2001, asking them what actions they have undertaken to respond to the recommendations in the 1996 Final Report.

Follow-up interviews were made in September 2002, to verify and update the information provided. Responses were received from all 14 jurisdictions.

Some jurisdictions have totally and abysmally failed to wake up to the reality of HIV/AIDS, HCV, and injection drug use in prisons.

This paper summarizes the information provided and comments on it. It highlights positive action undertaken by prison systems since 1996, as well as presenting a detailed picture of the current state of HIV/AIDS programs and services in the prisons of each jurisdiction. An overview of significant national trends is also provided.

It is hoped that this information will assist each jurisdiction in assessing where they are at, and where they should be, in responding to HIV/AIDS and HCV.

## Summary of Findings

### Prevalence of HIV/AIDS and HCV

The prevalence of HIV/AIDS and HCV in federal and provincial prisons has continued to increase since 1996. In particular, in Canada's federal prison system, the number of reported cases of HIV/AIDS rose from 14 in January 1989 to 159 in March 1996 and 217 in December 2000 (the last month for which CSC has released statistics). This means that since the release of the 1996 Final Report, known cases of HIV/AIDS have increased by over 35 percent within a four-year period.

Known cases of HIV infection among women in federal institutions were even higher, with 4.69 percent of incarcerated women known to be HIV-positive in December 2000. In one institution, Edmonton Institution for Women, 11.94 percent of prisoners were known to be HIV-positive.

The actual numbers may even be higher: the reported cases, provided by CSC, include only cases of HIV infection and AIDS *known* to CSC, but many prisoners may not have disclosed their HIV status to CSC, or may not know themselves that they are HIV-positive.

Generally, about one in 600 (approximately 50,000 of 30 million) Canadians are living with HIV, but depending on the various studies undertaken, one in 100 to one in nine prisoners are living with HIV. This means that the proportion of prisoners with HIV is six to 70 times higher than the proportion of all Canadians with HIV.

HCV prevalence rates in prisons are even higher than HIV prevalence rates, and have continued to rise since 1996. Overall, 19.2 percent of all federal prisoners and 41.2 percent of women prisoners were known to be HCV-positive in December 2000. At Edmonton Institution for Women, 74.6 percent of prisoners were known to be HCV-positive. One in 125

(approximately 240,000=0.8 percent) Canadians are living with HCV, but one in five to more than one in two prisoners (20 to 80 percent) are living with HCV.

## **Governments' Response**

There have been some significant, positive developments since the release of the 1996 Final Report. Some jurisdictions have implemented a number of the recommendations and have undertaken noteworthy, sometimes innovative, initiatives. No jurisdiction, however, has implemented all recommendations, and some jurisdictions have totally and abysmally failed to wake up to the reality of HIV/AIDS, HCV, and injection drug use in prisons. Among the key findings:

Basic HIV prevention measures continue to be denied to prisoners.

- All Canadian governments are failing to provide the resources, leadership, and vision necessary to address, in a comprehensive and progressive fashion, the issues raised by HIV/AIDS, HCV, and injection drug use in prisons.
- There is a lack of coordination and harmonization of prison HIV/AIDS programs and services across the country. As a result, the standard of care available to prisoners varies widely between jurisdictions, and often between institutions within jurisdictions.
- Basic HIV prevention measures continue to be denied to prisoners.
- In some jurisdictions, condoms, dental dams and lubricant are still not available to prisoners. Even where they are available, they are often not accessible enough.
- Bleach remains unavailable in most jurisdictions.
- Needle exchange or distribution programs have yet to be piloted in Canadian prisons, although the steadily increasing number of prison syringe distribution programs in Western and Eastern Europe over the past 10 years provides conclusive evidence that such programs can be successfully implemented in prison; and despite CSC's own committee, tasked with examining needle exchange programs, which concluded in 1999 that they should be piloted in all regions of Canada.
- In most jurisdictions, methadone maintenance treatment has become available at least to those prisoners who were on such treatment before being incarcerated.
- Most jurisdictions have failed to embrace a harm reduction approach to drug use.
- With some notable exceptions, provision of HIV and HCV prevention education for prisoners is poor. Education is not mandatory in the vast majority of jurisdictions, and some correctional systems still do not provide basic HIV educational programs. In many jurisdictions, HIV training for prison health staff is rare or non-existent.
- Significant barriers still exist in most jurisdictions to the optimal use of HIV combination therapies.
- There are few HIV programs and services designed specifically for incarcerated women.
- HIV programs for Aboriginal prisoners are also rare, and are unavailable even in some of the jurisdictions in which the majority of incarcerated people are Aboriginal.

## Conclusion

Prison systems have a moral, but also a legal responsibility to act without further delay to prevent the spread of infectious diseases among prisoners, and to prison staff and the public, and to care for prisoners living with HIV and other infections. Canadian prison systems

This paper calls upon the federal and provincial/territorial governments to show more leadership, action, and commitment, and to implement all recommendations in the 1996 Final Report.

continue to fail to meet this responsibility. Some positive developments have occurred since 1996, but Canadian governments are clearly not doing all they could.

Although they live behind prison walls, prisoners are still part of our communities and deserve the same level of care and protection provided to people on the outside. They are sentenced to be imprisoned, not to be infected.

Therefore, once again, this paper calls upon the federal and provincial/territorial governments to show more leadership, action, and commitment, and to implement all recommendations in the 1996 Final Report.

As Justice Kirby of the High Court of Australia states, we owe it to the prisoners, and we owe it to the community, to protect people from infection while they are incarcerated. “This

“We must take all proper steps to protect prison officers and prisoners alike. By protecting them we protect society.”

requires radical steps before it is too late.... The infection of a person who is in the custody of society, because that person does not have access to ready means of self-protection and because society has preferred to turn the other way, is ... unpalatable.... As a community we must take all proper steps to protect prison officers and prisoners alike. By protecting them we protect society.”





## Background

The issue of HIV/AIDS and prisons has been studied extensively in Canada<sup>1</sup> and internationally.<sup>2</sup> Since 1992, a number of reports have been released in Canada providing recommendations to the federal and provincial/territorial governments about how best to implement a comprehensive and compassionate response to the HIV/AIDS and hepatitis C (HCV) crisis in prisons.

In 1992, the Prisoners' HIV/AIDS Support Action Network (PASAN) released *HIV/AIDS in Prison Systems: A Comprehensive Strategy*.<sup>3</sup> Shortly after the release of the PASAN report, the Correctional Service of Canada created the Expert Committee on AIDS and Prisons (ECAP) to assist the federal government in promoting and protecting the health of prisoners and of staff, and preventing the transmission of HIV and other infectious agents in federal correctional institutions. In 1994, ECAP released a report with 88 recommendations.<sup>4</sup>

In 1996, *HIV/AIDS in Prisons: Final Report* was published by the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society.<sup>5</sup> The Final Report reviewed the history of the response to HIV/AIDS in prisons since the release of ECAP's report, nationally and internationally; presented relevant new developments in the area; examined whether there is a legal and/or ethical obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV; and addressed the issue of the potential liability for not providing condoms, bleach, and sterile needles and the resulting transmission of HIV in prisons. The goal was to assist the Correctional Service of Canada (CSC) and provincial/territorial prison systems in their efforts to reduce HIV transmission in prisons and to staff and the public. The Final Report contained a list of recommendations for action which updated some of the recommendations made by ECAP. It concluded that "unless CSC and provincial[/territorial] prison systems now act quickly and decisively, they may be held morally and legally responsible for the consequences of their inaction for prisoners, staff, and the public."<sup>6</sup> The Report was submitted to both the federal and the provincial/territorial governments for response and action.

In 2002, over five years after the release of the 1996 Final Report, and 10 years after CSC created ECAP, it is time to assess whether the call for action made in the Final Report has been heard, and to document what progress, if any, has been made in Canada in responding to HIV/AIDS in prisons.

## Methods

A questionnaire was developed and sent to the federal and provincial/territorial ministers of health and ministers responsible for corrections in September 2001, asking them what actions they had undertaken to respond to the recommendations in the 1996 Final Report. Follow-up interviews with officials from all 14 jurisdictions were made in September 2002, to verify and update the information provided. The information was then written up in a “report card” format and sent back to the officials for verification and approval. The “report cards” are published in this paper as approved by the officials, but are accompanied by a commentary. In addition, a scheme to grade the correctional systems’ response in the area of harm reduction measures was developed, and each system’s response was assessed using this scheme.

## Objectives

The objective of this paper is to assess how well (or poorly) Canadian prison systems have responded to HIV/AIDS, HCV, and injection drug use by implementing (or failing to implement) the recommendations in the 1996 Final Report. It highlights examples of good practice, so that they can be reproduced elsewhere, and examples of bad practice, so that they can be remedied. It is hoped that this will assist prison systems in strengthening their response, and assist advocates in their efforts to increase HIV and HCV prevention in prisons and to improve care, treatment, and support for prisoners living with HIV/AIDS and/or HCV.

### Further Reading

- R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, September 1996. Available via [www.aidslaw.ca/Maincontent/issues/prisons.htm](http://www.aidslaw.ca/Maincontent/issues/prisons.htm)
- World Health Organization. *Statement from the Consultation on Prevention and Control of AIDS in Prison. Global Programme on AIDS*. Geneva:WHO, 1987; and the *WHO Guidelines on HIV Infection and AIDS in Prisons*. Geneva:WHO, 1993. Reprinted in appendix 5 of the 1996 Final Report.
- PASAN. *HIV/AIDS in Prison Systems: A Comprehensive Strategy*. Toronto: PASAN, June 1992.
- Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Ministry of Supply and Services Canada, 1994.



## New Developments

Since the Final Report was released in 1996, there have been many significant developments that have had an impact on the issue of HIV/AIDS and HCV in prisons. It is useful to review some of these issues, as they have a bearing on the current situation, and on the findings of this paper.

### HIV Prevalence in Prisons

Since 1996, HIV prevalence in prisons has continued to increase. In particular, in Canada's federal prison system, the number of reported cases of HIV/AIDS rose from 14 in January 1989 to 159 in March 1996 and 217 in December 2000 (the last month for which CSC has made its statistics available).<sup>7</sup> This means that since the release of the 1996 Final Report, known cases of HIV/AIDS have increased by over 35 percent within a four-year period. In December 2000, 1.66 percent of all federal prison prisoners were *known* to be HIV-positive, with the following regional variations:

From 1996 to 2000, known cases of HIV/AIDS in federal prisons increased by over 35 percent.

### Percentage of Prisoners Known to be HIV-Positive CSC, 2000

<b>Atlantic:</b>	<b>1.15 percent</b>
<b>Québec:</b>	<b>2.81 percent</b>
<b>Ontario:</b>	<b>0.75 percent</b>
<b>Prairie:</b>	<b>1.69 percent</b>
<b>Pacific:</b>	<b>1.47 percent</b>
<b>Total:</b>	<b>1.66 percent</b>

Known cases of HIV infection among women in federal institutions were even higher, with 4.69 percent of incarcerated women known to be HIV-positive. In one women's institution, Edmonton Institution for Women, 11.94 percent of prisoners were known to be HIV-positive.

**Percentage of Prisoners Known to be HIV-Positive  
in Women's Institutions  
CSC, 2000**

<b>Atlantic (Nova):</b>	<b>4.88 percent</b>
<b>Québec (Joliette):</b>	<b>3.45 percent</b>
<b>Ontario (Grand Valley):</b>	<b>0 percent</b>
<b>Prairie (Edmonton Institution for Women):</b>	<b>11.94 percent</b>
<b>Pacific (Okimaw):</b>	<b>4.69 percent</b>
<b>Total:</b>	<b>4.69 percent</b>

The actual numbers may even be higher: the reported cases, provided by CSC, include only cases of HIV infection and AIDS *known* to CSC, but many prisoners may not have disclosed their HIV status to CSC, or may not know themselves that they are HIV-positive.

The proportion of prisoners with HIV is six to 70 times higher than the proportion of all Canadians with HIV.

While there is little new data concerning HIV prevalence in provincial prisons, data from studies undertaken before 1996 showed that rates of HIV infection are also high in provincial prisons, ranging from one to 7.7 percent (in a medium-security provincial prison for women in Québec).<sup>8</sup>

Generally, about one in 600 (approximately 50,000 of 30 million) Canadians are living with HIV, but depending on the various studies undertaken, one in 100 to one in nine prisoners are living with HIV. This means that the proportion of prisoners with HIV is six to 70 times higher than the proportion of all Canadians with HIV.

**HCV Prevalence in Prisons**

HCV prevalence rates in prisons are even higher than HIV prevalence rates, and have continued to rise since 1996. In one federal prison, 33 percent of study participants tested positive in 1998, compared to 27.9 percent in 1995.<sup>9</sup> Overall, 19.2 percent of all federal prisoners and 41.2 percent of women prisoners were known to be HCV-positive in December 2000. At Edmonton Institution for Women, 74.6 percent of prisoners were known to be HCV-positive.<sup>10</sup> This means that one in 125 (approximately 240,000=0.8 percent) Canadians are living with HCV, but one in five to more than one in two prisoners (20 to 80 percent) are living with HCV. The proportion of prisoners with HCV is thus at least 30 times higher (and in some prisons, 100 times higher).

Given the similar transmission routes of HCV and HIV, the very high and increasing prevalence of HCV has provided further illustration of the urgent need to implement comprehensive harm reduction measures in prisons. In particular, it makes it even more impor-

tant to introduce needle exchange or distribution programs in prisons, since there is no evidence that bleach is efficacious in destroying HCV.

Finally, the fact that many prisoners are living with both HIV and HCV places additional demands on prison health systems.

## **New Treatments**

The emergence of HIV anti-retroviral treatments and combination therapies since 1996 has also had an impact on the delivery of prison health services. Many of these new drug regimens have been successful in improving the health of people living with HIV/AIDS. While these treatments are also available in Canadian prisons, they have highlighted how inflexible prison systems sometimes are when faced with prisoners who have special needs.

The effectiveness of many of these therapies is closely linked to strict timing of doses, and coordination of medications with diet and mealtimes. In most cases, prisons are unable to adequately meet these demands, as medical rounds and mealtimes rarely coincide with drug protocols. When doses are missed, there is a risk of the virus developing resistance to certain drugs, with potentially serious consequences for the individual, but also for public health. However, prisoners often miss doses of medications when they are arrested and placed in remand centres, when they are taken to court hearings, when they are transferred between institutions, and when they are released.

## **Prevalence of HIV Among Aboriginal People**

Since 1996, evidence that HIV/AIDS is disproportionately affecting Aboriginal people has increased. Aboriginal Canadians represent less than three percent of Canada's total population, but as many as one in four new HIV infections in Canada are among Aboriginal people.<sup>11</sup> This fact takes on particular significance for prison health because Aboriginal people are vastly over-represented in Canadian prison systems. Although comprising less than three percent of the general population, Aboriginal people represent approximately 15 percent of the provincial prison population and 17 percent of the federal prison population.<sup>12</sup> In Saskatchewan and Manitoba more than half the prison population is Aboriginal.<sup>13</sup> These statistics clearly indicate dual impacts of HIV infection and incarceration on Aboriginal communities, and highlight the need to provide appropriate HIV/AIDS programs and services for Aboriginal prisoners.

## **Methadone Maintenance Treatment**

Increased accessibility of methadone maintenance treatment (MMT) in many parts of Canada has also had implications on prison health policy. In the mid-1990s, the federal government relinquished its control over methadone regulation to the provinces. Subsequently, many provinces significantly increased the availability of methadone in the community. This had an impact on prisons, as increased numbers of methadone users in the community meant increased numbers of people entering the prison system on MMT. As a result, many prison systems have had to revisit their policies and programs regarding methadone provision.

## Action against Inaction: Litigation and Coroners' Inquests

Already in 1996, the Final Report noted how an increasing number of cases had raised the issue of governments' responsibility for the health of prisoners in their care, showing the willingness of prisoners to take legal action against government inaction.<sup>14</sup> The Report remarked that "[i]t is to be hoped that governments and the prison systems in Canada will act without prisoners having to undertake [further] legal action to hold them responsible for the harm resulting from their refusal to provide adequate preventative means."<sup>15</sup>

However, since 1996, we have seen a number of very high profile cases in which prisoners have undertaken legal action against CSC for failing to provide methadone maintenance treatment and/or needle exchange or distribution programs in prisons.

Prisoners have undertaken legal action against the federal prison system for failing to provide methadone maintenance treatment and/or needle exchange or distribution programs in prisons.

In one such case, the court did not even have to pronounce on the substantive issues raised. CSC expanded access to methadone maintenance treatment before the court forced it to do so. The prisoner in the case, Barry Strykiwsky, said he spent most of his life robbing people to pay for his heroin addiction. In 1998 he wanted to end his addiction, and begged prison officials to let him begin methadone treatment. His doctors supported him, but prison officials refused his request. Strykiwsky

then filed a lawsuit alleging the federal government broke the law and violated his rights under the *Canadian Charter of Rights and Freedoms* by not providing him with a treatment commonly available to other Canadians. Shortly after the lawsuit was filed, Strykiwsky was given methadone and prison officials asked him to drop his case. Strykiwsky refused, saying that without court backing, his methadone could be taken away from him at any time.

On 30 April 2002, a federal court judge in Winnipeg heard his case. Two days later, on 2 May 2002, CSC expanded access to MMT in federal prisons.<sup>16</sup>

In another case, Jason Pothier – a 25-year-old man who has been in detention for almost all of the last eight years, and in the federal penitentiary system since September 1997 – is suing CSC for damages for the Service's negligence related to his infection with HIV and to his medical care after becoming infected with HIV. This action is based on common law principles of negligence, breach of fiduciary duty, and on the *Canadian Charter of Rights and Freedoms*.<sup>17</sup>

Two inquests under the Coroners Act<sup>18</sup> are also worth noting. Michael Joseph LeBlanc probably became infected with HIV and HCV while incarcerated in a federal penitentiary. On 18 November 1999, he died at the Regional Hospital in Kingston Penitentiary of complications relating to hepatitis C. Mr LeBlanc died inhumanely, in extreme physical, psychological and emotional distress. His death raised the issues of transmission and prevention of HIV and hepatitis C, compassionate release, and health care and palliative care in federal prisons.

An inquest was held in Kingston, Ontario from 30 January to 1 February 2001. The jury made one recommendation to address the "key issue" surrounding Mr LeBlanc's death: "That the Regional Hospital at Kingston Penitentiary seek outside accreditation by an independent agency as is done for other public hospitals in Canada." The jury also listed a number of other "issues that concerned the jury and which should be of ongoing concern to CSC, such as the prevalence of HIV/AIDS and [h]epatitis C underlying the need for both prevention and harm reduction methods through proactive strategies and pilot programs, the need

for continued work on palliative care at Kingston Penitentiary in conjunction with outside agencies, and the need for CSC to develop clear and well-publicized guidelines around compassionate release.”<sup>19</sup>

These same issues had been raised previously at an October 1997 Coroner’s Inquest into the death of William Bell, a person living with AIDS who died while incarcerated in another federal penitentiary, “like a dog in a back kennel.”<sup>20</sup> In 1997, the jury in the Bell Inquest made detailed and specific recommendations about what CSC needed to do to prevent the “unfortunate and regrettable circumstances surrounding Mr. Bell’s death.” The recommendations of the Bell Inquest jury went much farther and were much more concrete than the recommendations made by the LeBlanc Inquest jury.

## **Needle Exchange or Distribution in Prisons**

When the Final Report was released in 1996, only a relatively small number of prisons had introduced needle exchange or distribution programs. Since then, many more prisons in more countries have started such programs. An overview published in 2001 revealed that needle exchange programs were functioning in 19 prisons in Switzerland, Germany, and Spain.<sup>21</sup> More prisons, including in a poor Eastern European country such as Moldova, have started since. In some Swiss prisons, syringe exchange has now been available for almost a decade. The success of these programs, which have been rigorously evaluated, clearly demonstrates that needle exchange in prison is both effective in preventing disease transmission and improving the health of prisoners, and can be implemented without jeopardizing institutional security.

### *Further Reading*

- For regular updates on new developments related to HIV/AIDS and prisons in Canada and internationally, consult the *Canadian HIV/AIDS Policy & Law Review*. Over 80 articles can be accessed at [www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter-toc.htm#p](http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/newsletter-toc.htm#p)



## Honour Roll

No prison system in Canada has implemented all recommendations in the 1996 Final Report, and some systems have totally and abysmally failed to wake up to the reality of HIV/AIDS, HCV, and injection drug use in prisons. However, our survey also found examples of good practice and innovation in several systems that are worthy of attention and further examination. We highlight these programs and policies in the *Honour Roll*, and encourage other prison systems to review them carefully and to implement them in their own jurisdictions.

### Aboriginal HIV/AIDS Programs

#### ***Canadian Aboriginal AIDS Network/Correctional Service of Canada***

In 2002, the Canadian Aboriginal AIDS Network completed work on a peer education model designed specifically by and for Aboriginal people. This project was funded by CSC and will be implemented for Aboriginal federal prisoners across Canada.

### Anonymous HIV Testing

#### ***British Columbia, New Brunswick, Saskatchewan***

Anonymous HIV testing is provided to prisoners in these provinces through partnerships between correctional services and external public health units. Under these arrangements, health-care providers come into prisons on a regular basis to provide anonymous HIV testing services. Pre- and post-test counseling is conducted by these health workers, who maintain their own medical records separate from those of the institutions. In New Brunswick, anonymous HIV testing is also made available to young offenders.

*Honourable Mention: CSC, which has anonymous testing pilot projects in two institutions; and Québec, where anonymous testing is available in some prisons through community health-care clinics (CLSCs).*



## **Bleach Distribution**

### ***Her Majesty's Penitentiary, St. John's, Newfoundland***

Although the Department of Justice does not provide access to bleach in a “bleach kit” format or as part of a harm reduction policy, bleach is generally available to all prisoners on each unit for cleaning purposes. Therefore, prisoners who wish to access bleach to clean injection equipment can easily do so without having to identify themselves as injection drug users.

## **Compassionate Release**

### ***Northwest Territories***

Under the compassionate release process in the Northwest Territories, a prisoner does not need to disclose the specific nature of his/her illness to the institutional head (who adjudicates the requests). Instead, the applicant requires only a letter from the health unit and/or physician stating that he/she has a terminal illness. In this process, the adjudicator is provided sufficient medical information to make an informed decision on the application, and the prisoner is able to keep his/her HIV status confidential.

## **Dedicated Public Health Nurse Programs**

### ***New Brunswick, Saskatchewan***

In these provinces, the Ministries of Correctional Services and of Health have entered into partnerships under which dedicated public health nurses/health-care providers come into the prisons to provide HIV education, counseling, and testing services.

*Honourable Mention: Québec, where in some prisons public health provides additional services, such as vaccination and HIV testing and prevention education.*

“Experience in a range of prison systems has shown that health care in prisons can be delivered more effectively by public health authorities than by prison management.”

– UNAIDS, 1997

## **Diet and Nutrition**

### ***British Columbia***

In 2001, BC Corrections undertook an initiative to analyze the menus provided in its prisons. Working with the BC Centre for Excellence in HIV/AIDS, BC Corrections adjusted the standard diet for all prisoners to meet the Therapeutic Nutrition Guidelines in HIV/AIDS for people who live with HIV or HCV, but are asymptomatic. For people living with HIV and/or HCV who are symptomatic, enhanced diets are arranged through the medical unit. The result of this initiative has been an increase in the nutritional value of meals for all prisoners regardless of HIV or HCV status, and a reduction in the time and resources necessary for correctional staff to prepare special meals.

## Health Care Delivery

### **Nova Scotia**

In Nova Scotia, correctional services is completing an agreement with the provincial Department of Health to assume responsibility for the provision and management of health services within all institutions. This is in keeping with international best practice as suggested by the Joint United Programme on HIV/AIDS (UNAIDS). UNAIDS has said that “[e]xperience in a range of prison systems has shown that health care in prisons can be delivered more effectively by public health authorities than by prison management.”<sup>22</sup>

*Honourable Mention: Québec, where the Ministry of Public Security and the Ministry of Health are currently renegotiating a memorandum of understanding concerning prison health care between the two ministries.*

Prisoners in federal prisons across the country are now able to initiate methadone treatment while incarcerated.

## Methadone

### **Correctional Service of Canada**

In May 2002, CSC started the second phase of its methadone program. Prisoners in federal prisons across the country are now able to initiate methadone treatment while incarcerated.

*Honourable Mention: British Columbia, which provides methadone initiation programs in several of its institutions.*

## Planning and Collaboration

### **Québec**

The Ministry of Public Security and the Ministry of Health developed and implemented an interministerial action plan on infectious diseases in prisons covering the period from 1998 to 2002. This has led to much closer and more successful collaboration on issues related to HIV/AIDS in prisons than in most other jurisdictions, and to a more planned and strategic approach. Currently, a new plan is being developed.

## Staff Education

### **British Columbia, Québec**

For the past twelve years, BC Corrections has held an annual Corrections Health Care Workshop for all health-care staff. This three-day workshop – addressing HIV/AIDS testing, counseling, care, epidemiology, and research – involves participation from external agencies and community-based organizations.

In 2000, the Québec Ministry of Public Security commissioned a study on the attitudes of prison staff to harm reduction and HIV prevention measures. Based upon the findings of the study, the Ministry has developed a training program on harm reduction.



# Overview of 2002 Findings

Based upon a survey of each prison system, this section provides an overview of what prison systems across the country have done (or failed to do) to implement the recommendations in the 1996 Final Report.

We begin by restating the recommendations. For each major area, the response of prison systems is rated – *Excellent, Very Good, Good, Fair, Poor*.

## Resources, Accountability, and Strategic Planning

### Recommendation I

In order to prevent the further spread of HIV and other infectious diseases in prisons, and to provide better care, support, and treatment for inmates with such diseases, Canadian federal and provincial prison systems need to:

- 1.1 take a proactive rather than reactive approach to the issues raised by HIV/AIDS, hepatitis, tuberculosis, and drug use in prisons;
- 1.2 engage in a long-term, coordinated, strategic planning process;
- 1.3 coordinate their efforts and collaborate more closely;
- 1.4 staff and resource their AIDS and infectious diseases programs adequately;
- 1.5 involve prisoners and staff in the development of all initiatives taken to reduce the spread of HIV and other infectious diseases;

**1.6 ensure even implementation of initiatives by releasing clear guidelines and enforceable standards, by monitoring implementation, and by holding prison administrations accountable for timely and consistent implementation; and**

**1.7 evaluate all initiatives with the help of external experts.**

**Because prisoners come from the community and return to it, and because what is done – or is not done – in prisons with regard to HIV/AIDS, hepatitis, tuberculosis, and drug use has an impact on the health of all Canadians, Health Canada and provincial health ministries need to:**

**1.8 take a more active role and work in closer collaboration with the federal and provincial correctional systems to ensure that the health of all Canadians, including prisoners, is protected and promoted.**

The response of the federal, provincial, and territorial correctional systems to HIV continues to be piecemeal. No correctional system has adopted the comprehensive and integrated response to HIV and other infectious diseases (in particular, HCV) that was called for in recommendation 1 of the 1996 Final Report.

Lack of dedicated resources for developing HIV programs and services – and indeed for prison health generally – is cited by almost all jurisdictions as a major barrier to the development of new initiatives in this area. The continued under-resourcing of HIV/AIDS (and HCV) initiatives demonstrates the lack of appreciation by governments of the urgency of the issues related to HIV/AIDS and HCV, and of the human and financial benefits of enhancing access to HIV and HCV prevention and treatment options.

While a lack of financial support is undoubtedly an issue of significance, most jurisdictions have no clear vision of how they would develop HIV/AIDS services were resources provided. Few can demonstrate an overall strategic plan detailing objectives, timelines, and milestones in advancing HIV/AIDS policies and services. It is not uncommon to find an entire jurisdiction's commitment to developing HIV/AIDS services resting with one or two dedicated staff people with a personal commitment to the issue. While the efforts of such people are important and commendable, this is clearly no substitute for concrete vision, strategic planning, and dedicated resources from senior management and government.

The correctional services in many jurisdictions participate in various local, provincial, and national committees related to HIV/AIDS. Many of these committees are inter-departmental in nature, and include community representation. It is likely that the level of this participation has increased since 1996, particularly given the agenda of "partnership" promoted in the Canadian Strategy on HIV/AIDS. What is less clear, however, is the degree to which correctional policy and practice has been influenced by this external consultation.

There is a continued failure of federal, provincial, and territorial governments to harmonize their prison HIV strategies. The availability of HIV prevention and support programs varies widely between jurisdictions, and in many cases varies among institutions within individual jurisdictions. This lack of consistency was identified as a problem by PASAN as far back as 1992, and since that time little has been done to change the situation.

## **Overall Response: Poor**

## Research

### Recommendation 2

**2.1 In order to monitor the evolution of the HIV and hepatitis epidemics in Canadian prisons, and to evaluate and improve existing and future initiatives, research should be encouraged and funded by provincial and federal prison systems and health ministries. This research should provide information about seroprevalence, risk behaviours, and transmission of infections in prison, and help to improve necessary interventions to prevent the further spread of infectious diseases, and to care for infected prisoners. Research that serves the primary function of delaying necessary action is strongly opposed.**

**2.2 Research should be carried out with the active involvement of Health Canada and provincial health ministries and by individuals independent of, but in collaboration with, the federal and provincial prison systems. It should be preceded by and undertaken with consultation with inmates, staff, community groups and independent experts.**

Research on issues related to HIV/AIDS in prisons has mainly been undertaken in Ontario, Québec, British Columbia, and in the federal prison system. Most of the research that has been done, or is in development, studies HIV seroprevalence and risk behaviours amongst prisoners.

Unfortunately, research has seldom led to action. At least one jurisdiction, British Columbia, has acknowledged that there is no need for further research to demonstrate that rates of HIV and HCV infection among prisoners are many times higher than in the community at large, and that high risk behaviours for disease transmission are widespread. In its response to the questionnaire, BC Corrections said that it had not repeated its extensive HIV prevalence and risk behaviour studies of 1993 to 1995 because they felt that the available resources are better spent in care, treatment, and prevention.

Few systems, such as CSC, have evaluated their HIV/AIDS initiatives.

**Overall Response: Fair**

## Testing and Confidentiality

### Recommendation 3

**3.1 CSC should finally act on its promise to make anonymous testing for HIV available to prisoners in federal prisons; where it is not already available, such testing should also be made available to inmates in provincial prisons.**

**3.2 The federal and provincial prison systems need to make testing offered by prison health-care staff more accessible and acceptable to prisoners, by offering them the option of non-nominal testing, by training prison health-care staff in the delivery of pre- and post-test counseling, and by better protecting the confidentiality of medical information.**

**3.3 Disclosure of offender medical information is justified only in exceptional cases, when it is clearly necessary, likely to be effective, and is the least invasive and restrictive means available to prevent harms that cannot otherwise be prevented. The federal and provincial prison systems, in collaboration with inmates and independent experts, including the Privacy Commissioner of Canada and provincial equivalents, need to clearly define such exceptional cases.**

**3.4 A brochure on HIV testing and confidentiality for staff should be prepared, addressing issues such as medical confidentiality and its importance, the absence of a “need to know” prisoners’ HIV status, and the risk or absence of risk of transmission of HIV.**

**3.5 In each institution, health-care staff should meet to discuss and review how inmate medical information is handled. The goal would be to identify what barriers exist to protecting medical information, document these barriers, and identify possible solutions for overcoming them.**

**3.6 Model procedures should be developed for the protection of medical records against disclosure, and a strict enforcement scheme should be set up.**

**3.7 Standard procedures for escorts should be developed, establishing clear guidelines indicating whether and, if so, in which cases medical information is to be disclosed to escorts.**

HIV testing is available in all jurisdictions in Canada. In general, testing is nominal and is done by prison health staff. With some exceptions, voluntary HIV testing is offered to all prisoners upon their admission to the institution, and may be requested by a prisoner at any time during his/her incarceration.

However, some jurisdictions continue to offer testing to prisoners only based upon an assessment of “risk.” This is not good practice. Voluntary HIV testing must be made available to all prisoners, regardless of real or perceived risk factors.

Since the publication of the 1996 Final Report there has been a significant increase in the availability of anonymous HIV testing in prisons. Anonymous HIV testing is now offered to prisoners in the provinces of British Columbia, New Brunswick, and Saskatchewan, and in some prisons in Québec. CSC offers anonymous HIV testing on a pilot basis in two institutions. In all of these cases, anonymous testing is done through collaboration with outside public health units who come into the institutions to provide the service. This is a positive trend that clearly indicates that anonymous testing can be adapted to meet the needs of prisoners and prison staff across the country. Based upon the success of these programs, all jurisdictions must act quickly to implement anonymous testing programs for prisoners.

An issue of continuing concern is the provision of pre- and post-test counseling for prisoners accessing testing through prison health units. While most jurisdictions responded that their policy and practice is to provide pre- and post-test counseling, anecdotal evidence from prisoners and AIDS service organizations (ASOs) in various parts of the country would indicate that this is not the case. People in prison are still being tested – and in some cases receiving positive test results – without any kind of counseling or support from health staff.

Problems with protection of the confidentiality of medical information also continue.

While all jurisdictions have policy, legislation, or both, about confidentiality and disclosure of medical information, anecdotal evidence from prisoners and some prison staff would again indicate that confidentiality is routinely breached in the case of HIV status. This may be due to lack of education among staff, or lack of strictly enforced confidentiality guidelines.

## **Overall Response: Fair**

## **Educational Programs for Prisoners**

### **Recommendation 4**

**Education of inmates remains one of the most important efforts to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in prisons. CSC urgently needs to act on its promise to improve existing educational efforts, and provincial systems also need to improve education provided to inmates about HIV/AIDS, hepatitis, tuberculosis, and drug use. In particular:**

**4.1 Education should not be limited to written information or the showing of a video, but include ongoing educational sessions, and should be delivered or supplemented by external, community-based AIDS, health or prisoner organizations.**

**4.2 The results of and lessons learned in the pilot inmate peer health promotion project undertaken at Dorchester Penitentiary should be widely distributed and applied to other institutions: wherever possible, inmates should be encouraged and assisted in delivering peer education, counseling, and support programs, and inmate job positions as peer-health counsellors should be created.**

Educational programs for prisoners rarely meet the standards outlined in the 1996 recommendations.

Provision of health and harm reduction education varies widely across the country, with some jurisdictions offering a variety of educational interventions, and some offering none at all. With the exception of the federal system and Nunavut, HIV education remains a voluntary program in all jurisdictions, despite the fact that most systems could easily incorporate mandatory education on HIV and other infectious diseases as part of their institutional intake/orientation programs. Given the stigma and phobia that is linked to HIV, education must be mandatory if it is to have the greatest impact.

Some jurisdictions, such as New Brunswick, Québec, and Saskatchewan, have entered into partnerships with the provincial Ministries of Health. Under these agreements, dedicated public health workers are assigned to prisons to provide HIV/AIDS educational, counseling, and testing services. This is a model of interministerial partnership that should be investigated and adopted in other jurisdictions.

When questioned on educational programs, several jurisdictions could only identify the programs facilitated by a local AIDS service organization (ASO). While the involvement

of ASOs in providing educational services in prisons is crucial, community-based organizations on their own cannot and should not be expected to provide educational services in their entirety. ASOs have an important *supplementary* role to play in this effort, but their involvement in providing prison services does not relieve correctional systems of their responsibility to provide educational interventions.

Since the 1996 Report, CSC has dedicated significant resources to the development of peer education models. While this is a positive initiative that recognizes the value of peer-based interventions, the current CSC model has been criticized for its reliance on prison staff to choose the peer educators. In practice, this means that many prisoners – particularly known injection drug users or people seen as “heavies” in the institution – are denied the opportunity to participate in peer programs on security grounds. This has been criticized by some community-based organizations as antithetical to the philosophy of a peer program, as the prison system rather than the prisoners themselves are deciding who is a “peer.”

Blocking the participation of such prisoners is problematic on several levels. For example, the peers of injection drug users are other injection drug users, and if CSC truly wants to reach this population with harm reduction messages it needs to include people who are accepted by that group. Similarly, the exclusion of “heavies” is counterproductive as the participation of such respected prisoners within a peer program helps lend credibility to the project. In many institutions, these same “heavies” have been integrally involved in peer health and HIV prevention initiatives before such programs received “official” CSC sanction. Therefore, blocking the participation of such people in the official peer programs means a loss of experience and knowledge that should be used to benefit the prisoner population.

In recent months, the Canadian Aboriginal AIDS Network has completed the development of a specific Aboriginal Peer Health model for federal corrections. This is a commendable initiative, and CSC should act quickly to ensure that the model is implemented.

With some notable exceptions, provincial/territorial systems have been less active in developing peer education, in large part because the transient nature of the provincial prison population precludes the type of training necessary to engage in the work. That said, the provincial/territorial systems should further investigate options for including peer-generated educational materials and messages within non-peer programs.

## **Overall Response: Poor**

## **Preventive Measures for Prisoners**

### **Recommendation 5**

**5.1 Without any further delay, condoms, dental dams, and water-based lubricant need to be made easily and discreetly accessible to inmates in all federal and provincial prisons, in different locations throughout the institutions, and without inmates having to ask for them.**

**5.2 Bleach needs to be made easily and discreetly accessible to inmates in all federal and provincial prisons, and inmates need to be educated about the necessity of always cleaning injection equipment before and after its use.**

**5.3 In an effort to further reduce the harms from injection drug use and**



because injection equipment may not be effectively or consistently cleaned by bleach, sterile injection equipment needs to be made available in federal and provincial prisons. This does not mean condoning drug use or giving prisoners the right to use drugs, but is a pragmatic and necessary health measure that will better protect prisoners, staff, and the public.

Prison systems and governments should immediately start to put in place the measures that will make needle distribution possible. These include:

- consultation with prison staff and the unions. Staff's safety and other concerns need to be taken into account and they need to be involved in the planning and implementation of the programs;
- education of prisoners, staff, and the public about (1) the fact that making needles available in prisons does not mean condoning drug use or giving prisoners the right to use drugs, but is a pragmatic and necessary health measure that will better protect prisoners, staff, and the public; and (2) the benefits to society from making needles available, which include prevention of the spread of HIV among prisoners and to society, and avoidance of health-care costs related to it; and
- selection of prisons in which pilot projects can be undertaken.

**5.4 Prisoners who have been in methadone maintenance treatment on the outside should always be able to continue to receive such treatment in prison. Further, where such treatment is an option available to opioid-dependent persons outside prisons, it should also be made available to them in prisons.**

**In addition, opioid-dependent prisoners should have other treatment options, including methadone detoxification programs with reduction-based prescribing, which should be routinely offered to all opioid-dependent prisoners on admission.**

**5.5 Tattooing and piercing equipment and supplies should be classified as hobby-craft equipment and be authorized for use in all federal and provincial institutions.**

Condoms, dental dams, and water-based lubricant are available in most jurisdictions. Only New Brunswick, Nunavut, Prince Edward Island, and some institutions in the Northwest Territories do not provide them. Québec provides condoms, but not dental dams or water-based lubricant. However, problems remain even in jurisdictions where condoms, dental dams, and lubricant are available. Access often remains difficult.

The 1996 Final Report recommended that safer sex materials be made "easily and discreetly accessible...in different locations throughout the institution, without inmates having to ask for them." In 2002, this level of accessibility is still the exception rather than the rule. While some jurisdictions do meet this threshold, the vast majority of jurisdictions providing safer sex materials do so primarily (or solely) through the medical units. This means that prisoners seeking access to condoms must make a request to staff. This is a clear barrier to prisoners seeking to practice safer sex. In the case of Ontario, correctional policy specifically prohibits prisoners from accessing more than one condom at a time, or having more than two in their possession.

Barriers such as these to the use of condoms and other safer sex measures must end.

The availability of bleach has increased since 1996. Nevertheless, only CSC, British Columbia, and Québec make bleach available specifically as a harm reduction measure.

No jurisdiction in Canada provides sterile syringes to prisoners, although calls for the introduction of needle exchange or distribution programs have been made in Canada for the last 10 years, and although such programs have been implemented successfully in prisons in Europe.

Since 1996, the most progress has been achieved with regard to access to methadone maintenance treatment (MMT). At the time of the Final Report, methadone was not available in any Canadian jurisdiction. In 2002, methadone is available to some extent in most jurisdictions. Some jurisdictions, such as Manitoba and Nova Scotia, only provide methadone in the urban institutions, while Alberta will only provide access to MMT for a maximum of thirty days. The only jurisdictions failing to provide MMT at all are jurisdictions in which the treatment is also not available in the community: Newfoundland and Labrador, Nunavut, and Prince Edward Island.

Few jurisdictions enable prisoners to begin a methadone program while incarcerated. Only the federal system and the provincial system in British Columbia provide formalized methadone initiation programs. Although initiation is sometimes available on an exceptional basis in Québec, Saskatchewan, and the Yukon, most jurisdictions providing MMT do so only for prisoners who enter the system on the therapy. While this increase in the availability of MMT is a positive development, the inability of many opioid dependent prisoners to initiate MMT while incarcerated still leaves a significant gap in the current overall response.

As in 1996, no jurisdiction in Canada allows access to safer tattooing equipment, and there are no safer tattooing programs in operation in any prison in the country. While CSC is continuing to study the issue, and Québec has created some specific educational materials on safer tattooing, the measures necessary to practice tattooing safely are still denied to prisoners.

## **Overall Response: Poor**

## **Responding to Drug Use**

### **Recommendation 6**

**Federal and provincial prison systems need to adopt a more pragmatic approach to drug use, acknowledging that, because of HIV/AIDS and hepatitis C, they cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy: reduction of drug use is an important goal, but reduction of the spread of HIV and other infections — in particular, hepatitis C — is more important.**

**At a minimum, they need to coordinate their efforts in the areas of HIV/AIDS and of drug use; allow for evaluation of existing education, treatment, and, where applicable, urinalysis programs, by external experts; and offer a greater variety of treatment options to inmates, including in drug-free prisons or wings.**

Few, if any, jurisdictions have taken a more pragmatic approach to drug use. Reduction of drug use, rather than reduction of the harms from drug use, remains the primary objective of drug policy.

No jurisdiction can boast a truly comprehensive harm reduction approach that includes syringe exchange. A small number of jurisdictions such as BC and Québec – and to a lesser

extent CSC – have adopted an approach that includes the provision of some harm reduction programs and education for prisoners, training for staff in the harm reduction philosophy, drug treatment options including methadone initiation, and other innovative programs.

The use of random urinalysis continues to be a concern, especially at the federal level. Most provincial/territorial jurisdictions do not employ random urine screening to detect drug use among prisoners. The federal system, however, uses it extensively as a security measure.

Significant concerns have been raised about this practice by community-based organizations and some physicians, given anecdotal evidence that it leads many drug using prisoners to choose to switch to injecting drugs such as heroin, which clear from the urine more quickly than do smokeable drugs such as marijuana or hashish. Given the known risks from the sharing of injection equipment in prisons, random urinalysis – particularly if it continues to screen for cannabis – needs to be reconsidered.

## **Overall Response: Poor**

## **Education of Staff**

### **Recommendation 7**

**7.1 Health-care staff need to receive ongoing training about HIV/AIDS, the different testing options, pre- and post-test counseling, and confidentiality; community groups and persons living with HIV should be delivering part of the training.**

**Training programs should also include sections on hepatitis, tuberculosis, and other infectious diseases.**

**7.2 Training about HIV/AIDS, hepatitis, tuberculosis, and other infectious diseases needs to become part of core training for all prison staff, including correctional officers. In particular, staff need to learn about how to deal with prisoners living with HIV/AIDS and to respect their rights and dignity, the absence of risk of HIV transmission from most contact with inmates, and the need to respect medical confidentiality. Community groups and persons living with HIV should be delivering part of the training.**

**7.3 All staff need to be educated about drugs, drug use, and the concept of harm reduction; at least part of this training should be delivered by community groups and users or ex-users.**

As with education for prisoners, educational opportunities for staff vary from region to region. While all jurisdictions offer infectious disease education to new employees as part of an initial training and orientation program, the opportunity for staff to access ongoing refresher courses is less common. Some provide annual updates as a matter of course. Some provide voluntary educational sessions on an occasional basis. Some provide nothing following the basic training. Opportunities for medical staff to access ongoing training on HIV and related issues is similarly patchy. While some jurisdictions, most notably British Columbia, do provide ongoing staff development in this area, the majority fall short of the 1996 recommendation.

**Overall Response: Fair**

## **Protective Measures for Staff**

### **Recommendation 8**

**8.1 Prison systems need to continue to regularly review staff access to and use of protective materials and equipment.**

**8.2 Staff's concerns about overcrowding in the institutions and understaffing need to be addressed by the federal and provincial correctional systems: overcrowding and understaffing - not measures to prevent the spread of HIV in prisons - constitute the real threat to their safety.**

**8.3 Staff need to be involved, from the beginning, in the planning and implementation of measures to prevent the spread of HIV and other infectious diseases in prisons, in order to ensure that their safety concerns be a primary consideration in the design.**

All jurisdictions provide universal precaution measures for staff. In most cases, such supplies are carried by staff on their persons and are accessible at various sites around the institution. Some jurisdictions provide for ongoing monitoring of protective measures within correctional policy, and some have health and safety committees in place who serve this function.

In some larger systems – particularly those with institutions located in and around urban areas – overcrowding and double/triple bunking presents an ongoing concern. In provinces such as Ontario and BC, where significant budget cuts and institutional down-sizing has occurred in recent years, concerns of community-based organizations about overcrowding have been heightened.

**Overall Response: Good**

## **Health Care**

### **Recommendation 9**

**9.1 Efforts need to be undertaken in federal and provincial prisons to ensure that prisoners receive care, support, and treatment equivalent to that available outside. This includes, but is not limited to:**

- (1) making sure that inmates in pain have equal access to narcotics routinely given for pain relief to patients on the outside;**
- (2) allowing inmates equal access to investigational drugs or nonconventional therapies;**
- (3) ensuring that inmates have equal access to the Community AIDS Treatment Information Exchange (CATIE);**

- (4) **emphasizing health promotion strategies for all prisoners, but in particular for prisoners living with HIV or AIDS, in order to slow down the progression of their disease;**
- (5) **making sure that complaints from individual inmates about lack of medical care or access to support and treatment in a particular institution be dealt with appropriately; and**
- (6) **assessing health-care services in each institution in consultation with outside experts to ensure that the expertise necessary for the medical care, support, and treatment of inmates with HIV or AIDS is available, accessible and efficient.**

**9.2 In the longer term, correctional health care needs to evolve from a reactive sick-call system to a proactive system emphasizing early detection, health promotion, and prevention.**

In their responses to the questionnaire, prison systems generally did not provide enough information to allow us to adequately assess their response to the recommendations in the 1996 Report. Quality and responsiveness of care, and barriers to services, may only be measured through a much more detailed study that includes consultations with prisoners themselves. That said, there is sufficient information and knowledge to provide a general commentary.

As with many aspects of HIV services, health care varies widely across the country, and significantly within jurisdictions. With notable exception – such as British Columbia – prison medical staff are afforded little or no opportunity for ongoing training on HIV care, treatment, and support. Given the constantly evolving nature of medical information in this field, ongoing training is essential in maintaining up-to-date practice.

Access to medications remains a significant issue in many jurisdictions. There was little evidence of correctional systems adapting their medical practice to facilitate the proper use of HIV combination therapy. Medicine distribution, in many cases, is not designed to meet the specific timing requirements of HIV prescriptions. Diet and nutrition remains an issue, and few jurisdictions make provisions to adjust meal times to meet the needs of HIV combination therapies. As many of these combinations must be taken at very specific times, and in concert with specific eating schedules, this lack of adaptability means that prisoners living with HIV/AIDS across the country are forced to use their medications in a suboptimal manner.

While all jurisdictions report that prisoners are able to access narcotic-based pain medications, the anecdotal evidence from prisoners and ASOs would indicate that significant barriers still exist in many institutions.

Some jurisdictions specifically noted that they are willing to assist with access to alternative therapies, although most would expect the prisoner to purchase the therapy him/herself.

Still, there are some developments that are promising – such as the involvement of dedicated public health workers in providing services in prisons – that have earned recognition in the Honour Roll.

Nova Scotia's impending transfer of the management and delivery of prison health services to the Ministry of Health is an important development. Also, recent moves by BC Corrections to improve prison nutrition demonstrate that increasing the quality of prison diets can actually produce a savings in staff time and resources.

**Overall Response: Fair**

## Compassionate Release

### Recommendation 10

**10.1 Continued efforts need to be undertaken to ensure that inmates with progressive life-threatening diseases, including AIDS, be released from prison earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety. This should include, but not be limited to, education of all involved in decisions about early release, about the position taken by CSC in response to ECAP's report.**

All jurisdictions make allowance for humanitarian or medical release. In the provincial/territorial systems, this most often takes place through the use of the Temporary Absence Program (TAP).

TAP applications are most often decided by the institutional head, and are appealable to the Ministry. While accessibility of these programs can be an issue, particularly for those with lengthy criminal records where security considerations are heightened, the reality remains that compassionate release is rarely an issue in the provincial/territorial systems due to the typically short sentences people are serving. In the federal system, where people are serving longer sentences, early release on humanitarian grounds is a much greater concern. However, barriers on the federal level remain significant.

There is no such thing as “compassionate release” under federal legislation. Early release on medical or humanitarian grounds is accessed under the terms of the “parole by exception” section of the *Corrections and Conditional Release Act*. Under this section, a prisoner may apply to have his/her parole eligibility date moved forward based upon exceptional circumstances, which may include terminal illness. There is no expressly medical basis for the application for parole by exception, and there is no explicitly medical component to the decision-making process. Rather, applications are heard by the National Parole Board, whose mandate it is to assess security and risk of re-offending, rather than medical urgency.

As a result, it is the experience of many prisoners living with HIV/AIDS and AIDS service providers that parole by exception is an inappropriate mechanism to adjudicate compassionate release applications.

National Parole Board members are not skilled in assessing complex medical circumstances. The fact that a person has applied to move their parole eligibility date forward often means they have not completed their agreed correctional plan, which places them at an “increased risk of re-offending” in the parole board’s eyes. Applications are often rejected based upon previous criminal record, without consideration of the individual’s medical needs. As a result, prisoners are still dying in federal prison of HIV-related illnesses, or are receiving “compassionate” release only hours or days before dying.

This is a situation that needs to be addressed as a matter of urgency. The Canadian government must act to put mechanisms in place to responsibly and compassionately adjudicate applications for humanitarian release. Until this is done, the federal government will continue to fall well short of meeting this recommendation.

### Overall Response: Fair

## Women Prisoners

### Recommendation 11

**The federal and provincial prison systems need to take immediate action to develop and implement effective education and prevention programs targeted specifically to female inmates.**

Women comprise less than 10 percent of the total Canadian prison population. In the federal system, they comprise five percent. While they represent only a small fraction of the total prison population, studies have consistently shown that rates of HIV and HCV among women prisoners are much higher than among male prisoners. This adds additional urgency to the need to implement comprehensive HIV/AIDS services for incarcerated women, and to develop those services specifically to meet the needs of women.

Because of their small numbers, incarcerated women are housed in a very small number of institutions. The Correctional Service of Canada manages five regional institutions for women across the country. On the provincial/territorial level, it is rare for a system to have more than a single facility for women. It is not uncommon for a province or territory to have no specific women's prison at all, and instead house women in separate sections of male institutions. As a result, issues of geographic isolation from family supports, stress, and lack of adequate women-centred programs and facilities are common – all of which have an impact on HIV/AIDS and broader health-care services.

Female physicians are not consistently available, which can be a particular barrier for women who are survivors of male physical and/or sexual violence. Knowledge of HIV opportunistic infections common to women, or the optimal use of HIV therapies for women, is often limited.

Programs and services for incarcerated women are often based upon those designed to meet the needs of men. This is equally true in health services. Correctional services commonly disputes this claim by pointing to budgetary figures that show that spending per capita is greater for incarcerated women than incarcerated men. However, this statement in itself oversimplifies the issue.

On the one hand, it is not surprising that per capita spending is higher for women prisoners than men precisely because women are such a small percentage of the overall prison population. Since the numbers of incarcerated men are so much higher, and the institutions housing men are so much larger, the actual cost per capita among men is reduced through economies of scale.

On the other hand, per capita spending alone is no indication of program quality or appropriateness. Few jurisdictions are able to state that they have developed and implemented HIV/AIDS education and support programs designed specifically for women. Indeed, few jurisdictions could identify a response to HIV/AIDS specifically designed to meet the needs of women.

### Overall Response: Poor

## Aboriginal Prisoners

### Recommendation 12

**The federal and provincial prison systems need to take immediate action to develop and implement effective education and prevention programs targeted specifically to Aboriginal inmates.**

Aboriginal people comprise less than three percent of Canada's population, but they make up 15 percent of the provincial prison population and 17 percent of the federal prison population.<sup>23</sup> In provincial systems such as those of Manitoba and Saskatchewan, Aboriginal people represent more than 50 percent of prisoners.<sup>24</sup>

At the same time, Aboriginal people are disproportionately affected by HIV infection. Recent studies have shown that as many as one in four new HIV infections in Canada are in the Aboriginal community.<sup>25</sup>

Taken together, these two facts clearly indicate the need for correctional services to implement a comprehensive HIV/AIDS strategy specifically designed to meet the needs of Aboriginal prisoners. However, no jurisdiction can claim to have developed or implemented such a strategy. This is true even for jurisdictions where the majority of the prison population is Aboriginal.

In the same way that programs and services for women are often based upon those designed for men, programs and services for Aboriginal prisoners are often based upon those designed for non-Aboriginal prisoners. While many jurisdictions report that access to elders and other Aboriginal community representatives is provided to Aboriginal prisoners, there is no guarantee that these individuals are knowledgeable about HIV, or comfortable in discussing issues such as sexuality and harm reduction that are an essential component of HIV/AIDS services.

In 1997, the Correctional Service of Canada initiated the National Roundtable on HIV/AIDS and Aboriginal People as a forum to discuss these issues with representatives of the Aboriginal community. Since then, a model peer education program has been developed in partnership with the Canadian Aboriginal AIDS Network, who CSC contracted to develop the project. This model will now be implemented throughout the federal system. Similar partnerships with Aboriginal ASOs should be developed in other jurisdictions.

### Overall Response: Poor

#### Further Reading

- For further information about the recommendations for action in the 1996 Final Report and the rationale behind them, see R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, September 1996, at 97-117. Available via [www.aidslaw.ca/Maincontent/issues/prisons.htm](http://www.aidslaw.ca/Maincontent/issues/prisons.htm)





## Jurisdictional Report Cards

**The following report cards are based upon written and verbal feedback from the ministries responsible for correctional services and the health ministries in each jurisdiction. We summarized the feedback we received from each jurisdiction, and sent the summary back for approval. All jurisdictions “signed off” on the information in the report cards, with the exception of the Network’s comments and the “Harm Reduction Report Card.” We took this step to ensure that the information provided was accurate from the point of view of the correctional systems.**

Some limitations to what we could do are worth noting. We did not have an opportunity to gather information from prisoners, community-based organizations, and physicians working in each jurisdiction. Experience has shown that good policies are often not implemented consistently, and that educational programs, developed with the best of intentions, fail to pass the test of prisoners. Prisoners, community-based organizations providing services in prisons, and physicians working in prisons, but also individual staff working in prison could have provided useful additional information about the practice of responding to HIV/AIDS in prisons. Nevertheless, the information provided by the correctional systems themselves is an extremely useful tool for monitoring the response of Canadian prison systems to HIV/AIDS.

All jurisdictions “signed off” on the information in the report cards.

Following each of the official, approved summaries are comments from the Canadian HIV/AIDS Legal Network. These comments are our own and are based upon our analysis of the feedback received from the jurisdictions. We comment on the strengths and weaknesses of each jurisdiction’s response, measuring it against the recommendations in the 1996 Report. Finally, at the end of each report is a *Harm Reduction Report Card*. This report card assigns numerical and letter grades to each jurisdiction in various areas of HIV prevention and harm reduction. Marks have been assigned as follows.

- |   |           |
|---|-----------|
| (1) Condoms, dental dams, lubricant available<br>(for prison systems that have adopted an official policy of making condoms, dental dams, and lubricant available to prisoners; where the policy does not provide for the availability of lubricant, only one point is given)                             | 2 points  |
| (2) Condoms, dental dams, lubricant accessible<br>(this recognizes that making condoms, dental dams, and lubricant available is not enough, and that they must be easily accessible to prisoners, rather than being made available only through health-care services – see the 1996 Final Report, at 105) | 4 points  |
| (3) Bleach available<br>(for prison systems that have adopted an official policy of making bleach available)  | 2 points  |
| (4) Bleach accessible<br>(recognizing that bleach must be easily and discreetly available to prisoners)   | 4 points  |
| (5) Methadone treatment continuation provided<br>(for prison systems that allow prisoners who were on methadone maintenance treatment before incarceration to continue the treatment while in prison)   | 6 points  |
| (6) Methadone treatment initiation provided<br>(for prison systems that allow prisoners to start methadone maintenance treatment in prison if they would qualify for such treatment outside)  | 6 points  |
| (7) Needle exchange or distribution available   | 6 points  |
| Total possible  | 30 points |

Letter grades for each jurisdiction have been determined by dividing the number of points awarded by the total number of points possible.

24 points and above	A
21 points	B
18 points	C
15 points	D
14 points and below	F

### Harm Reduction Report Card: Ranking of Canadian Jurisdictions

	Total Score	Grade
<b>British Columbia</b>	<b>22 points</b>	<b>B</b>
<b>Federal Prison System (CSC)</b>	<b>21 points</b>	<b>B-</b>
<b>Québec</b>	<b>14 points</b>	<b>F</b>
<b>Saskatchewan</b>	<b>10 points</b>	<b>F</b>
<b>Newfoundland and Labrador</b>	<b>9 points</b>	<b>D*</b>
<b>Yukon</b>	<b>8 points</b>	<b>F</b>
<b>Ontario</b>	<b>8 points</b>	<b>F</b>
<b>Northwest Territories</b>	<b>7 points</b>	<b>F</b>
<b>Manitoba</b>	<b>6 points</b>	<b>F</b>
<b>New Brunswick</b>	<b>6 points</b>	<b>F</b>
<b>Nova Scotia</b>	<b>5 points</b>	<b>F</b>
<b>Alberta</b>	<b>3 points</b>	<b>F</b>
<b>Nunavut</b>	<b>0 points</b>	<b>F*</b>
<b>Prince Edward Island</b>	<b>0 points</b>	<b>F*</b>

\* In this jurisdiction, methadone is not available in the community. Therefore, the letter grade is calculated using a possible total of 18 points.

## Alberta

### Response from Correctional Services

The Correctional Services Division of the Alberta Solicitor General manages nine adult correctional centres, with an average daily count of approximately 2000 prisoners (approximately 100 of whom are women).

The Division also manages a daily average of approximately 280 young offenders, of whom 25 are female. These young offenders are housed among four young offender centres, two young offender units of other facilities and a contracted facility.

### Resources, Accountability, and Strategic Planning

Alberta Correctional Services Division has representation on the provincial consortium established to address HIV/AIDS in the province. It participates in the correctional working group of this consortium. The Division is also represented on the Alberta Community HIV Fund Consortium. This Consortium makes decisions on applications for funding to a jointly supported federal/provincial HIV/AIDS fund. Infectious disease coordinators have recently been appointed in each centre. Their role is largely to liaise with and support staff.

### Research

Alberta Corrections prepares semi-annual reports on HIV seroprevalence and risk behaviour among those prisoners known to be HIV-positive in the system. It has not engaged in any HIV-specific research.

### Testing and Confidentiality

Non-nominal HIV testing is provided in all correctional centres. Pre-test counseling is available but not mandatory. Post-test counseling is always provided to those testing HIV-positive. Testing services are generally promoted and are offered to individual prisoners based on an assessment of symptoms and risk behaviours, as well as upon request. Confidentiality is governed under policy.

### Educational Programs for Prisoners

Staff at one young offender centre provide regular monthly sessions on HIV. Outside of this facility, Alberta Corrections relies on ASOs to provide HIV education or information in most of the remaining adult and young offender facilities.

### Preventive Measures for Prisoners

Alberta Corrections maintain persons on methadone treatment for a maximum of one month.

Condoms, dental dams, and water-based lubricant are available in all adult centres through the medical units, but are not provided in young offender facilities. Bleach, needle exchange, and safer tattooing measures are not available. Methadone is available on a very limited basis to people already on treatment at the time of incarceration. In such circumstances, Alberta

Corrections will maintain the person on methadone for a maximum of one month. If the individual is still incarcerated after one month, the institution will begin a withdrawal regime to taper them off. Methadone initiation is not provided.

### **Responding to Drug Use**

Alberta Corrections provides their own drug education/awareness programs. Harm reduction education for prisoners does not occur. Random urinalysis is not used, although urinalysis is used to confirm symptoms that an offender has ingested an intoxicant.

### **Education of Staff**

Infectious disease training is part of the basic correctional officers training curriculum. Training workshops for frontline correctional officers from all institutions are held annually and facilitated by community-based organizations and other outside professionals. These workshops address issues such as HIV, HCV, harm reduction, and confidentiality. Each centre has an infectious disease coordinator in the health-care unit who is available for consultation by staff.

### **Protective Measures for Staff**

Joint union/management health and safety committees are in place in all institutions. Universal precaution measures are available.

### **Health Care**

Correctional services nurses along with contracted physicians provide health care for each centre. One centre has an HIV clinic, and an outside HIV specialist comes into the centre to provide services. In other centres, prisoners access community specialists under escort. A private contractor provides food services and special diets must be requested through health care.

### **Compassionate Release**

Applications for conditional release on medical or humanitarian grounds are decided by correctional services officials. There is an internal appeal process available to prisoners who are denied and these decisions can also be reviewed by the provincial ombudsman.

### **Women Prisoners**

There are no prisons for women in Alberta. Women and men are housed in separate wings of co-correctional facilities. Programs delivered by correctional services staff are co-ed. There are some specialized women's programs delivered by community agencies in certain centres.

### **Aboriginal Prisoners**

There is specialized programming available in some centres, although not necessarily HIV-related. Aboriginal community groups are contracted to provide services. There is a correctional centre contracted to be operated on the Blood Reserve. As well, contracts have been developed with community groups to provide Aboriginal residential treatment programs for both adult and young offenders.

Alberta's response to HIV/AIDS in prisons ranks among the worst in the country.

### **Young Offenders**

Staff at one young offender centre provide regular monthly sessions on HIV. Outside of this facility, Alberta Corrections relies on ASOs to provide HIV education or information in the remaining young offender facilities. Condoms, dental dams, and water-based lubricant are not provided in young offender facilities.

## Legal Network Comments

Alberta's response to HIV/AIDS in prisons ranks among the worst in the country.

Correctional services provides no HIV educational programs of its own for adults, and relies solely on the ability of ASOs to fill this role.

Condoms, dental dams, and lubricant, while available in adult facilities, can only be accessed through the health units. Methadone treatment continuation is available only to a maximum of one month, following which time the person is tapered off the therapy. Bleach and needle exchange are not available.

Pre- and post-test counseling is not always provided.

There is no women-specific programming available, as women participate in the men's programs.

## Harm Reduction Report Card

Cumulative Grade	F
Condoms, dental dams, lubricant available	2
Condoms, dental dams, lubricant accessible	0
Bleach available	0
Bleach accessible	0
MMT continuation	1
MMT initiation	0
Needle exchange	0
<b>TOTAL SCORE</b>	<b>3</b>

## **British Columbia**

### **Response from Correctional Services**

BC Corrections maintains 10 institutions with an average daily head count of approximately 2200 prisoners, and a total of over 25,000 admissions annually.

### **Resources, Accountability, and Strategic Planning**

BC Corrections participates in various committees and working groups focussing on infectious diseases, drug use, and harm reduction. They have established working links with the Centre for Disease Control and the BC Centre for Excellence in HIV/AIDS in the delivery of health services.

Recent restructuring by the BC government has had significant effects on all levels of the prison system, including health services. This may slow the development of new health initiatives in the short to medium term.

### **Research**

BC conducted research on seroprevalence between 1993 and 1995. In recent years, such research has not been repeated, so that all resources can be used for HIV prevention, care, and treatment.

### **Testing and Confidentiality**

Anonymous HIV testing is provided in six of 10 institutions, and is conducted by outside public health nurses. These nurses maintain their own files separate from those of the institution. The number of anonymous testing programs is limited by the availability of public health nurses to provide the service. Nominal testing is available in all institutions through the health unit. Pre- and post-test counseling is done by nurses.

Each health unit maintains its own medical records. These files are not disclosed outside of medical staff.

Methadone continuation has been available in all BC institutions since 1996.

### **Educational Programs for Prisoners**

BC has had a comprehensive health education program in place since 1996 that includes HIV. Participation in the program is voluntary. In 1998, a substance abuse management program was put in place that addresses harm reduction and disease transmission. Peer education and counseling is available in some institutions.

### **Preventive Measures for Prisoners**

Condoms, dental dams, water-based lubricant, and bleach are available in all institutions and are accessible freely in various places around the institutions. Methadone continuation has been available in all institutions since 1996. Methadone initiation is available in some institutions, depending upon resources. BC Corrections recently appointed a specialized methadone nurse and a dedicated pharmacist team to assist in the provision of methadone. Needle exchange is not available, nor are measures other than bleach to reduce the risk of disease transmission via tattooing.

### **Responding to Drug Use**

In December 2001, BC Corrections and the federal Ministry of Justice initiated a drug treatment court to provide an alternative to prison for people convicted of drug charges. The

program is being externally evaluated. The substance abuse management program addresses harm reduction and disease transmission. Drug counsellors are available for individual and group therapy. Random urinalysis is not used.

### **Education of Staff**

Infectious disease training is mandatory for all staff as part of their initial orientation. This training includes HIV. Annual refresher courses are held in which participation is voluntary. The substance abuse management program is co-facilitated by correctional officers, which enables this group to receive additional training on harm reduction and disease transmission. Annual three-day workshops are held for all medical staff, and includes updates on HIV.

### **Protective Measures for Staff**

All staff carry universal precaution materials on their persons. Blood and body fluid clean-up protocols are in place in all institutions. Occupational health and safety committees are in place to address staff safety issues.

### **Health Care**

Two of British Columbia's 10 institutions have 24-hour medical health units. Two others have a 24-hour capability if patients in the centres are in need of round-the-clock care. The others provide service between 6 am and 11 pm. Physicians are contracted in each institution, and people requiring HIV/AIDS care are referred to the BC Centre for Excellence in HIV/AIDS and taken there under escort. Pain management medication is available, although Corrections is cautious in its use. The standard diet for all prisoners has recently been improved to meet the minimum standard of nutrition for non-symptomatic HIV and HCV infection. Other special diets are available in consultation with the health unit.

### **Compassionate Release**

Early release on medical or humanitarian grounds is considered based upon security considerations.

### **Women Prisoners**

Education, counseling, and testing programs are run on a weekly basis by outside public health nurses. Programs are available on various health and other issues. Programs are specifically developed as stand-alone programs for women.

### **Aboriginal Prisoners**

British Columbia has been a leader in responding to HIV/AIDS in prisons.

Aboriginal services, elder services, Native brotherhood and sisterhood programs, and Native liaison officers are in place. Health services are not specifically tailored for Aboriginal prisoners. The new drug treatment court is increasingly being specifically tailored to meet the needs of Aboriginal people.

### **Legal Network Comments**

British Columbia has been a leader in responding to HIV/AIDS in prisons. Despite the lack of needle exchange programs, the response of BC Corrections remains the most comprehensive in the country.

Many examples of good practice are evident. Corrections works in partnership with local public health nurses who come into the prisons to deliver HIV education/counseling services



and anonymous testing. Corrections provides annual training for all medical staff on HIV and other infectious diseases, and the diets for all prisoners have recently been improved to meet the minimum nutritional standards for non-symptomatic HIV/HCV infection.

All the news is not positive, however. Recent budget cuts by the provincial government have had serious effects on the prison system. Nearly half of the institutions have been closed, without a corresponding reduction in overall prisoner population. This increases concerns about overcrowding which, previously, had not been an issue in the BC system. These cuts, and the political perspective of the new government, also raise concerns about the ability of BC to continue to be a national leader in the initiation of new HIV and harm reduction programs.

### Harm Reduction Report Card

<b>Cumulative Grade</b>	<b>B</b>
<b>Condoms, dental dams, lubricant available</b>	<b>2</b>
<b>Condoms, dental dams, lubricant accessible</b>	<b>4</b>
<b>Bleach available</b>	<b>2</b>
<b>Bleach accessible</b>	<b>4</b>
<b>MMT continuation</b>	<b>6</b>
<b>MMT initiation</b>	<b>4</b>
<b>Needle exchange</b>	<b>0</b>
<b>TOTAL SCORE</b>	<b>22</b>

## **Federal Prison System (CSC)**

### **Response from the Correctional Service of Canada**

The Correctional Service of Canada (CSC) is accountable to the Solicitor General of Canada. CSC's national headquarters is in Ottawa, and the Service is divided into five administrative regions: Atlantic, Québec, Ontario, Prairies, and Pacific.

CSC operates 53 facilities of various security classifications, five of which are women's institutions. The approximate number of federal prisoners in custody at any time is 12-13,000 (350-400 of whom are women).

### **Resources, Accountability, and Strategic Planning**

In February 1994, CSC released the report of the Expert Committee on AIDS and Prisons (ECAP), which detailed over eighty recommendations to the service on HIV/AIDS services. CSC monitors its progress in relation to these recommendations.

CSC receives funding from Health Canada under the Canadian Strategy on HIV/AIDS for its HIV programs.

CSC convenes stakeholder meetings to consult on HIV programs. There is currently a move underway to make this process more formalized, and to include prisoners.

### **Research**

CSC has supported seroprevalence research in a number of institutions in the past, and is currently preparing to undertake an HCV prevalence study that will include HIV. CSC also conducts evaluations on various HIV-related programs.

### **Testing and Confidentiality**

Nominal HIV testing is available on admission, and at any time during custody on a prisoner's request. Pre- and post-test counseling by health staff is offered. An anonymous testing pilot project is currently in operation at Saskatchewan Penitentiary, and has recently been evaluated. CSC will be initiating a second anonymous testing project in New Brunswick by the end of 2002. New confidentiality directives for staff are currently in development.

### **Educational Programs for Prisoners**

Information on HIV, drug use, and harm reduction are included as a mandatory part of the reception process. Health education is also available in other programs such as Choosing Health in Prison (CHIPs). CSC has developed a Peer Education and Counseling (PEC) model that is operating in some institutions. The Canadian Aboriginal AIDS Network has recently developed an Aboriginal peer education model for CSC. Outside community-based groups provide additional educational programs in some institutions. A fund has been established through which prisoners may access money for innovative peer-generated educational initiatives.

### **Preventive Measures for Prisoners**

Condoms, dental dams, water-based lubricant, and bleach are available in all institutions and are accessible in various places. Methadone maintenance treatment (MMT) continuation is available for people entering the system on treatment. Initiation of MMT has been possible under a new policy adopted in May 2002. Needle exchange is not available. While no meas-

ures are currently in place to reduce the risk of disease transmission via tattooing, CSC is developing a framework for a pilot tattooing project for presentation to the Commissioner.

### **Responding to Drug Use**

Methadone maintenance treatment is available in all institutions. Harm reduction education is included in the reception program. Alcohol and drug treatment programs are available. Addiction specialist physicians have been identified in each region to consult with CSC medical staff as necessary. Random urinalysis is used as a security measure.

### **Education of Staff**

Awareness sessions on HIV and other infectious diseases are provided but are not mandatory. CSC is pilot testing a computer-based training module on infectious diseases. Responsibility for ongoing refresher training falls to each region. CSC has also begun producing an infectious disease newsletter for staff.

### **[Protective Measures for Staff**

All staff carry universal precaution materials on their persons. Materials are also available at various sites in the institution. Policies governing universal precautions are in place and are reviewed regularly.

### **Health Care**

Most institutions do not have 24-hour medical units. Each region has a designated 24-hour hospital unit to which patients requiring round-the-clock care can be transferred. Depending upon the region or institution, HIV specialists may attend at the institution, or prisoners may be brought out under escort for appointments.

Access to alternative therapies is available on an individual basis. If approved, such therapies are usually paid for by the prisoner. Pain management medication is available. Special diets are available through the health unit, and there is some ability to adapt eating times to medications. ASOs provide services in some institutions.

### **Compassionate Release**

Applications for compassionate release are considered by the National Parole Board under the terms of the "Parole by Exception" policy of the *Corrections and Conditional Release Act*.

### **Women Prisoners**

The Peer Education and Counseling (PEC) program includes a component designed for women. CSC is currently developing an infectious disease strategy for women.

CSC still is far from having a pro-active response to HIV/AIDS and HCV in its institutions.

### **Aboriginal Prisoners**

Native liaison officers, elders, and traditional healers are available in some institutions. The Canadian Aboriginal AIDS Network has recently completed the development of an Aboriginal peer education model. CSC is collaborating with the National Aboriginal Council on HIV/AIDS in developing an Aboriginal HIV/AIDS strategy for federal prisons.

### **Young Offenders**

N/A

## Legal Network Comments

Since 1996, there have been some positive developments in how CSC is responding to HIV/AIDS (and HCV) in prisons. Most notably, methadone maintenance treatment has become available.

However, CSC is still far from having a pro-active response to HIV/AIDS and HCV in its institutions. To mention only a few of many examples:

- The methadone maintenance treatment initiation program did not start until CSC was sued by prisoners for failing to provide adequate care. CSC continues to react, rather than be pro-active and develop a long-term vision and plan.
- Problems persist with the implementation of some of the measures introduced in the past. For example, there is anecdotal evidence, including from CSC staff, that access to condoms, dental dams, lubricant, and particularly bleach has actually decreased in recent years. Also, bleach is often so diluted that it is questionable whether it has any protective effect.

Although CSC's own working group in 1999 recommended to pilot test needle exchange programs in all five regions, prisoners are still denied access to sterile injection equipment.

- Although CSC's own inmate survey has shown that almost half of all prisoners admit to getting tattooed while in prison, and although tattooing has long moved into mainstream society outside prisons, CSC continues to resist making tattooing safer in prisons.
- Although injection drug use is prevalent in federal institutions across Canada, and although CSC's own working group in 1999 recommended pilot testing needle exchange programs in all five regions, prisoners are still denied access to sterile injection equipment.
- The implementation of the Peer Education and Counseling (PEC) program has been marred by a screening process that disqualifies prisoners who are deemed "unacceptable" by staff from becoming peers, although it is often exactly these prisoners who are trusted by their fellow prisoners. In addition, this program does not even exist in over half of all institutions.
- Lack of adequate compassionate release provisions means that people are still dying in prison from HIV-related illnesses.

## Harm Reduction Report Card

Cumulative Grade	B-
Condoms, dental dams, lubricant available	2
Condoms, dental dams, lubricant accessible	3
Bleach available	2
Bleach accessible	2
MMT continuation	6
MMT initiation	6
Needle exchange	0
<b>TOTAL SCORE</b>	<b>21</b>

## Manitoba

### Response from Correctional Services

Manitoba Justice maintains seven institutions with an average daily head count of approximately 1200 prisoners (approximately 50 of whom are women).

### Resources, Accountability, and Strategic Planning

Manitoba Justice and Manitoba Health participate in the Federal/Provincial/Territorial Working Group on HIV/AIDS and Prisons, and have recently agreed to fund a full-time infectious disease nurse at Headingly Institution in Winnipeg. Manitoba Justice and Manitoba Health are working with Saskatchewan Corrections in developing a joint research proposal to investigate drug use and risk behaviour among provincial prisoners. This proposal is currently on hold.

### Research

Manitoba Justice and Manitoba Health are working with Saskatchewan Corrections in developing a joint research proposal to investigate drug use and risk behaviour among provincial prisoners. The outcome of this research would be used to better focus resources in education, harm reduction, and reintegration. However, this proposal is currently on hold.

### Testing and Confidentiality

Non-nominal HIV testing is provided in all institutions in accordance with guidelines from Manitoba Health. Testing services are not widely promoted, and are often only offered based upon an assessment of the individual's risk behaviour and/or symptoms of infection. Medical information and disclosure must conform to the guidelines of the provincial *Personal Health Information Act*.

Condoms and dental dams are available in all prisons in Manitoba – but water-based lubricant is not.

### Educational Programs for Prisoners

Access to HIV education is not consistent across the province, and is often related to institutional resources and to the availability of local public health nurses to come in and provide the service.

### Preventive Measures for Prisoners

Condoms and dental dams are available in all institutions, although water-based lubricant is not. Bleach and needle exchange are not available, nor are measures to reduce the risk of infection via tattooing. Accessibility of condoms and dental dams varies – some institutions requiring a request to staff and others providing more free access.

Methadone is available in the institutions in and around Winnipeg – including the women's prison – but not in more rural facilities. Prisoners needing to access methadone in rural institutions are transferred to the Winnipeg area. Methadone is only available to those previously accessing it in the community. Methadone initiation is not available.

### Responding to Drug Use

Manitoba provides methadone continuation for those entering the system on the therapy. Random urinalysis is not used. Interest has been shown in conducting research on drug use and risk behaviours in order to set policy, although this project is currently on hold.

### Education of Staff

Infectious disease training is mandatory for all staff as part of their initial orientation. This training includes HIV. Refresher training is not consistently offered, and often gets overlooked in favour of other issues. Correctional nurses are able to participate in regional training held by the Correctional Service of Canada.

### Protective Measures for Staff

All staff carry universal precaution materials on their persons. Materials can also be accessed at various distribution points in the institutions.

### Health Care

Manitoba Justice works with the Village Clinic in Winnipeg to provide HIV specialist services. Prisoners may be taken under escort to access services as required. Special diets are available through a request to the health unit, although mealtimes are not coordinated with drug prescriptions. There is no policy prohibiting narcotic pain management.

Manitoba's response to HIV/AIDS in prisons is poor.

### Compassionate Release

Release on medical or humanitarian grounds is processed through institutional superintendents. Decisions are appealable to the Assistant Deputy Minister.

### Women Prisoners

Some educational programs are in place, which are coordinated by the head nurse.

### Aboriginal Prisoners

There are no specialized services provided for Aboriginal prisoners. Access to elders is available upon request, but they are not necessarily trained in HIV.

### Legal Network Comments

Manitoba's response to HIV/AIDS in prisons is poor.

Provision of health education programs is inconsistent. While condoms are available, water-based lubricant is not. Bleach and needle exchange are not available.

*While non-nominal HIV testing is offered, it is not generally promoted to prisoners. Instead, testing is suggested based upon assessment and perceived risk.*

Although over 50 percent of prisoners are Aboriginal,<sup>26</sup> corrections offers no special health programs for Aboriginal prisoners.

### Harm Reduction Report Card

Cumulative Grade	F
Condoms, dental dams, lubricant available	1
Condoms, dental dams, lubricant accessible	1
Bleach available	0
Bleach accessible	0
MMT continuation	4
MMT initiation	0
Needle exchange	0
<b>TOTAL SCORE</b>	<b>6</b>

## **New Brunswick**

### **Response from Correctional Services**

New Brunswick has six correctional institutions with an overall population of approximately 300. The system is managed by the Department of Public Safety.

Unlike other provincial jurisdictions, people sentenced to 12 months or more (or six months for sex offenders) are incarcerated in federal institutions. Therefore, the average length of stay in a provincial institution in New Brunswick is quite short (60-90 days).

New Brunswick has recently implemented a new HIV counseling, education, and anonymous testing service. This pilot project – a joint initiative with the Department of Health and Wellness – provides dedicated public health nurses to work in all institutions. This project started in June 2001, and is currently being externally evaluated.

### **Resources, Accountability, and Strategic Planning**

Due to the small size of the system, the Department of Public Safety prefers to work with external agencies and departments in providing services, rather than developing their own. The Department collaborates with Health and Wellness in the resourcing, development, and training of the public health nurse pilot project. It also participates in various provincial committees and working groups related to drug use, health, and methadone.

### **Research**

The Department does not initiate or participate in any research related to HIV. It does dedicate resources to program evaluation.

### **Testing and Confidentiality**

Anonymous HIV testing is provided in all institutions (including to young offenders) under the public health nurse pilot project. Testing and pre- and post-test counseling are conducted by the public health nurses who come into the institution for this purpose. The public health nurses maintain their own files separate from those of the institution.

Each institutional health unit maintains its own medical records. These files are not disclosed outside of medical staff.

### **Educational Programs for Prisoners**

Education and information on infectious diseases (including HIV, HCV, HBV, and STDs) is provided by outside public health nurses under the pilot project. Public health nurses enter the institution weekly for this purpose. Participation in the education program is voluntary. Peer education programs are not available.

### **Preventive Measures for Prisoners**

New Brunswick does not provide condoms, dental dams, and water-based lubricant to prisoners. Bleach is not available. There is no needle exchange, nor provisions for safer tattooing. Methadone is maintained for those who enter the system on the treatment. There is no methadone initiation.

### **Responding to Drug Use**

With the exception of the methadone program, there are no harm reduction measures or programs available for prisoners. Drug treatment services are provided through an arrangement

with an outside agency. Random urinalysis is not used except for those on a methadone program.

### **Education of Staff**

Infectious disease training is mandatory for all staff as part of their initial orientation. This training includes HIV. Ongoing training on universal precautions occurs on a bi-annual basis. The public health nurses employed under the pilot project provide awareness and education services to staff on an individual basis upon request.

### **Protective Measures for Staff**

All staff carry universal precaution materials on them. Materials can also be accessed at various distribution points in the institutions. Training on the use of universal precautions is on a bi-annual basis. Due to the small number of prisoners in New Brunswick, a progressive pre-release program, and an agreement with the Correctional Service of Canada to house people with sentences greater than 12 months, overcrowding is not seen as a problem.

### **Health Care**

Health care is provided during daytime hours through the health unit in each institution, and by physicians contracted to provide services in the institutions. After hours, medications are delivered by correctional officers. All institutions have access to a “telenurse” service in case of emergencies or questions.

New Brunswick is one of the only jurisdictions in Canada that does not provide condoms, dental dams, and water-based lubricant to prisoners.

Access to HIV specialists is arranged as necessary. Outside specialists cannot prescribe directly as all medications, including pain management, must be approved by the institutional physician. Special diets can be arranged on a case-by-case basis through request to a nurse. Mealtimes are not structured to accommodate medication timing.

Counseling is provided by the public health nurses through the pilot project. As part of this service, the public health nurses liaise with health and community services in the prisoner’s home community. ASOs come in on occasion to provide services.

### **Compassionate Release**

Release on medical or humanitarian grounds is processed under the provisions of the Temporary Absence Program (TAP). Decisions are made by a management review committee, and appeals of negative decisions may be made to the Department.

### **Women Prisoners**

There are very few provincially incarcerated women in New Brunswick. These women are housed in separate wings of two different male institutions. One wing houses Francophone women, the other Anglophone women.

Under the public health nurse pilot project, public health nurses provide the women with HIV education and counseling, as well as anonymous testing. Educational programs are designed for women, and are different from those provided to male prisoners.

### **Aboriginal Prisoners**

There are no specialized services provided for Aboriginal prisoners. Access to elders and traditional healers is available upon request.



### Young Offenders

The public health nurse pilot project is also provided to young offenders. This includes access to anonymous testing for youth aged 16 and older.

### Legal Network Comments

The response of New Brunswick to HIV/AIDS in prisons is a mix of both best and worst practice.

The recently implemented public health nurse project is an example of good practice in the sector. Dedicated external public health nurses come into all institutions (including young offender facilities) to provide education, counseling, and anonymous HIV testing services. Although HIV education is not mandatory under this initiative, it does provide for specialized educational interventions for incarcerated women and for prison staff. While some report that the implementation of this program is not without problems and requires ongoing monitoring, the initiative remains an innovative one that is very promising.

However, despite the positive programs identified above, New Brunswick falls far short of best practice in many other important areas. The province is one of the only jurisdictions in Canada that does not provide condoms, dental dams, and water-based lubricant to prisoners. Bleach and needle exchange are not available, nor are measures to reduce HIV and HCV transmission via tattooing. Methadone continuation is available, but initiation is not. After established health unit hours, medications are delivered to prisoners by correctional officers, which raises concerns about confidentiality.

### Harm Reduction Report Card

Cumulative Grade	F
Condoms, dental dams, lubricant available	0
Condoms, dental dams, lubricant accessible	0
Bleach available	0
Bleach accessible	0
MMT continuation	6
MMT initiation	0
Needle exchange	0
<b>TOTAL SCORE</b>	<b>6</b>

## **Newfoundland and Labrador**

### **Response from Correctional Services**

The Department of Justice, Corrections and Community Services manages eight institutions in the province, one of which is a women's facility.

### **Resources, Accountability, and Strategic Planning**

The Department of Justice does not have an active infectious disease program, although the Department does liaise with ASOs and community health nurses on HIV issues and services.

### **Research**

None.

### **Testing and Confidentiality**

Nominal HIV testing is available upon request. Pre- and post-test counseling is conducted by a nurse. According to policy, medical information may only be disclosed to non-medical staff if written consent is provided by the prisoner. Confidentiality is not clearly understood by some staff, and therefore not always adhered to.

### **Educational Programs for Prisoners**

The Department provides no HIV educational programs of its own for prisoners. HIV education is provided where possible by outside ASOs and community health nurses who come into the institution for this purpose. Participation in these programs is voluntary, and they are run on an occasional basis.

### **Preventive Measures for Prisoners**

Condoms, dental dams, and water-based lubricant are available in all institutions. In some institutions, a request must be made to health staff, while in others they are more freely available. Bleach is not made available as a harm reduction measure, although it is available for general cleaning purposes. Methadone and needle exchange are not available, nor are provisions for safer tattooing.

### **Responding to Drug Use**

Methadone is not available. The Department provides no harm reduction education of its own, and relies on outside agencies for this service where they are available. Random urinalysis is used.

### **Education of Staff**

Training on infectious diseases is a part of the basic staff training. Refresher courses are periodically provided but not on a regular schedule.

### **Protective Measures for Staff**

All staff carry universal precaution materials on their persons. Materials are also available at various sites in the institution.

### **Health Care**

Most medical services are provided by institutional medical staff. Prisoners requiring access to an HIV specialist may be taken out of the institution under escort. Special diets are avail-

able through a request to the health unit, although mealtimes are not coordinated with drug prescriptions. Pain management medication is available if prescribed.

**Compassionate Release**

Release on medical or humanitarian grounds is processed under the provisions of the Temporary Absence Program. Decisions are made by the institutional superintendent, and appeals of negative decisions may be made to the director.

**Women Prisoners**

Some educational sessions are provided by external agencies.

**Aboriginal Prisoners**

There are no specialized services provided for Aboriginal prisoners.

**Legal Network Comments**

The response of Newfoundland and Labrador to HIV/AIDS in prisons is unsatisfactory.

The province provides no HIV educational programs of its own within the prison system, and relies solely upon the services of external agencies. Education is not mandatory, and is not consistently available.

Condoms, dental dams, and water-based lubricant are provided in all institutions, but some institutions distribute them through the health unit, thus limiting access. Needle exchange is not available, nor are measures to reduce HIV and HCV transmission via tattooing. Methadone is not available in the province, and is therefore not provided to people in prison.

One positive note is the availability of bleach. While bleach is not available in a “bleach kit” form, it is generally available on the units for cleaning purposes. Prisoners may therefore easily access bleach for use as a harm reduction measure without having to identify themselves.

**Harm Reduction Report Card**

<b>Cumulative Grade</b>	<b>D</b>
<b>Condoms, dental dams, lubricant available</b>	<b>2</b>
<b>Condoms, dental dams, lubricant accessible</b>	<b>1</b>
<b>Bleach available</b>	<b>2</b>
<b>Bleach accessible</b>	<b>4</b>
<b>MMT continuation</b>	<b>N/a</b>
<b>MMT initiation</b>	<b>N/a</b>
<b>Needle exchange</b>	<b>0</b>
<b>TOTAL SCORE</b>	<b>9</b>

Note: Since methadone treatment is generally not available in Newfoundland and Labrador, the institutions’ lack of access to such treatment was not taken into account. As a result, the cumulative grade is calculated using a possible total of 18 points.

## **Northwest Territories**

### **Response from Correctional Services**

Northwest Territories Justice manages three adult institutions, one of which is an institution for women. There are also four facilities for young offenders.

### **Resources, Accountability, and Strategic Planning**

Correctional services works with the Health Protection Unit, public health, and all the community health centres on infectious disease issues. The Inmate Advisory Committees are consulted on HIV programs, and public health nurses offer additional education and counseling support.

### **Research**

None.

### **Testing and Confidentiality**

Nominal HIV testing is offered in all institutions on admission, or may be requested by a prisoner at any time during incarceration. Pre- and post-test counseling is performed by medical staff. Health records are not available to non-medical staff without written consent from the prisoner.

### **Educational Programs for Prisoners**

Correctional services is currently developing a voluntary educational program in consultation with a public health nurse and the Inmate Advisory Committee. The Inmate Advisory Committee at Yellowknife Correctional Centre has recently received funding to develop a peer education project on HIV and HCV prevention and awareness.

### **Preventive Measures for Prisoners**

Condoms are available for sentenced prisoners through the health-care units in all institutions. Condoms are not currently available for remand prisoners. Bleach and needle exchange are not available, nor are measures to reduce the risk of infection via tattooing. Methadone treatment continuation is available for those accessing the therapy prior to incarceration. Methadone treatment initiation is not available.

### **Responding to Drug Use**

Some education on drug use is provided. Alcohol and drug treatment is provided by correctional services. A drug free unit is scheduled to open in the near future. Random urinalysis is not practiced.

### **Education of Staff**

Infectious disease training is mandatory for all staff as part of their initial orientation. Refresher training is offered annually.

### **Protective Measures for Staff**

All staff carry universal precaution materials on their persons. Materials can also be accessed at various distribution points in the institutions.

### **Health Care**

Physicians are contracted to provide services in the institutions. Prisoners requiring specialist medical services – including HIV care – are routinely escorted to Edmonton. Special diets are available through a request to the health unit, and mealtimes may be coordinated with drug prescriptions. There is access to narcotic pain management. Nursing staff is supported in accessing some ongoing HIV training. Additional support is provided by public health nurses who provide services in the institutions.

### **Compassionate Release**

Prisoners may request “early release for compassionate reasons.” The prisoner does not need to disclose his/her status, only have the health unit confirm that he/she has a terminal illness. Applications are decided by the institutional head, and decisions are appealable to the Ministry.

### **Women Prisoners**

Corrections provides no formal programs on HIV/AIDS for incarcerated women. There is some cooperation with public health to provide educational sessions in the women’s institution.

### **Aboriginal Prisoners**

There are elders and traditional healers on staff who work in collaboration with the health unit. These staff participate in HIV counseling upon request, and have access to staff refresher courses in HIV.

### **Legal Network Comments**

Although a small jurisdiction, the Northwest Territories exhibits examples of innovative practice in several areas. The compassionate release process is conducted using a system that does not require the prisoner to disclose his/her HIV status. The Yellowknife Correctional Centre, the largest institution in the territory, has recently initiated development of a peer education program on HIV/HCV. The Inmate Advisory Committee participates in consultations with health staff and public health on HIV programs.

That said, access to harm reduction measures is inconsistent. Condoms are available only for sentenced prisoners, and are not available for people on remand. Bleach and needle exchange are not available, nor are measures to reduce HIV and HCV transmission via tattooing. Methadone treatment continuation is available, but methadone treatment initiation is not (reflecting limited access to methadone maintenance treatment in the territory).

### Harm Reduction Report Card

<b>Cumulative Grade</b>	<b>F</b>
<b>Condoms, dental dams, lubricant available</b>	<b>1</b>
<b>Condoms, dental dams, lubricant accessible</b>	<b>0</b>
<b>Bleach available</b>	<b>0</b>
<b>Bleach accessible</b>	<b>0</b>
<b>MMT continuation</b>	<b>6</b>
<b>MMT initiation</b>	<b>0</b>
<b>Needle exchange</b>	<b>0</b>
<b>TOTAL SCORE</b>	<b>7</b>

## **Nova Scotia**

### **Response from Correctional Services**

The Correctional Services Division of the Nova Scotia Department of Justice maintains five institutions with an average daily head count of approximately 320 prisoners (approximately 20 of whom are women). There is no separate women's prison in Nova Scotia.

### **Resources, Accountability, and Strategic Planning**

Correctional services collaborates with the provincial Medical Officer of Health, the Communicable Disease Control Coordinator for Public Health Services, public health nurses, and ASOs in examining HIV, hepatitis, and tuberculosis issues. Correctional services also participates in the Federal/Provincial/Territorial Working Group on HIV.

Correctional services is completing an agreement with the provincial Department of Health to assume responsibility for the provision and management of health services within all institutions.

### **Research**

None.

### **Testing and Confidentiality**

Non-nominal HIV testing is offered in all institutions on admission, or may be requested at any time during incarceration. Pre- and post-test counseling is optional. Policies and procedures are in place governing confidentiality and duty to warn. This information is also made available in an information pamphlet. Health records are secured in the medical units, and are not available to non-medical staff.

### **Educational Programs for Prisoners**

Educational programming is provided based upon needs identified by health-care staff at each institution. HIV education is primarily delivered via one-on-one interventions between nursing staff and prisoners. Some peer education is available in the larger institutions.

### **Preventive Measures for Prisoners**

Condoms and dental dams are available through the health-care units in all institutions, although water-based lubricant is not. Bleach and needle exchange are not available, nor are measures to reduce the risk of infection via tattooing.

Methadone continuation is available in the institutions in Halifax, but not in more rural facilities. Prisoners needing to access methadone in rural institutions are transferred to Halifax. Methadone initiation is not available.

### **Responding to Drug Use**

Random urinalysis is used in the largest institution.

### **Education of Staff**

Infectious disease training is mandatory for all staff as part of their initial orientation. Refresher training is offered on occasion.

### **Protective Measures for Staff**

All staff carry universal precaution materials and gloves on their persons. Materials can also be accessed at various distribution points in the institutions.

### **Health Care**

Correctional services is concluding an agreement with the provincial Department of Health to assume responsibility for the provision and management of health services within all institutions.

Depending upon the institution, HIV specialists may attend at the prison, or prisoners may be brought out under escort for appointments. Special diets are available through a request to the health unit, although mealtimes are not coordinated with drug prescriptions. There is no policy prohibiting access to narcotic pain management.

### **Compassionate Release**

Release on medical or humanitarian grounds is processed through the Temporary Absence Program (TAP), and is approved by the TAP administrator. Decisions are appealable to the director.

### **Women Prisoners**

Incarcerated women are housed in the Central Nova Scotia institution, which is designed to house both men and women. There is some access of outside groups to provide service, and the Women's Wellness Clinic provides a weekly service.

### **Aboriginal Prisoners**

Nova Scotia has a small population of Aboriginal prisoners. There are no specialized services provided for Aboriginal prisoners. However, access to elders is available upon request.

### **Young Offenders**

Correctional services is concluding an agreement with the provincial Department of Health to have the Children's Hospital assume responsibility for the provision and management of health services for young offenders. Regular programs on blood-borne diseases, STDs, and drug use are provided by nurses.

### **Legal Network Comments**

Correctional services is currently concluding an agreement with the Department of Health to allow the latter to assume responsibility for managing health services in prisons. This is a clearly a good development that reflects best practice internationally. However, despite this important development, HIV programs and services in many other areas are poor.

Condoms and dental dams are only available through the health units. Water-based lubricant is not provided. Bleach and needle exchange are not available, nor are measures to reduce HIV and HCV transmission via tattooing. Methadone continuation is available in Halifax institutions, but not in rural facilities. Methadone initiation is not available in any institution. Pre- and post-test counseling is not a mandatory part of HIV testing protocols.

It is hoped that transferring the management of health services to the Department of Health may improve this situation.



### Harm Reduction Report Card

<b>Cumulative Grade</b>	<b>F</b>
<b>Condoms, dental dams, lubricant available</b>	<b>1</b>
<b>Condoms, dental dams, lubricant accessible</b>	<b>0</b>
<b>Bleach available</b>	<b>0</b>
<b>Bleach accessible</b>	<b>0</b>
<b>MMT continuation</b>	<b>4</b>
<b>MMT initiation</b>	<b>0</b>
<b>Needle exchange</b>	<b>0</b>
<b>TOTAL SCORE</b>	<b>5</b>

## **Nunavut**

### **Response from Correctional Services**

Nunavut is a small jurisdiction with only two institutions and an overall prisoner population of approximately 150. The system is managed by the Department of Justice. The vast majority of the prisoner population is Inuit. Nunavut does not have any facilities for incarcerating women. Women prisoners from the territory are held in the Northwest Territories.

### **Resources, Accountability, and Strategic Planning**

The Department recently completed an institutional planning review. This process included consideration of HIV. A health committee has been constituted to make recommendations and help draft policy.

Prison health services are jointly funded by the Department of Justice and the Department of Health and Social Services. The Department of Justice collaborates with the Department of Health and Social Services, as well as the hospital, in developing these programs and services.

### **Research**

The Department does not initiate or participate in any research related to HIV at this time. However, this may change based upon the development of its institutional plans.

### **Testing and Confidentiality**

Nominal HIV testing is available in the institutions. Testing is conducted by institutional health staff, or at the local hospital. Pre- and post-test counseling is expected to be part of standard practice.

The health units maintain all medical records, which are not to be disclosed outside of medical staff.

In Nunavut, HIV education is conducted by an institutional nurse, and is mandatory for all prisoners as part of the reception program.

### **Educational Programs for Prisoners**

HIV education is conducted by an institutional nurse, and is mandatory for all prisoners as part of the reception program. HIV is also addressed in the life-skills program. There is no peer education.

### **Preventive Measures for Prisoners**

Condoms, dental dams, and water-based lubricant are not provided to prisoners. Bleach is not available. There is no needle exchange, nor provisions for safer tattooing. Methadone is not available, as there is no methadone provision in the territory.

### **Responding to Drug Use**

There are no harm reduction measures or programs available for prisoners. In the opinion of the Department, there are no injectable drugs available in the institutions. Drug treatment services are provided through an internal program. As there are no residential treatment centres in Nunavut, people wishing to access such services are transferred out of the territory.

### **Education of Staff**

Infectious disease training is mandatory for all staff as part of their initial orientation. This training includes HIV. This training is supplemented by annual training provided by an institutional nurse.

### **Protective Measures for Staff**

All staff carry universal precaution materials on their persons.

### **Health Care**

Health care is provided during daytime hours through the health unit in each institution. Physicians are contracted from an outside hospital to provide services.

Access to HIV specialists is arranged as necessary through the hospital. Pain management is available if prescribed by a physician and approved by the institutional nurse.

Special diets can be arranged on a case-by-case basis. While formal mealtimes are not structured to accommodate medication timing, if it is indicated, additional food will be provided as necessary.

### **Compassionate Release**

Release on medical or humanitarian grounds is processed under the provisions of the Temporary Absence Program. Decisions are made by the director, and appeals of negative decisions may be made to the minister.

### **Women Prisoners**

Nunavut does not have facilities to house women prisoners. Incarcerated women from Nunavut are housed in the Northwest Territories.

### **Aboriginal Prisoners**

The vast majority of prisoners in Nunavut are Inuit, and therefore all programs and services are designed to meet their needs. It is not clear whether this includes HIV education. Elders are available from the community. The Department is in the process of employing an elder on staff.

### **Young Offenders**

Young offenders receive the same services as are available to adults.

### **Legal Network Comments**

As the territory of Nunavut was only recently created as a separate jurisdiction, the Department of Justice is also new and is working towards developing various policies related to health and other issues. Given its geographic location, access to services also presents challenges.

This does not excuse Nunavut, however, for not providing condoms, dental dams, and water-based lubricant to prisoners. Bleach and needle exchange are also not available, with the Department claiming that there are no injectable drugs available in prisons.

The Department must examine the successful HIV prevention initiatives identified in this report, and move quickly to implement them as part of the ongoing development of their health policies.

On a positive note, Nunavut is one of the only jurisdictions in which HIV education for prisoners is mandatory.

### Harm Reduction Report Card

<b>Cumulative Grade</b>	<b>F</b>
<b>Condoms, dental dams, lubricant available</b>	<b>0</b>
<b>Condoms, dental dams, lubricant accessible</b>	<b>0</b>
<b>Bleach available</b>	<b>0</b>
<b>Bleach accessible</b>	<b>0</b>
<b>MMT continuation</b>	<b>n/a</b>
<b>MMT initiation</b>	<b>n/a</b>
<b>Needle exchange</b>	<b>0</b>
<b>TOTAL SCORE</b>	<b>0</b>

Note: Since methadone treatment is generally not available in Nunavut, the lack of access to such treatment in prisons was not taken into account. As a result, the cumulative grade is calculated using a possible total of 18 points.

## **Ontario**

### **Response from Correctional Services**

In October 2002, the Ontario Ministry of Security and Public Safety housed 4200 male and 300 female prisoners in 43 institutions.

### **Resources, Accountability, and Strategic Planning**

Ontario has implemented various policies with respect to infectious diseases, including HIV. The Ministry liaises to some degree with external agencies (ASOs, public health units) in providing HIV/AIDS services to prisoners.

### **Research**

The Ministry participated in a large HIV seroprevalence study in 1994. It is currently working with the University of Toronto on an HCV/HIV seroprevalence study, which should be initiated by the end of 2002.

### **Testing and Confidentiality**

Nominal HIV testing is available in all institutions, and is offered on admission or at any time during incarceration upon a prisoner's request. Pre- and post-test counseling is provided by health staff.

### **Educational Programs for Prisoners**

The Ministry provides no formal HIV educational programs of its own for prisoners, although nurses in some institutions provide some educational interventions. HIV education is provided where possible by external ASOs and community health nurses who come into the institution for this purpose. Participation in these programs is voluntary, and they are run on an occasional basis.

In Ontario prisons, methadone maintenance treatment initiation is only considered in the case of pregnant women.

### **Preventive Measures for Prisoners**

Condoms, dental dams, and water-based lubricant are available in all institutions, and must be requested from nursing staff. According to policy, one condom/lubricant or dental dam will be provided per request, and a prisoner may possess no more than two. Sex is prohibited.

Methadone continuation is available for people entering the system on the therapy, although a small number of institutions will not provide it. In such cases, the individual prisoner will be transferred to another facility. Methadone initiation is only considered in the case of pregnant women. Bleach and needle exchange are not available, nor are provisions for safer tattooing.

### **Responding to Drug Use**

Methadone continuation is available in most institutions. The Ministry provides no formal harm reduction education of its own, and relies on outside agencies for this service where they are available. Alcohol and drug treatment programs are available. Random urinalysis is not used.

### **Education of Staff**

Training on communicable diseases is a mandatory component of staff orientation. Annual refresher courses are held in some institutions.

### **Protective Measures for Staff**

All staff carry universal precaution materials on their persons. Materials are also available at various sites in the institution. Access to protective measures is monitored by the Ministry. Transfers are used to reduce double-bunking where possible.

### **Health Care**

Most medical services are provided by institutional medical staff. Prisoners requiring access to an HIV specialist may be taken out of the institution under escort. Special diets are available through a request to the health unit, although mealtimes are not coordinated with drug prescriptions. Pain management medication is available. In several of the larger institutions, 24-hour health units are in place.

### **Compassionate Release**

Ministry policy allows for early release based upon individual circumstance, which may include terminal illness.

### **Women Prisoners**

The Ministry provides no specialized HIV education of its own. Educational services are provided by external agencies where possible. Plans are currently underway to open a new institution for women in Ontario, and as a result, much program planning is on hold.

### **Aboriginal Prisoners**

Education and prevention programs specifically for Aboriginal prisoners are in development at one institution.

### **Young Offenders**

Education is available in written and video formats, and through sessions with institutional nurses. External agencies are also used for education where available. Condoms are available, and must be requested through health-care staff.

## **Legal Network Comments**

Ontario's response to HIV/AIDS in prisons remains unsatisfactory.

Correctional services provides no health education programs of its own, and relies primarily on the ability of ASOs and public health nurses to fill this role.

Condoms, dental dams, and lubricant, while available, can only be accessed through the health units. Policies that limit the number of condoms provided, and prohibiting consensual sex in the institutions, create unnecessary additional barriers to safer sex. Methadone treatment continuation is available in most institutions, although a small number of prisons still refuse to provide the treatment. Methadone treatment initiation is considered only in the case of pregnant prisoners. Bleach and needle exchange are not available.

Recent changes in Ontario corrections also raise concerns for HIV/AIDS services. These include the opening of "super-jails" that house up to 1000 people, and the provincial government's move to privatize some institutions.

### Harm Reduction Report Card

<b>Cumulative Grade</b>	<b>F</b>
<b>Condoms, dental dams, lubricant available</b>	<b>2</b>
<b>Condoms, dental dams, lubricant accessible</b>	<b>0</b>
<b>Bleach available</b>	<b>0</b>
<b>Bleach accessible</b>	<b>0</b>
<b>MMT continuation</b>	<b>5</b>
<b>MMT initiation</b>	<b>1</b>
<b>Needle exchange</b>	<b>0</b>
<b>TOTAL SCORE</b>	<b>8</b>

## **Prince Edward Island**

### **Response from Correctional Services**

The PEI Office of the Attorney General manages two institutions, one 96-bed facility in Charlottetown and one 24-bed facility in Summerside. Women prisoners are held in a separate unit of the Charlottetown institution, and rarely number more than five.

### **Resources, Accountability, and Strategic Planning**

PEI medical services works with outside medical practitioners in providing infectious disease services. Correctional services participates on a community harm reduction committee, however the system is still in the “early stages” of addressing the issue in a strategic fashion.

### **Research**

None.

### **Testing and Confidentiality**

Nominal HIV testing is provided through the prison health unit upon request. Pre- and post-test counseling is done by the institutional nurse.

### **Educational Programs for Prisoners**

Voluntary HIV educational services are provided by the prison health unit, as well as by outside medical staff and ASOs.

### **Preventive Measures for Prisoners**

Condoms, dental dams, and water-based lubricant are not available to prisoners. Bleach is not provided, nor is needle exchange. Measures to reduce the risk of infection via tattooing are not available. Methadone treatment is not available in the province, and therefore is not available to people in prison.

### **Responding to Drug Use**

Some drug education programs are provided, as well as drug treatment programs. Random urinalysis is practiced. The development of a drug free “intensive support unit” is currently in process.

### **Education of Staff**

Infectious disease education is mandatory for all staff as part of core training. Refresher training is offered once or twice annually by prison medical staff or the Medical Officer of Health.

### **Protective Measures for Staff**

All staff are trained in the use of universal precautions, and access to universal precaution materials is available.

### **Health Care**

Most medical services are provided by institutional health-care staff. Prisoners requiring access to an HIV specialist are taken out of the institution under escort. Special diets are available through a request to the health unit. Mealtimes are not coordinated with drug pre-



scriptions, although the system does provide flexibility on a case-by-case basis. Pain management medication is available if prescribed.

**Compassionate Release**

Release on medical or humanitarian grounds is processed under the provisions of the Temporary Absence Program. Decisions are made by the institutional superintendent, and appeals of negative decisions may be made to the superintendent.

**Women Prisoners**

Women’s programming is coordinated through a Provincial Women Offender Committee. There are no HIV programs specifically for women, who participate in general educational sessions with the men.

**Aboriginal Prisoners**

There are currently no HIV programs specifically for Aboriginal prisoners. Correctional services has an Aboriginal caseworker on staff who is able to access infectious disease training.

**Legal Network Comments**

The provision of HIV prevention measures to prisoners in PEI is among the worst in Canada.

The province is one of the only jurisdictions in Canada that does not provide condoms, dental dams, and water-based lubricant to prisoners. Bleach and needle exchange are not available, nor are measures to reduce HIV and HCV transmission via tattooing. Methadone is not available in the province, and is therefore not provided to prisoners.

**Harm Reduction Report Card**

<b>Cumulative Grade</b>	<b>F</b>
<b>Condoms, dental dams, lubricant available</b>	<b>0</b>
<b>Condoms, dental dams, lubricant accessible</b>	<b>0</b>
<b>Bleach available</b>	<b>0</b>
<b>Bleach accessible</b>	<b>0</b>
<b>MMT continuation</b>	<b>n/a</b>
<b>MMT initiation</b>	<b>n/a</b>
<b>Needle exchange</b>	<b>0</b>
<b>TOTAL SCORE</b>	<b>0</b>

Note: Since methadone treatment is generally not available in PEI, the lack of access to such treatment in prisons was not taken into account. As a result, this cumulative grade is calculated using a possible total of 18 points.

## Québec

### Response from Correctional Services

As of 25 September 2002, the Ministry of Public Security (*Ministère de la Sécurité publique*, MSP) housed 3 524 male prisoners in 16 institutions, and 185 female prisoners in two institutions.

### Resources, Accountability, and Strategic Planning

In April 1992, the *Direction générale des services correctionnels du Québec* (DGSC) put in place a policy on infectious diseases for the correctional system, with the aim of establishing HIV information and prevention programs as well as universal precaution measures for prison staff in the event of exposure to blood or bodily fluids.

In September 1998, an action plan for the correctional system for the period 1998-2002 was jointly developed by the DGSC and the *Centre québécois de coordination sur le sida* (CQCS), a provincial body operated by the Ministry of Health and Social Services (*Ministère de la Santé et des Services sociaux*, MSSS). This action plan allowed the DGSC to link its efforts to the MSSS's overall provincial strategy on HIV/AIDS over the same time period. The DGSC action plan incorporated a harm reduction approach as well as training and awareness activities for prison staff, availability of condoms and bleach, and access to methadone maintenance treatment.

Prisoners are identified as a key target group within the provincial HIV/AIDS strategy, and both regional and province-wide projects have been set up as part of the DGSC action plan with the MSSS providing funding for HIV programs in prisons in some regions. Currently, a new action plan on infectious diseases and drug addiction is being developed as part of a review of the memorandum of understanding between the MSP and the MSSS.

### Research

In 2000, a research study was conducted by Laval University on the degree to which prison staff would accept or not accept making HIV prevention materials available to prisoners. More recently, the Canadian Institute for Health Research and the MSSS contributed funding for a study of HIV and HCV prevalence among prisoners and of approaches to intervention. The bulk of this study will be undertaken in 2003.

### Testing and Confidentiality

A broader effort to increase access to HIV/HCV/STD testing in the province is underway. Prisoners have been identified as a target group for this effort. Currently, HIV testing is available in all institutions through prison health-care staff or through local community health clinics in collaboration with frontline workers from community organizations.

### Educational Programs for Prisoners

The CQCS funded the *Association des intervenants en toxicomanie du Québec* (AITQ) to develop deck of cards as a tool to educate prisoners about HIV/AIDS, hepatitis C and other STDs. The cards provide information for both male and female prisoners regarding risks of transmission and prevention measures for diseases transmitted sexually and through the exchange of bodily fluids. This educational tool will be available in January 2003 and will be evaluated. A dissemination plan will also be developed to support implementation of this project in each provincial institution.

### **Preventive Measures for Prisoners**

Condoms are available in all institutions, and are distributed in various ways (some freely, some upon request). Dental dams and water-based lubricant are not available in any of the provincial prisons. According to policy, bleach should be available in all institutions. Access to bleach varies, with some institutions providing access through the prison canteen, and some institutions making bleach freely available in the living quarters.

Methadone maintenance is considered to be a medical treatment with the same status as any other treatment, and methadone continuation is available to all prisoners who were on the treatment prior to incarceration. Methadone initiation is permitted in some cases based on assessment by a prisoner's physician (methadone is considered to be an excellent means for preventing HIV in that it reduces the circulation and concealment of used syringes). A committee has been established to review and improve the prison MMT program in the Montréal area.

Needle exchange is not available. In its response to the questionnaire, the MSP states that "although we support the principles that underlie all of the recommendations, including the recommendation concerning establishment of needle exchange programs in prisons, we think that we need firstly to obtain a picture of the situation in provincial prisons in Québec with regard to needle use, as well as provide training to our staff about harm reduction."

Although measures to prevent disease transmission via tattooing are not available, the MSP notes that it is aware "...of the necessity of continuing our thinking and our actions so that we can eventually minimize the risks related to tattooing."

### **Responding to Drug Use**

The MSP has decided to officially support a harm reduction approach. In the spring of 1999, specially developed training sessions on harm reduction were held for managers within the corrections system. The sessions were jointly organized by the MSSS and the MSP. A harm reduction training program has also been developed for prison staff and will be pilot tested by the end of 2002 in one region.

### **Education of Staff**

Harm reduction education has been developed, and province-wide education for staff on infectious diseases was held in 1995, 1997, and 2001.

### **Protective Measures for Staff**

All staff are trained in the use of universal precautions, and access to universal precaution materials is available at various sites in each institution including in supervisors' offices as well as in admissions areas.

### **Health Care**

Discussions about a new memorandum of understanding between the MSSS and the MSP on the provision of health care within prisons are underway. In the meantime, health care is still mainly provided by the MSP, although some supplemental services are being offered by public and private health-care providers.

### **Compassionate Release**

Currently, release on medical or humanitarian grounds is processed under the provisions of the Temporary Absence Program. Requests are made to the institution's Temporary Absence Committee (*Comité d'absence temporaire*). The committee provides a non-binding recommendation to the prison director, who makes the decision. Appeals of negative decisions may be made to the *Commission québécoise des libérations conditionnelles*.

With the implementation of the new *Loi sur le système correctionnel du Québec* in February 2003, temporary absence provisions will be replaced by a new process for *permissions de sortir* that will permit prison directors' to grant releases on medical grounds when necessary.

### Women Prisoners

A frontline community worker has been doing outreach at the institution for women in Québec City. A prevention and psychosocial support program is currently being offered at the institution for women in Montréal.

### Aboriginal Prisoners

Although there are currently no specific services, Québec recognizes that there is a need and has started planning services and programs specifically for Aboriginal offenders.

### Legal Network Comments

Québec's response to HIV in prisons demonstrates innovation and good practice in several areas.

Québec's response to HIV in prisons demonstrates innovation and good practice in several areas.

In terms of overall strategic planning, the close interministerial collaboration between the MSP and the MSSS is well conceived and developed to a much greater extent than in most other jurisdictions. The inclusion of prisoners as a key target population within the provincial AIDS strategy has also meant that increased resources have been made available to external community groups to provide services in prisons. This has resulted in innovative projects such as outreach programs by frontline community workers operating in some institutions. The proposed transfer of prison health-care management from the MSP to the MSSS, currently in discussion, is also a positive development.

Other examples of good practice include the formal adoption of a harm reduction philosophy by the MSP, and ongoing, targeted education and training with prison staff to help expand their support for harm reduction initiatives.

In terms of current HIV prevention and harm reduction services, however, improvement is needed. Condoms are available in all institutions, but they are not always freely accessible and dental dams and water-based lubricant are not available. Although bleach is supposed to be available in all institutions, it is only accessible in some institutions. Methadone continuation is provided, although initiation is only offered in exceptional cases. Needle exchange is not provided, nor are measures to reduce HIV and HCV transmission via tattooing.

### Harm Reduction Report Card

Cumulative Grade	F
Condoms, dental dams, lubricant available	1
Condoms, dental dams, lubricant accessible	2
Bleach available	2
Bleach accessible	2
MMT continuation	6
MMT initiation	1
Needle exchange	0
<b>TOTAL SCORE</b>	<b>14</b>

## **Saskatchewan**

### **Response from Correctional Services**

Saskatchewan Corrections and Public Safety manages six correctional centres, one of which is a woman's institution. The total prisoner population is approximately 1,200.

### **Resources, Accountability, and Strategic Planning**

Saskatchewan Corrections has established a Health Care Review Committee to review and make recommendations on various health issues and programs, including HIV, harm reduction, education, and staff training. This is an internal correctional group that accepts input from various outside professionals. Corrections also works with the Department of Health in providing public health nurses to provide infectious and communicable disease education, counseling, and testing services in the institutions.

### **Research**

Saskatchewan Corrections is working with Manitoba Justice in developing a joint research proposal on drug use and risk behaviour among provincial prisoners. The outcome of this research would be used to better focus resources in education, harm reduction, and reintegration. However, this proposal is currently on hold. Saskatchewan is currently engaged in no other research initiative in the area of HIV.

### **Testing and Confidentiality**

Anonymous HIV testing is provided in all institutions by public health nurses who come into the prison for this purpose. Pre- and post-test counseling is conducted by the health-care providers. Nominal testing is also available upon request from the institutional health units.

### **Educational Programs for Prisoners**

Infectious and communicable disease education is voluntary and is provided by public health nurses on a weekly basis. One-on-one educational interventions are also provided by the institutional nurses.

### **Preventive Measures for Prisoners**

Condoms, dental dams, and water-based lubricant are available through the health unit or the public health nurses. Bleach is not provided, nor is needle exchange. Measures to reduce the risk of infection via tattooing are not available.

Methadone is available to those who were accessing it prior to incarceration. Methadone initiation is available in exceptional circumstances upon approval from the Assistant Deputy Minister.

### **Responding to Drug Use**

Saskatchewan Corrections provides alcohol and drug programs. The Health Care Review Committee is established to consider issues of harm reduction and education. Urinalysis may be used for prisoners in drug treatment programs.

### **Education of Staff**

Infectious disease training is mandatory for all staff as part of their core staff training. Refresher training, including HIV, is organized at an institutional level.

### **Protective Measures for Staff**

All staff carry universal precaution materials on their persons. Materials can also be accessed at various distribution points in the institutions. Policy and procedures for blood spills are in place.

### **Health Care**

Access to HIV specialists varies from institution to institution. In some, the physician comes into the prison. In others, the prisoner is brought out under escort to see the doctor. Special diets can be accessed through the health unit. Ongoing training on HIV is provided for medical staff.

### **Compassionate Release**

Release on medical or humanitarian grounds can be authorized by the director of an institution. Decisions are appealable to the Assistant Deputy Minister.

### **Women Prisoners**

The Health Care Review Committee is currently reviewing women's health programming with the intention of developing specific women's health programs.

### **Aboriginal Prisoners**

The Health Care Review Committee is currently reviewing Aboriginal health programming with the intention of developing specific Aboriginal health programs.

## **Legal Network Comments**

Saskatchewan's response to HIV/AIDS in prisons is notable for its examples of both good and bad practice.

On the positive side, Saskatchewan was one of the first jurisdictions in Canada to provide anonymous HIV testing for prisoners. This testing is provided by outside health workers who enter the prisons to provide this service. Saskatchewan's model is the one adopted by CSC in its own anonymous testing pilot projects. Saskatchewan Corrections also works in partnership with the Department of Health to provide public health nurses to deliver HIV education and counseling services.

However, despite its good work in this area, bleach and needle exchange are not available, nor are measures to reduce HIV and HCV transmission via tattooing. Methadone continuation is made available, although except in exceptional circumstances, methadone initiation is not.

Condoms, dental dams, and water-based lubricant must be accessed through the health unit. While there is some increased access through the public health nurses, who provide anonymous testing, education, and counseling programs, this still falls short of the recommendation in the 1996 Final Report.

HIV programming specifically for women and Aboriginal prisoners is not currently in place, although this is under review.

## Harm Reduction Report Card

<b>Cumulative Grade</b>	<b>F</b>
<b>Condoms, dental dams, lubricant available</b>	<b>2</b>
<b>Condoms, dental dams, lubricant accessible</b>	<b>1</b>
<b>Bleach available</b>	<b>0</b>
<b>Bleach accessible</b>	<b>0</b>
<b>MMT continuation</b>	<b>6</b>
<b>MMT initiation</b>	<b>1</b>
<b>Needle exchange</b>	<b>0</b>
<b>TOTAL SCORE</b>	<b>10</b>

## **Yukon**

### **Response from Correctional Services**

The Yukon has one institution in Whitehorse that houses both men and women. The average population of the institution is approximately 60 men, and three to five women.

### **Resources, Accountability, and Strategic Planning**

The Yukon currently has no long term coordinated strategic planning process for HIV. Issues are dealt with on a case-by-case basis. Corrections participate in the Federal/Provincial/Territorial Working Group, and collaborate with Public Health on a local level in providing infectious disease education for prisoners and staff.

### **Research**

None.

### **Testing and Confidentiality**

Nominal HIV testing is provided through the prison health unit, and is offered to all prisoners on admission. Pre- and post-test counseling is conducted by a public health nurse. Medical information is only shared outside of health care with the written consent of the prisoner.

### **Educational Programs for Prisoners**

Infectious disease education, including HIV, is conducted by a public health nurse who comes into the institution twice weekly.

### **Preventive Measures for Prisoners**

Condoms are available through the health unit. Dental dams and water-based lubricant are not provided. Bleach is not provided, nor is needle exchange. Measures to reduce the risk of infection via tattooing are not available.

People on methadone maintenance treatment prior to incarceration may continue the treatment in prison. Methadone initiation is available in some circumstances.

### **Responding to Drug Use**

Some drug education is provided by nursing staff and Public Health. Methadone continuation is provided. Random urinalysis is not used.

### **Education of Staff**

Infectious disease training is mandatory for all staff as part of their core training. Refresher training, which includes HIV, is organized at an institutional level.

### **Protective Measures for Staff**

All staff carry universal precaution materials on their persons. Materials can also be accessed at various distribution points in the institutions.

### **Health Care**

HIV specialist care is provided by a physician who travels from Alberta every three months. Prisoners may also be taken out of the prison under escort to access other specialist medical



care. Special diets can be accessed through the health unit. Mealtimes are not coordinated with prescriptions, although extra food is provided when necessary. Pain management medications are available.

**Compassionate Release**

There are currently no provisions for early release, and situations are addressed on a case-by-case basis.

**Women Prisoners**

There are currently no HIV programs specifically for women.

**Aboriginal Prisoners**

As a majority of the prison population is Aboriginal, programs are oriented towards their needs. Access to elders and traditional medicines is available.

**Legal Network Comments**

As the Yukon only has a single institution, the jurisdiction is able to utilize partnerships with outside public health workers to provide some HIV/AIDS services, including pre- and post-test counseling and education for both prisoners and staff. Although done on a smaller scale than in some of the larger jurisdictions, this sort of external collaboration is positive. Regular collaboration with HIV specialists from Alberta, who provide services locally, is a useful practice in overcoming barriers to care.

Still, the provision of HIV prevention measures to prisoners in the Yukon is inadequate. The jurisdiction provides access to condoms through the health unit, yet dental dams and water-based lubricant are not available. Methadone access is better than in the other Territories, as initiation is possible in some circumstances. Still, there is no access to bleach, needle exchange, nor measures to reduce HIV and HCV transmission via tattooing.

**Harm Reduction Report Card**

<b>Cumulative Grade</b>	<b>F</b>
<b>Condoms, dental dams, lubricant available</b>	<b>1</b>
<b>Condoms, dental dams, lubricant accessible</b>	<b>0</b>
<b>Bleach available</b>	<b>0</b>
<b>Bleach accessible</b>	<b>0</b>
<b>MMT continuation</b>	<b>6</b>
<b>MMT initiation</b>	<b>1</b>
<b>Needle exchange</b>	<b>0</b>
<b>TOTAL SCORE</b>	<b>8</b>



## Conclusions

Although the prevalence of HIV among Canadian prisoners is at least 10 times higher than in the general community, far from enough is being done to prevent the spread of HIV infection in prisons and to provide prisoners living with HIV or AIDS with adequate treatment, support and care. ...[M]any of ECAP's and PASAN's recommendations – including some recommendations CSC agreed with in response to ECAP's report – have not been implemented, putting prisoners, staff, and members of the public at risk of their lives.

If federal and provincial/[territorial] prison systems want to fulfil their moral and legal obligations, they need to reconsider their response (or lack of response) to the recommendations made, and implement a longer-term strategy to deal with the many issues raised by HIV/AIDS and drug use – instead of pursuing the current piecemeal approach, characterized by a lack of coordination, commitment, inspiration, and vision.<sup>27</sup>

In 1996, these words began the conclusion to *HIV/AIDS in Prisons: Final Report*. Unfortunately, six years later, these same words are still valid.

Since 1996, the prevalence of HIV/AIDS and HCV in federal and provincial/territorial prisons has continued to increase. For example, in federal institutions, known cases of HIV/AIDS have increased by over 35 percent within a four-year period. The proportion of prisoners with HIV is six to 70 times higher than the proportion of all Canadians with HIV. HCV prevalence rates in prisons are even higher than HIV prevalence rates. 20 to 80 percent of prisoners are living with HCV.

There have been some significant, positive developments since the release of the 1996 Final Report. Some jurisdictions have implemented a number of the recommendations and have undertaken noteworthy, sometimes innovative, initiatives. No jurisdiction, however, has implemented all recommendations, and some jurisdictions have totally and abysmally failed to wake up to the reality of HIV/AIDS, HCV, and injection drug use in prisons.

All Canadian governments are failing to provide the resources, leadership, and vision necessary to address, in a comprehensive and progressive fashion, the issues raised by

HIV/AIDS, HCV, and injection drug use in prisons. Basic HIV prevention measures continue to be denied to prisoners. Most jurisdictions have failed to embrace a harm reduction approach to drug use. With some notable exceptions, provision of HIV and HCV prevention education for prisoners is poor.

Prison systems have a moral, but also a legal responsibility to act without further delay to prevent the spread of infectious diseases among prisoners, and to prison staff and the public, and to care for prisoners living with HIV and other infections. Canadian prison systems continue to fail to meet this responsibility. While some positive developments have occurred since 1996, Canadian governments are clearly not doing all they could. For example, measures that have been successfully undertaken outside prison with government funding and support, such as making sterile injection equipment available to injection drug users, are not being undertaken in Canadian prisons, although other prison systems have shown that they can be introduced successfully, and receive support from prisoners, staff, prison administrations, politicians, and the public.

Protection of prisoners is  
protection of our  
communities.

It is to be hoped that governments and the prison systems in Canada will take the findings of this report seriously and act immediately to implement the recommendations in the 1996 Final Report. As the Joint United Nations Programme on HIV/AIDS (UNAIDS) said in a statement to the United Nations Commission on Human Rights:

[B]y entering prisons, prisoners are condemned to imprisonment for their crimes; they should not be condemned to HIV and AIDS. There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities.<sup>28</sup>



# List of Respondents

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### **Yukon**

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## Endnotes

<sup>1</sup> See, R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montreal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, September 1996, at 5, for a listing of organizations that have addressed the issue of HIV/AIDS in prisons between 1987 and 1992. The Final Report is available via [www.aidslaw.ca/Maincontent/issues/prisons.htm](http://www.aidslaw.ca/Maincontent/issues/prisons.htm)

<sup>2</sup> See, in particular, World Health Organization. *Statement from the Consultation on Prevention and Control of AIDS in Prison. Global Programme on AIDS*. Geneva: WHO, 1987; and the *WHO Guidelines on HIV Infection and AIDS in Prisons*. Geneva: WHO, 1993. Available as appendix 5 of the 1996 Final Report, supra, note 1.

<sup>3</sup> PASAN. *HIV/AIDS in Prison Systems: A Comprehensive Strategy*. Toronto: PASAN, June 1992.

<sup>4</sup> Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. Ottawa: Ministry of Supply and Services Canada, 1994.

<sup>5</sup> Supra, note 1.

<sup>6</sup> Ibid, at 98.

<sup>7</sup> Correctional Service of Canada. *Infectious Diseases Year 2000*. Ottawa: CSC, 13 February 2001.

<sup>8</sup> For an overview, see Appendix 2: R Elliott. Prisoners' Constitutional Right to Sterile Needles and Bleach. In R Jürgens, supra, note 1.

<sup>9</sup> P Ford. HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison. *Canadian HIV/AIDS Policy and Law Newsletter* 1999; 4(2/3): 52-54. Available at [www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/prisons.htm](http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/spring99/prisons.htm)

<sup>10</sup> All data from CSC, 2001, supra, note 7.

<sup>11</sup> Health Canada. *HIV/AIDS Epi Update: HIV and AIDS Among Aboriginal People in Canada*. Ottawa: Health Canada, 2002. Available at [www.hc-sc.gc.ca](http://www.hc-sc.gc.ca)

<sup>12</sup> Statistics Canada. Prison Population and Costs 1997/98. *Juristat* 1999; 19(4). Available at [www.statcan.ca/english/indepth/85-002/feature/jurl1999004006sda.htm](http://www.statcan.ca/english/indepth/85-002/feature/jurl1999004006sda.htm)

<sup>13</sup> Statistics Canada. Sentenced Offenders Admitted to Custody who are Aboriginal Peoples by Jurisdiction, 1996-97. Available at [www.statcan.ca/english/kits/justic/justic.htm](http://www.statcan.ca/english/kits/justic/justic.htm)

<sup>14</sup> Jürgens, supra, note 1, at 48-9.

<sup>15</sup> Ibid, at 120.

<sup>16</sup> For more details, see HIV/AIDS in Prisons: More New Developments. *Canadian HIV/AIDS Policy & Law Review* 2002; 7(1). Available at [www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol7no12002/prisons.htm](http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol7no12002/prisons.htm)

<sup>17</sup> For more details, see HIV/AIDS in Prisons: New Developments. *Canadian HIV/AIDS Policy & Law Review* 2002; 6(3). Available at [www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6no3-2002/prisons.htm](http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6no3-2002/prisons.htm)

<sup>18</sup> RSO 1990, C 37.

<sup>19</sup> Verdict of the Jury. Coroner's Inquest into the Death of Michael Joseph LeBlanc. 1 February 2001. On file and available from the Office of the Chief Coroner: Eastern Region, 51 Heakes Lane, Kingston, ON, K7M 9B1; (613) 531-5737. See also G Betteridge. Inquest into the death of a prisoner co-infected with HIV and hepatitis C: How many more will there be? *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1/2). Available at [www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/prisons2.htm](http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol6nos1-22001/prisons2.htm)

<sup>20</sup> For an account of the Inquest into the Death of William Bell see: R Lines. Death exposes treatment of prisoners living with HIV/AIDS. *Canadian HIV/AIDS Policy & Law Newsletter* 1998: 3(4)&4(1). Available at [www.aidslaw.ca/Maincontent/otherdocs/Newsletter/Winter9798/24LINES1E.html](http://www.aidslaw.ca/Maincontent/otherdocs/Newsletter/Winter9798/24LINES1E.html)

<sup>21</sup> Heino Stöver et al. *An overview study: Assistance to drug users in European Union prisons*. Lisbon: European Monitoring Centre for Drugs and Drug Addiction, August 2001, at 24.

<sup>22</sup> Joint United Nations Programme on HIV/AIDS (UNAIDS). *Prisons and AIDS: UNAIDS Technical Update*. Geneva: UNAIDS, April 1997, at 7. Available at [www.unaids.org](http://www.unaids.org)

<sup>23</sup> *Supra*, note 12.

<sup>24</sup> *Supra*, note 13.

<sup>25</sup> *Supra*, note 11.

<sup>26</sup> *Supra*, note 13.

<sup>27</sup> Jürgens, *supra*, note 1, at 119.

<sup>28</sup> United Nations Commission on Human Rights (fifty-second session, item 8 of the agenda). HIV/AIDS in Prisons – Statement by the Joint United Nations Programme on HIV/AIDS (UNAIDS). Geneva, Switzerland, April 1996.