"Do the Right Thing":
An evidence-based response to addiction and mental health in federal prisons

Brief to the House of Commons Standing Committee on Public Safety and National Security regarding its study *Federal Corrections: Mental Health and Addiction*

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1. Executive summary

Despite the sustained efforts of prison systems to prevent drug use by people in prison, the reality is that drugs can and do enter. Conflict with the law and incarceration are often a result of offences arising out of the criminalization of certain drugs, related to financing drug use or related to behaviours brought about by drug use.[1] In a criminal justice environment preoccupied with the incarceration of people who use drugs and where substance abuse is a contributing factor to the criminal behaviour of 70 percent of people admitted to federal institutions,[2] it should come as no surprise that many of those who are incarcerated use drugs, often by injection—a fact confirmed by numerous studies. Indeed, in the Canadian HIV/AIDS Legal Network's interviews with formerly incarcerated people across Canada, many confirmed the accessibility of drugs, the extent of addiction and the pervasiveness of injection drug use in prison.[3] As in many other countries, the extent of injection drug use in Canadian prisons has led to increasing rates of HIV and hepatitis C (HCV) among incarcerated people who are, as a result, at higher risk of HIV and HCV infection.

Because of the scarcity of needles and syringes in prison, people who inject drugs in prison (including those with addictions) are more likely to share injecting equipment than those in the community, thereby increasing their risk of contracting HIV and HCV. Programs that ensure access to sterile injecting equipment are, therefore, an important component of a comprehensive approach to reducing the vulnerability of incarcerated people to HIV and HCV infection. The best available evidence strongly suggests that in countries where prison-based needle and syringe programs (PNSPs) exist, such programs reduce risk behaviour and disease, do not increase drug consumption or injecting, do not endanger staff or prisoner safety, and have other positive outcomes for the health of people in prison, including increasing referrals of users to drug addiction treatment programmes. These findings were confirmed in *Prison Needle Exchange: Review of the Evidence*, a 2006 review by the Public Health Agency of Canada undertaken at the request of Correctional Service Canada (CSC).[4]

The government's desire to address the health problem of addictions in prisons is laudable, but a 'zero tolerance' approach is not realistic—and to the extent that it impedes the correctional system from implementing evidence-based services that are well established outside prisons to reduce the very serious harms associated with drugs, such an approach is damaging to the health of individual people in prison and to the public health more broadly. The federal government department responsible for

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[1] R. Lines et al, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience, Second edition*, Canadian HIV/AIDS Legal Network, 2006 at 9.

[2] Public Health Agency of Canada (PHAC), *Atlantic Region: Environmental Scan of Injection Related Drug Use, Related Infectious Diseases, High Risk Behaviours, and Relevant Programming in Atlantic Canada*, March 2006 at 38–39.

[3] S. Chu and K. Peddle, *Under the Skin: A People's Case for Prison Needle and Syringe Programs in Canada*, Canadian HIV/AIDS Legal Network, 2009.

[4] PHAC, *Prison needle exchange: Review of the evidence, report prepared for Correctional Service of Canada*, April 2006.

Canada's federal prisons has acknowledged that "drugs in prisons are an unfortunate fact around the world."[5] Moreover, a focus on abstinence, especially in a federal prison context where 12 percent of men and 26 percent of women have been identified as having "very serious mental health problems,"[6] ignores the substantial body of research that demonstrates that addiction is a chronic and relapsing condition, shaped by many behavioural and social-contextual characteristics.[7] By refusing to implement PNSPs, CSC unnecessarily places those individuals with the most severe drug dependence at risk of HIV and HCV infection, many of whom may have relied on needle and syringe programs (NSPs) in the community prior to their incarceration. An ill-considered policy of prohibiting PNSPs discriminates against people who inject drugs in prison and aggravates the public health by contributing further to the harms associated with unsafe drug use. Conversely, PNSPs benefit not only the people who use drugs in prison, but other prisoners, prison staff and the public as a whole. By reducing the risk of HIV and HCV infection among people who inject drugs in prison—the majority of who return to the community upon release—all Canadians face fewer risks of also becoming infected.

2. About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading organization working on the legal and human rights issues raised by HIV/AIDS.

The Legal Network is a national non-governmental organization with 150 members across Canada, many of whom are community-based AIDS service organizations. The Legal Network has been involved in extensive government and community consultations regarding a wide range of HIV/AIDS-related legal and policy issues, and has developed particular expertise on prison law and policy, especially as they relate to people who are at risk of HIV infection as a result of injection drug use.

A body of research and analysis by the Legal Network has addressed a number of issues that are relevant to the Standing Committee on Public Safety and National Security's study on *Federal Corrections: Mental Health and Addiction*, including:

- wide-ranging recommendations for better addressing the HIV epidemic among people who inject drugs, including legal reforms to support more effective health-protection and promotion services for this vulnerable population;[8] and

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[5] Public Safety and Emergency Preparedness Canada, *Corrections Fast Facts No. 2: Drugs in Prisons*, undated.

[6] Correctional Service of Canada (CSC), *Changing Offender Population: Quick Facts*, April 2007.

[7] D. Werb et al, "Drug treatment courts in Canada: an evidence-based review," *HIV/AIDS Policy & Law Review*, 12(2/3) (2007): 12–17 at 16.

[8] E.g., *Injection Drug Use and HIV/AIDS* (1999); *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues* (2001); *Nothing About Us Without Us: Greater, meaningful involvement of people who use illegal*

- extensive work on the need to address HIV in prisons as a matter of both sound public health practice and human rights, such as addressing the risk of HIV and HCV transmission through the use of non-sterile injection equipment — including:

    - the most comprehensive international report on the successful experience of other countries in implementing PNSPs in prisons;[9]

    - the most comprehensive review of policies and programs in Canadian prisons aimed at preventing HIV and HCV infections (done jointly with the Prisoners' HIV/AIDS Support Action Network and with the input of federal, provincial and territorial government officials in the fields of health and corrections);[10]

    - a pioneering review of the Canadian and international legal and human rights arguments for the implementation of PNSPs in Canadian federal prisons;[11] and

    - a compelling report of the testimonials of incarcerated and formerly incarcerated people nationwide concerning their experiences with injection drug use, addiction and HIV/HCV infection in federal prisons;[12]

We appreciate the opportunity to comment on the Standing Committee on Public Safety and National Security's study *Federal Corrections: Mental Health and Addiction* and to draw the Committee's attention to certain elements which are particularly relevant from the perspective of public health and human rights.

3. Public Health Arguments for PNSPs

Prevalence of HIV and HCV in Canadian prisons

In Canada, estimates of HIV prevalence in Canadian federal and provincial prisons range from two to eight percent, or at least ten times the reported prevalence in the population

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drugs: A public health, ethical, and human rights imperative (Canadian edition, 2005; International edition, 2008); *Legislating for Health and Human Rights: Model Law and Drug Use and HIV/AIDS* (2006); *Dependent on Rights: Assessing Treatment of Drug Dependence from a Human Rights Perspective* (2007); *Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs* (2007); *A Helping Hand: Legal Issues Related to Assisted Injection at Supervised Injection Facilities* (2007).

[9] R. Lines et al, *Prison Needle Exchange* (supra).

[10] G. Betteridge and G. Dias, *Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada*, Canadian HIV/AIDS Legal Network and Prisoners' HIV/AIDS Support Action Network (PASAN), 2008.

[11] S. Chu and R. Elliott, *Clean Switch: The Case for Prison Needle and Syringe Programs in Canada*, Canadian HIV/AIDS Legal Network, 2009.

[12] S. Chu and K. Peddle, *Under the Skin* (supra).

as a whole.[13] Estimates of HCV prevalence in the Canadian prison population range from 19.2 to 39.8 percent,[14] or at least 20 times the estimated HCV prevalence in Canada[15]—and prevalence rates have been reported to be significantly higher for individuals who inject drugs.[16] According to recent figures from the Public Health Agency of Canada (PHAC), approximately 67 percent of people incarcerated in federal prisons have substance use problems, of which 20 percent require treatment.[17] Research over many years and from many jurisdictions has demonstrated not only the higher prevalence of both HIV and HCV infections among people in prison, but also the close relation between such infections and injection drug use, a result of the prevalence of HIV and HCV infections among people who inject drugs in the wider community, the widespread incarceration of people who use drugs, including those suffering from addiction, and high-risk activities within prisons.[18]

Drug use in Canadian prisons

CSC's response to increasing rates of HIV and HCV in federal prisons include forms of harm reduction such as bleach and methadone maintenance treatment. While these pragmatic responses help reduce the harm of drug dependence among people in prison, they are neither sufficient, given increasing rates of HIV and HCV among those who are incarcerated, nor is focusing primarily on prison drug interdiction—as CSC has. From 1998 to 2007, CSC spent significantly more time and money than it had in previous years on efforts to prevent drugs from entering prisons, yet drug use declined less than one percent during that period.[19] As the Correctional Investigator of Canada has concluded, "Drug interdiction can only go so far in reducing the rate of infection among the offender population."[20]

Evidence of the continuing frequency of injection drug use in prisons has been confirmed in numerous studies, including:

- A 1995 survey by CSC in which 11 percent of men incarcerated in federal prisons reported having injected an illegal drug since arriving at their current institution;[21]

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[13] R. Lines et al, *Prison Needle Exchange* (supra) at 6.

[14] S. Skoretz, G. Zaniewski and N.J. Goedhuis, "Hepatitis C virus transmission in the prison/inmate population," *Canada Communicable Disease Report* 30 (16) (2004): 141–148 at 142.

[15] R. Remis et al, *Estimating the number of blood transfusion recipients infected by hepatitis C virus in Canada, 1960–85 and 1990–92*, Report to Health Canada, June 1998.

[16] CSC, *Springhill Project Report*, 1999 at 12.

[17] PHAC, *HIV/AIDS: Populations at Risk*, 2006.

[18] R. Elliott, "Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and hepatitis C virus infections in prisons," *Canadian Medical Association Journal* 177(3) (2007): 262–264.

[19] Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator 2006-2007*, Minister of Public Works and Government Services Canada, 2007 at 12.

[20] Ibid., p. 12.

[21] CSC, *1995 National Inmate Survey: Final Report*, 1996.

- A 2003 study of federally incarcerated women in which 19 percent reported injecting drugs while in prison;[22]

- A study released in 2005 in which 76 percent of 1,475 injection drug users enrolled in the Vancouver Injection Drug Users Study (VIDUS) reported being in prison since they first began injecting drugs, of which 31 percent reported injecting in prison;[23]

- A 1998 study in which 24.3 percent of those incarcerated at Joyceville Institution in Kingston, Ontario reported injecting drugs in prison, compared to 12 percent in a similar study at the same prison in 1995;[24] and

- A study released in 2005, in which 21 percent of study participants in a British Columbia women's prison reported injecting drugs in prison.[25]

Although people who inject drugs may inject less frequently in prisons, the scarcity of sterile syringes and the punitive consequences of drug use mean people in prison resort to using non-sterile injecting equipment.[26] A needle may circulate among large numbers of incarcerated people who inject drugs, thereby increasing the risk of transmission of HIV and HCV because of the presence of blood in needles after injection.[27] In a Quebec study of seven provincial prisons, 63 percent of men and 50

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[22] A. DiCenso et al, *Unlocking Our Futures: A National Study on Women, Prisons, HIV and Hepatitis C*, PASAN, 2003.

[23] E. Wood et al., "Recent incarceration independently associated with syringe sharing by injection drug users," *Public Health Reports* 120 (2005): 150–156.

[24] P. Ford et al, "HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison," *Canadian HIV/AIDS Policy & Law Newsletter* 4(2/3) (1999): 52–54.

[25] R. Martin, "Drug use and risk of bloodborne infections," *Canadian Journal of Public Health* 96(2) (2005): 97–101.

[26] See, for example M.-J. Milloy et al, "Incarceration experiences in a cohort of active injection drug users," *Drug and Alcohol Review* (2008): 1–7; C. Poulin et al, "Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons," *Canadian Medical Association Journal* 177(3) (2007): 252–256; European Monitoring Centre for Drugs and Drug Addiction, *Annual report on the state of the drugs problem in the European Union and Norway*, 2002 at 47; E. Wood et al, "Recent incarceration independently associated with syringe sharing by injection drug users" (supra); W. Small et al, "Incarceration, Addiction and Harm Reduction: Inmates Experience Injecting Drugs in Prison," *Substance Use and Misuse* 40 (2005): 831–843; and K. Dolan, *The Epidemiology of Hepatitis C Infection in Prison Populations*, University of South Wales, National Drug and Alcohol Research Centre, 1999 at 6.

[27] See, for example S. Shah et al., "Detection of HIV-1 DNA in needle/syringes, paraphernalia, and washes from shooting galleries in Miami: a preliminary laboratory report," *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology* 11(3) (1996): 301–306; P. Shapshak et al., "HIV-1 RNA load in needles/syringes from shooting galleries in Miami: a preliminary laboratory report," *Journal of Drug and Alcohol Dependency* 58 (1–2) (2000): 153–157; R. Needle et al., "HIV risk behaviors associated with the injection process: multiperson use of drug injection equipment and paraphernalia in injection drug user networks," *Substance Use and Misuse* 33(12) (1998): 2403–2423; and B. Jose et al., "Syringe-mediated drug-sharing (backloading): a new risk factor for HIV among injecting drug users," *AIDS* 7(12) (1993):1653–1660, erratum in *AIDS* 8(1) (1994).

percent of women who reported injecting in prison also reported having shared equipment.[28] In an Ontario study, 32 percent of those who reported injecting while incarcerated reported injecting with used needles.[29] A study in Vancouver estimated that incarceration more than doubled the risk of HIV infection for people who use illegal drugs, and estimated that 21 percent of all HIV infections among people in Vancouver who inject drugs may have been acquired in prison.[30] Furthermore, a number of outbreaks of HIV and HCV infection in prison have been attributed to the sharing of injection equipment. Outbreaks have been documented in Australia,[31] Lithuania,[32] the Russian Federation[33] and Scotland.[34] As discussed in greater detail below, possible outbreaks have also been documented in Canada.

Springhill, Nova Scotia
In 1996, two HIV- and HCV-positive men incarcerated at Springhill Institution, a federal institution in Nova Scotia, informed health care staff that they had shared needles and other injection equipment with a significant number of other incarcerated people. A disease outbreak containment intervention was initiated, and 17 contacts of the two men were tested, though the results of those tests were not made public. No attempt was made to prove that, as a result of sharing needles and injection equipment with the known positive men, the contacts had contracted HIV or HCV while in prison.[35]

Joyceville, Ontario
In 1997, a man who had been sharing injection equipment with other men incarcerated at Joyceville Institution, a medium-security federal prison, revealed that he was HIV-positive, causing concern among the large number of people who had shared injection equipment with him. Those men were reluctant to seek HIV testing from the prison's health care staff for fear of revealing their drug use. The prison's inmate committee therefore requested that an HIV-seroprevalence study be carried out as a way of providing people in prison with access to anonymous HIV testing.

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[28] C. Poulin et al, "Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons" (supra).

[29] L. Calzavara et al., "Prior opiate injection and incarceration history predict injection drug use among inmates," *Addiction* 98 (9) (2003): 1257–1265.

[30] H. Hagan, "The relevance of attributable risk measures to HIV prevention planning," *AIDS* 17(6) (2003): 911–913 at 912.

[31] K. Dolan and A. Wodak, "HIV transmission in a prison system in an Australian State," *Medical Journal of Australia* 171(1) (1999): 14–17.

[32] M. MacDonald, *A Study of Health Care Provision, Existing Drug Services and Strategies Operating in Prisons in Ten Countries from Central and Eastern Europe*, The European Institute for Crime Prevention and Control, 2005.

[33] A. Bobrik et al., "Prison health in Russia: the larger picture," *Journal of Public Health Policy* 26 (2005): 30–59.

[34] A. Taylor et al, "Outbreak of HIV Infection in a Scottish Prison," *British Medical Journal* 310 (1995): 289–292.

[35] CSC, *Springhill Project Report* (supra).

The study showed that risk behaviours and rates of infection in the prison had increased substantially since a previous study that had been undertaken at the same prison in 1995. In addition, the researchers reported individuals with equivocal test results who were likely in the process of seroconverting. After the study was completed, researchers became aware of one person who had injected drugs and was negative for HIV in 1998, who subsequently tested HIV-positive, and one person who had also injected drugs, who contracted HCV.[36]

Bleach is an inadequate response to risks associated with drug use in prisons

While bleach is an important second-line strategy in the absence of access to sterile needles and syringes, it is not an adequate substitute for the provision of PNSPs.[37] In particular, cleaning syringes with bleach is not fully effective in reducing HCV transmission.[38] While research has demonstrated that thorough, repeated applications of bleach may eliminate HIV in syringes,[39] field studies also indicate that many people who inject drugs have trouble following the correct procedure to properly disinfect syringes of HIV using bleach[40] and have concluded that disinfection with bleach appeared to offer no, or at best little, protection against HIV infection.[41] In numerous studies, half or more of people injecting drugs did not know or did not practise the proper method of using bleach effectively for disinfecting needles.[42] Because drug use is prohibited in prisons and prisoners can be accosted at any moment by prison staff, injecting is a hurried affair, particularly if injecting equipment is being shared.[43] In a

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[36] P. Ford et al, "HIV and hep C seroprevalence and associated risk behaviours in a Canadian prison" (supra).

[37] See World Health Organization (WHO), *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users, Evidence for Action Technical Papers*, 2004 at 28; Ontario Medical Association, *Improving our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons? A Position Paper by the Ontario Medical Association*, October 2004 at 8; and R. Carlson et al., "A preliminary evaluation of a modified needle-cleaning intervention using bleach among injection drug users," *AIDS Education and Prevention* 10(6) (1998): 523–532.

[38] H. Hagan and H. Thiede, "Does bleach disinfection of syringes help prevent hepatitis C virus transmission?" *Epidemiology* 14(5) (2003): 628–629.

[39] N. Abdala et al., "Can HIV-1-contaminated syringes be disinfected? Implications for transmission among injection drug users," *Journal of Acquired Immune Deficiency Syndromes* 28(5) (2001): 487–494.

[40] See W. Small et al, "Incarceration, Addiction and Harm Reduction" (supra); C. McCoy et al., "Compliance to bleach disinfection protocols among injecting drug users in Miami," *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 773–776.

[41] S. Titus et al., "Bleach use and HIV seroconversion among New York City injection drug users," *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 700–704; D. Vlahov et al., "Field effectiveness of needle disinfection among injecting drug users," *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 760–766; C. McCoy et al, ibid.; and W. Small et al, ibid.

[42] C. McCoy et al, ibid.; A. Gleghorn et al, "Inadequate bleach contact times during syringe cleaning among injection drug users," *Journal of Acquired Immune Deficiency Syndromes* 7(7) (1994): 767–772; and R. Carlson et al, "A preliminary evaluation of a modified needle-cleaning intervention using bleach" (supra).

[43] WHO Europe, *Status Paper on Prisons, Drugs and Harm Reduction*, 2005 at 12, noting "Serious problems are related to the use of bleach in prisons. For example, prisoners are highly to unlikely to spend 45 minutes shaking the

comprehensive review of the available evidence as of 2004, the World Health Organization (WHO) concluded that "[b]leach and other forms of disinfection are not supported by good evidence of effectiveness for reducing HIV infection."[44] Conclusively, sterile needles and syringes that have never been used are safer than previously used needles and syringes that have been cleaned, often imperfectly, with bleach.

NSPs are a key health service outside prisons

In the community, needle and syringe programs (NSPs) have been studied in great detail for over 20 years and have been proven to be an important mechanism for reducing the risk of infection from the use of non-sterile injecting equipment. Health Canada reported that in 2001 there were over 200 NSPs in the country, with more in development,[45] and NSPs have enjoyed the support of federal,[46] provincial and territorial,[47] and municipal governments.[48] Numerous evaluations of community NSPs have demonstrated that they reduce the risk of HIV and HCV,[49] are cost effective,[50] and facilitate access to care,

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syringes to clean them while waiting to inject in some hidden corner of the prison. Bleach can therefore create a false sense of security between prisoners sharing paraphernalia."

[44] WHO, *Effectiveness of Sterile Needle and Syringe Programming* (supra) at 28.

[45] A. Klein, *Sticking Points: Barriers to Access to Needle and Syringe Programmes in Canada*, Canadian HIV/AIDS Legal Network, 2007 at 9, citing Health Canada, *Harm reduction and injection drug use: an international comparative study of factors influencing the development and implementation of relevant policies and programs*, September 2001 at 13.

[46] See Government of Canada, *Federal Initiative to Address HIV/AIDS in Canada: Strengthening Federal Action in the Canadian Response to HIV/AIDS*, 2004; Government of Canada, *Canada's Drug Strategy: Working Together to Reduce the Harmful Use of Substances*, 2005; F/P/T Advisory Committee on Population Health, F/P/T Committee on Alcohol and Other Drug Issues, F/P/T Advisory Committee on AIDS and F/P/T Heads of Corrections Working Group on HIV/AIDS, *Reducing the Harm Associated with Injection Drug Use in Canada*, 2001 at 11.

[47] See, for example Alberta Alcohol and Drug Abuse Commission, *Stronger Together: a provincial framework for action on alcohol and other drug use*, 2005; Ministry of Health and Social Services, Government of Quebec, *Plan d'action interministérielle en toxicomanie 2006–2011*, 2006; and Government of Saskatchewan, *Premier's Project Hope: Saskatchewan's action plan for substance abuse*, August 2005.

[48] See, for example Toronto Drug Strategy Advisory Committee, *The Toronto Drug Strategy: a comprehensive approach to alcohol and drugs*, December 2005 at 31–32 and City of Vancouver, *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*, 2001.

[49] R. Jürgens, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies*, WHO, UNODC and UNAIDS, 2007 at 12; M. Macdonald et al., "Effectiveness of needle and syringe programmes for preventing HIV transmission," *International Journal of Drug Policy* 14 (2003): 353–357; R. Bluthenthal et al., "The effect of syringe exchange use on high-risk injection drug users: a cohort study," *AIDS* 14(5) (2000): 605–611; D. Gibson et al., "Effectiveness of syringe exchange programs in reducing HIV risk behaviour and HIV seroconversion among injecting drug users," *AIDS* 15(11) (2001): 1329–1341; K. Ksobiech, "A meta-analysis of needle sharing, lending and borrowing behaviours of needle exchange program attenders," *AIDS Education and Prevention* 15(3) (2003): 257–268; and A. Wodak and A. Cooney, "Effectiveness of sterile needle and syringe programmes," *International Journal of Drug Policy* 16S (2005): S31–S344.

[50] M. Gold et al., "Needle exchange programs: an economic evaluation of local experience," *Canadian Medical Association Journal* 157(3) (1997): 255–262 and F. Laufer, "Cost effectiveness of syringe exchange as an HIV prevention study," *Journal of Acquired Immune Deficiency Syndrome* 28(3) (2001): 273–278.

treatment and support services.[51] For example, the WHO in 2004 undertook a comprehensive study of the effectiveness of sterile needle distribution in reducing HIV infection among persons who inject drugs, and found that "there is compelling evidence that increasing the availability and utilization of sterile injecting equipment" among people who inject drugs "reduces HIV infection substantially."[52] The study also concluded that "there is no convincing evidence of any major, unintended negative consequences" from such programmes, including "no persuasive evidence that needle syringe programmes increase the initiation, duration or frequency of illicit drug use or drug injecting."[53]

NSPs operate successfully in prisons in numerous countries

Since the first PNSP was introduced in a Swiss prison for women in 1992, more than 16 years ago, a growing number of countries have implemented such health services in a growing number of prisons. To date, PNSPs have been introduced in over 60 prisons of varying sizes and security levels in Switzerland, Germany, Spain, Moldova, Kyrgyzstan, Armenia, Luxembourg, Romania, Portugal and Iran.[54] In Kyrgyzstan and Spain, PNSPs have been rapidly scaled up and operate in a large number of prisons. In every case, PNSPs have been a response to evidence of the risk of HIV and HCV transmission within prisons through the sharing of syringes to inject illicit drugs. A number of these PNSPs have undergone systematic evaluations, including in 2004 by the Canadian HIV/AIDS Legal Network and in 2006 by PHAC, at the request of CSC.[55] While these PNSPs have

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[51] R. Heimer, "Can syringe exchange serve as a conduit to substance abuse treatment?" *Journal of Substance Abuse Treatment* 15(3) (1998): 183–191 and H. Hagan et al., "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors," *Journal of Substance Abuse Treatment* 19(3) (2000): 247–252.

[52] WHO, *Effectiveness of Sterile Needle and Syringe Programming* (supra) at 28.

[53] Ibid., p. 28.

[54] R. Jürgens, *Interventions to Address HIV/AIDS in Prisons* (supra) at 25.

[55] R. Lines et al, *Prison Needle Exchange* (supra); PHAC, *Prison needle exchange* (supra); K. Stark et al., "A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin, Germany," *Epidemiology and Infection* 13(4) (2006): 814–819; H. Stöver and J. Nelles, "10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies," *International Journal of Drug Policy* 14 (2003): 437–444; S. Rutter et al., *Prison-Based Syringe Exchange Programs: A Review of International Research and Program Developments, NDARC Technical Report No. 112*, National Drug and Alcohol Research Centre, University of New South Wales, 2001; J. Nelles et al., "Provision of syringes: the cutting edge of harm reduction in prison?" *British Medical Journal* 317(7153) (1998): 270–273; K. Dolan et al., "Prison-based syringe exchange programmes: a review of international research and development," *Addiction* 98 (2003): 153–158; J. Nelles et al., *Prevention of drug use and infectious diseases in the Realta Cantonal Men's Prison: Summary of the Evaluation* (Berne: University Psychiatric Services, 1999); J. Nelles et al., "Provision of syringes and prescription of heroin in prison: The Swiss experience in the prisons of Hindelbank and Oberschöngrün," in J. Nelles and A. Fuhrer (eds.) *Harm Reduction in Prison* (Berne: Peter Lang, 1997), 239–262 at 239; H. Stöver, "Evaluation of needle exchange pilot projects show positive results," *Canadian HIV/AIDS Policy & Law Newsletter* 5(2/3) (2000): 60–64; C. Menoyo et al., "Needle exchange programs in prisons in Spain," *Canadian HIV/AIDS Policy & Law Review* 5(4)(2000): 20–21; Ministerio Del Interior/Ministerio De Sanidad y Consumo, *Needle Exchange in Prison: Framework Program*, 2002; J. Sanz Sanz et al., "Syringe-exchange programmes in Spanish prisons," *Connections: The Newsletter of the European Network Drug Services in Prison & Central and Eastern European Network of Drug Services in Prison* 13 (2003): 9–12; N. Bodrug, "A pilot project breaks down resistance," *Harm Reduction News* 3(2)(2002): 11.

been implemented in diverse environments and under differing circumstances, the results of the programmes have been remarkably consistent.

The experience of prisons in which needles have been made available, including scientific evaluation of the pilot phases carried out in many projects, provides many lessons. Among the most important are:

PNPS are safe
Needles can be made available in prisons in a manner that is non-threatening to staff and that increases staff safety. Since the first PNSP in 1992, there have been no reported cases of a needle being used as a weapon either against prison staff or other people in prison. People in prison are also usually required to keep their kits in a pre-determined location in their cells. This assists staff when they enter the cell to conduct searches and has decreased accidental needle-stick injuries to staff.

PNSPs do not lead to increased drug use
Evaluations of existing programs have consistently found that the availability of needles does not result in an increased number of people injecting drugs, an increase in overall drug use or an increase in the amount of drugs in the institutions.

PNSPs do not condone drug use
Drugs remain prohibited in institutions where PNSPs are in place and security staff continue to be responsible for locating and confiscating illegal drugs. However, it is recognized that if and when drugs find their way into the prison and are used by those who are incarcerated, the priority must be to prevent the transmission of HIV and HCV via unsafe injecting practices. Therefore, while drugs themselves remain illegal, needles that are part of the official PNSP are not.

In most cases, PNSPs have been introduced as only one component of a more comprehensive approach to dealing with drug-related harms, including abstinence-based programs, drug treatment, drug-free units and other harm reduction measures. Evaluations have found that PNSPs actually facilitate referrals of users to drug addiction treatment programs and have led to an increase in the number of people making use of such programs.

PNSPs have been successfully introduced in various prison environments
While programs were first introduced in small Swiss prisons, they have since been successfully implemented in prisons for men and for women, in small, medium and large institutions, and in prisons of all security classifications. After having been introduced in well-resourced prison systems, programs have also been established in systems with very limited resources. There are several models of distribution of sterile injection equipment, including automatic dispensing machines, distribution by medical staff or counsellors and distribution by prisoners trained as peer outreach workers. What is appropriate in a particular institution depends on many factors, such as the size of the institution, the extent of injection drug use, the security level, whether it is a prison

for men or for women, the commitment of health-care staff and the "stability" of the relations between staff and those who are incarcerated.

PNSPs reduce risk behaviour, thereby helping to prevent disease transmission
Most importantly, evaluations of existing programs have shown that reports of needle sharing declined dramatically. In addition, other positive health outcomes have been documented in some prisons, such as a decrease in fatal and non-fatal overdoses and a decrease in abscesses and other injection-related infections.

PNSPs function best when prison administration, staff and prisoners support them
The support of the prison administration and staff is important, and educational workshops and consultations with prison staff should be undertaken. While staff in some prisons were initially reluctant to support PNSPs, many supported the program after they experienced its benefits.

PNSPs can be compromised if access to needles or syringes is limited
Limitation of access may result from physical barriers, such as dispensing machines not working; from restrictive practices, such as limited program hours; and from people fearing that, because of a lack of anonymity or confidentiality, using the program could result in negative consequences for them. In order to benefit from the protective effects of PNSPs, prisons must ensure that incarcerated people have easy access to adequate numbers of needles and syringes.

Further reinforcing the public-health imperative for PNSPs in Canada, a number of organizations, including the Canadian Medical Association,[56] the Ontario Medical Association, [57] the Correctional Investigator of Canada,[58] and the Canadian Human Rights Commission[59] have recommended that CSC develop, implement and evaluate pilot NSPs in prisons under its jurisdiction. In 2005, the Canadian Centre on Substance Abuse concluded that there was ample justification for the government to implement pilot studies to assess the effectiveness and feasibility of PNSPs.[60] The WHO, UNAIDS and

[56] Canadian Medical Association, *Annual Meeting Resolution 26*, 17 August 2005.

[57] Ontario Medical Association, *Improving our Health* (supra).

[58] See Correctional Investigator of Canada (CI), *Annual Report of the Correctional Investigator 2003–2004,* June 2004; CI, *Annual Report of the Office of the Correctional Investigator of Canada 2005–2006,* September 2006; and CI, *Annual Report of the Office of the Correctional Investigator 2006–2007,* June 2007.

[59] Canadian Human Rights Commission (CHRC), *Protecting Their Rights: A Systemic Review of Human Rights in Correctional Services for Federally Sentenced Women*, 2004.

[60] G. Thomas, *Assessing the need for prison-based needle exchange programs in Canada: a situational analysis, Canadian Centre for Substance Abuse*, 2005.

UNODC have all also endorsed PNSPs as part of a comprehensive national framework for addressing HIV in prisons.[61]

4. Legal and Human Rights Arguments for PNSPs

People in prison are part of our communities, and most incarcerated people leave prison at some point to return to their community, some after only a short time inside. People in prison deserve the same level of care and protection that people outside prison get. They are sentenced to prison, not to be infected with disease. Under international and Canadian law, people in prison have a right to health, which includes having access to tools to protect themselves from disease. Given the ample public health benefits of PNSPs, there are strong legal arguments for incarcerated people's correlative right to PNSPs. The following section outlines some of the international and Canadian laws and policy supportive of PNSP implementation in Canada.

(a) International law and policy

In the context of PNSPs, two principles are particularly relevant to the rights of people in prison. First, the international community has generally accepted the "principle of retaining all rights," which means that people in prison retain all human rights that are not taken away as a result of the loss of liberty flowing from imprisonment.[62]

This includes the right to the highest attainable standard of health, which is recognized in the *International Covenant on Economic, Social and Cultural Rights*.[63] According to the U.N. Committee on Economic, Social and Cultural Rights, "States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees … to preventive, curative and palliative health services."[64]

Since HIV and HCV are potentially fatal diseases, the right to life is also relevant in considering states' obligation to take effective measures to prevent the transmission of blood-borne viruses in prisons. The U.N. Human Rights Committee has clarified that under the *International Covenant on Civil and Political Rights*, states are obligated to take "positive measures" in order to "increase life expectancy" and "eliminate … epidemics."[65]

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[61] See OHCHR and UNAIDS, *International Guidelines* (supra), Guideline 4 at para. 21(e); WHO, *WHO Guidelines* (supra), Guideline 24; UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, 2006, Recommendation no. 60.

[62] U.N. General Assembly, *Basic Principles for the Treatment of Prisoners*, UNGAOR, 45th Sess., Supp. N 49A, UN Doc. A/45/49 (1990), Principle 5.

[63] See Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights,* 16 December 1966, 993 U.N.T.S. 3 (entered into force 3 January 1976) [ICESCR].

[64] U.N. Committee on Economic, Social and Cultural Rights, "General Comment 14: The Right to the Highest Attainable Standard of Health," 22nd Sess., (2000) UN Doc E/C.12/2000/4, para. 34.

[65] U.N. Human Rights Committee, *General Comment No. 6:* "The Right to Life (Article 6)," 16th Sess., (1982) UN Doc. HRI\GEN\1\Rev.1 at para 5.

Second, the "principle of equivalence" entitles people in detention to have access to a standard of health care equivalent to that available outside prison, including preventive measures comparable to those available in the general community. The right of people in prison to access health care equivalent to that available in the community is reflected in declarations and guidelines from the U.N. General Assembly,[66] the World Health Organization (WHO),[67] the U.N. Office on Drugs and Crime (UNODC)[68] and the Joint U.N. Programme on HIV/AIDS (UNAIDS).[69]

Moreover, numerous international health and human rights bodies support the position that, as a corollary to the right of people in prison to preventive health services, the state has an obligation to prevent the spread of contagious diseases in places of detention. Prison health standards and declarations from the WHO[70] and the World Medical Association,[71] for example, are clear that incarcerated people must be provided with measures to prevent the transmission of disease.

The specific issue of providing sterile syringes to people in prison as a means of preventing the spread of blood-borne viruses has also been considered and supported by numerous international organizations, as a matter of both sound public-health policy and human rights. For example, in the *International Guidelines on HIV/AIDS and Human Rights*, UNAIDS and the Office of the U.N. High Commissioner on Human Rights call on prison authorities to "provide prisoners … with access to … condoms, bleach and clean injection equipment."[72] In its *Guidelines on HIV Infection and AIDS in Prisons,* the WHO affirms the principle of equivalence by recommending that in "countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request it."[73] Similarly, in *HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response*, the UNODC, the WHO and UNAIDS recommend that prison systems "ensure the measures available outside of prisons to prevent transmission of HIV through the exchange of bodily fluids are also available to prisoners," and specifically recommend that

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[66] U.N. General Assembly, *Basic Principles* (supra), para. 9.

[67] WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993.

[68] UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings* (supra) at 10.

[69] UNAIDS, "Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996," in *Prison and AIDS: UNAIDS Point of View* (Geneva: UNAIDS, 1997) p. 3.

[70] WHO, *WHO Guidelines* (supra).

[71] World Medical Association, *Declaration of Edinburgh on Prison Conditions and the Spread of Tuberculosis and Other Communicable Diseases*, 2000.

[72] Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, *Consolidated Version*, U.N. Doc. HR/PUB/06/9, 2006, Guideline 4 at para. 21(e).

[73] WHO, *WHO Guidelines* (supra), Guideline 24. More recently, the WHO reiterated that the range of services required for people in prison includes "clean needle and syringe provision": WHO, *Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector*, 2008, p. 25.

sterile needles and syringes be accessible to incarcerated people in a confidential and non-discriminatory manner.[74]

(b) Canadian correctional law

CSC is governed by the *Corrections and Conditional Release Act* (CCRA) and its accompanying regulations.[75] The CCRA obligates CSC to "take all reasonable steps to ensure that penitentiaries, the penitentiary environment, the living and working conditions of inmates and the working conditions of staff members are safe, healthful and free of practices that undermine a person's sense of personal dignity."[76] The CCRA also reflects the principle of retaining all rights by stipulating that "offenders retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence."[77]

The CCRA mandates that the CSC must provide every incarcerated person with "essential health care" that will contribute to his or her rehabilitation and reintegration into the community.[78] Further, the CCRA stipulates that medical care for people in prison "shall conform to professionally accepted standards," thereby implying a right to comparable health care as offered in the community at large. This is confirmed by CSC *Commissioner's Directive 800* on "Health Services," which stipulates that people in prison "have reasonable access to other health services … which may be provided in keeping with community practice."[79]

While the principle of equivalence is not directly stated in the CCRA, the broad definition given to "health care" and the proviso to provide health services "in keeping with community practice," are correctly interpreted as meaning that people in prison are entitled to equivalence of essential health services, including HIV prevention services, particularly in light of the CCRA's explicit statement that people in prison retain all rights except those necessarily limited by incarceration.

(c) The *Charter*

Finally, under the Canadian *Charter of Rights and Freedoms*, the right to PNSPs could be based on three provisions:

- The right to life, liberty and security of the person (Section 7);
- The right not to be subjected to any cruel and unusual treatment or punishment (Section 12); and
- The right to equality (section 15).

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[74] UNODC, WHO and UNAIDS, *HIV/AIDS Prevention* (supra), Recommendation no. 60.

[75] *Corrections and Conditional Release Act* (CCRA), S.C. 1992, c 20; SOR/92-620; and *Corrections and Conditional Release Regulations* (CCRR), SOR/92-620.

[76] CCRA, s. 70.

[77] CCRA, s. 4(e).

[78] CCRA, ss. 85–88.

[79] CSC, *Commissioner's Directive 800: Health Services*, 2004.

In the context of PNSPs, section 7:

- is violated because it engages the right to life. For example, the B.C. Supreme Court has held that allowing a criminal prohibition on drug possession to extend to the premises of a supervised injection site violated the right to life because it "forces the user who is ill from addiction to resort to unhealthy and unsafe injection in an environment where there is a significant and measurable risk of morbidity or death."[80] Similarly, CSC's failure to provide PNSPs prevents safer injection by people in prison, which could lead to HIV and HCV infection and potentially death;

- is violated because it engages the right to liberty. For example, the Ontario Court of Appeal has held that a criminal prohibition against the use of marijuana to alleviate severe pain violated the right to liberty since it limited an individual's liberty to choose a medically suitable course of treatment.[81] The B.C. Provincial Court has held that a blanket imposition of a "red zone" as a condition of probation for all people convicted of drug offences was a violation of the rights to liberty and life because it was arbitrary, did not take into account the accused's need to access the NSP located within the "red zone" part of the city (which the order prohibited him from entering), and put the accused's life at risk because he was "effectively forbidden from accessing necessary health and other social services."[82] Similar arguments could be made about CSC's prohibition of PNSPs, especially for those who suffer from addiction; and

- is violated because it engages the right to security of the person. The B.C. Supreme Court has held that denying an addict access to a health-care facility "where the risk of morbidity associated with infectious disease is diminished, if not eliminated" threatened security of the person.[83] Similarly, denying people in prison the health benefits of PNSPs—which include a significantly diminished risk of HIV and HCV infection as a result of reduced syringe sharing—violates their right to health and to security of the person.

In the context of PNSPs, section 12:

- has been interpreted by courts to include conditions of incarceration as "treatment" contrary to section 12.[84] As such, CSC's failure to provide PNSPs falls within the ambit of treatment covered under section 12;

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[80] *PHS Community Services Society v. Attorney General of Canada*, 2008 B.C.S.C. 661 at para. 140.

[81] *R. v. Parker* (2000), 49 O.R. (3d) 481.

[82] *R. v. Reid*, [1999] B.C.J. No. 1603, paras. 78 and 80.

[83] *PHS Community Services Society* (supra), paras. 144–145.

[84] See, for example, cases cited in pp. 32–33 of S. Chu and R. Elliott, *Clean Switch* (supra).

- is violated when treatment is (1) "grossly disproportionate"; (2) so excessive as to "outrage standards of decency"; and (3) having regard to all contextual factors;[85]

- is violated because the impact of CSC's inaction on PNSPs is prisoners' heightened risk of HIV and HCV infection, an outcome that is grossly disproportionate to any rationale for their incarceration. Not only people who inject drugs in prisons, but others in prison and the community as a whole face greater risk of grave illness when incarcerated people become increasingly infected with blood-borne viruses;

- is violated because—given the magnitude of this public health risk—CSC's failure to provide PNSPs outrages a collective standard of decency. People in prison retain all their rights and are entitled to access an equivalent standard of health care, principles that should inform "public standards of decency" with respect to PNSPs. In an environment where NSPs enjoy widespread support and there is significant evidence of the efficacy of PNSPs in reducing the use of non-sterile injection equipment, denying people in prison, particularly those who are addicted to drugs, the right to protect themselves against HIV and HCV infection constitutes treatment that is contrary to minimum standards of decency and human rights; and

- is violated because such "treatment" is senseless in light of the alternative of providing PNSPs, a move that would fulfil CSC's obligations under the CCRA and be in accordance with international health and human rights standards.

In the context of PNSPs, section 15:

- has been interpreted by the Supreme Court of Canada to include intersecting grounds of discrimination;[86]

- is violated because people in prison disproportionately embody multiple immutable characteristics recognized as traditional grounds on which discrimination is prohibited.[87] In particular, the denial of PNSPs to people in prison

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[85] See, for example *Lord v. Canada* (2001), 203 F.T.R. 1; *R. v. Wiles,* [2005] 3 S.C.R. 895; *R.* v. *Smith*, [1987] 1 S.C.R. 1045; *R. v. Luxton*, [1990] 2 S.C.R. 711; *R.* v. *Goltz* [1991] 3 S.C.R. 485; and *R.* v. *Morrisey*, [2000] 2 S.C.R. 90.

[86] *Law v. Canada (Minister of Employment and Immigration*), [1999] 1 S.C.R. 497, paras. 93–94.

[87] S. Galea and D. Vlahov, "Social determinants and the health of drug users: socioeconomic status, homelessness and incarceration," *Public Health Reports* 117 (Supp.1) (2002): 135–145; A. Palepu et al, "The social determinants of emergency department and hospital use by injection drug users in Canada," *Journal of Urban Health* 76(4) (1999): 409–18; R. Room, "Stigma, social inequality and alcohol and drug use," *Drug and Alcohol Review* 2 (2005):

disproportionately affects Aboriginal people, who are disproportionately represented in federal prisons.[88] In *Sauvé v. Canada (Chief Electoral Officer),* Justice McLachlin, writing for the majority of the Supreme Court, noted that the negative effects of the impugned provision prohibiting people in prison from voting in federal elections had "a disproportionate impact on Canada's already disadvantaged Aboriginal population."[89] Similarly, denying incarcerated people access to sterile needles and syringes would have a disproportionate impact on Aboriginal Canadians, who already disproportionately represent people who inject drugs and people living with HIV in the population as a whole;[90]

- is violated because people with mental illnesses are overrepresented among people in prison. In 2001, a CSC study found that, in the Pacific region, 84 percent of people in prison had at least one lifetime diagnosis of a mental disorder at entry, including substance abuse.[91] More broadly, the CSC reported that 12 percent of men and 26 percent of women in federal prisons had been identified with "very serious mental health problems";[92] 15 percent of men and 29 percent of women in federal prisons had previously been hospitalized for "psychiatric reasons";[93] and the percentage of people in federal prisons prescribed medication for "psychiatric concerns" at admission had more than doubled from 10 percent in 1997–1998 to 21 percent in 2006–2007;[94]

- is violated because over 20 percent of people admitted to federal prisons have least one drug-related conviction.[95] Substance abuse is identified as a contributing factor to the criminal behaviour of 70 percent of the people admitted to federal prisons.[96] A significant number of people in prison who inject drugs are also addicted to drugs. According to PHAC, approximately 67 percent of people in

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143–155; and Canadian Association of Social Workers, *The Declining Health and Well-Being of Low Income Women in Canada,* 2006.

[88] In 2006–2007, Aboriginal people represented approximately 17 percent of people incarcerated in federal prisons but less than three percent of the adult population in Canada: Public Safety Canada Portfolio Corrections Statistics Committee, *Corrections and Conditional Release Statistical Overview 2007*, 2007, p. 57. This ratio is even more disproportionate for Aboriginal women in federal prisons, who comprise 28 percent of female prisoners: CSC, *Basic Facts about the Correctional Service of Canada,* 2005.

[89] *Sauvé v. Canada (Chief Electoral Officer),* [2002] 3 S.C.R. 519 at para. 60.

[90] National HIV estimates indicate that 53 percent of all new HIV infections among Aboriginal people in 2005 were attributable to injection drug use, a proportion considerably higher than the 14 percent of overall new HIV infections in this category: PHAC, *HIV/AIDS Epi Updates*, November 2007, p. 74.

[91] M. Daigle, "Mental health and suicide prevention services for Canadian prisoners," *International Journal of Prisoner Health* 3(2) (2007): 163–171 at 164.

[92] CSC, *Changing Offender Population: Quick Facts*, 2007.

[93] Public Safety Canada Portfolio Corrections Statistics Committee, *Corrections and Conditional Release Statistical Overview 2007*, 2007, p. 55.

[94] Ibid.

[95] PHAC, *Atlantic Region: Environmental Scan* (supra) at 39.

[96] Ibid., pp. 38–39.

federal prisons have substance abuse problems, of which 20 percent require treatment.[97] People with addictions have been recognized by Canadian tribunals and courts as worthy of protection against discrimination on the basis of the disability of drug dependence,[98] and there is significant jurisprudence from labour arbitrators, human rights commissions and courts recognizing drug dependence as a disability.[99] While people who inject drugs both inside and outside prison may share the experience of disability, as a group people who inject drugs in prison arguably suffer from a more severe dependency, as conflict with the law and incarceration are often a result of offences related to the financing of drug use or offences related to behaviours brought about by drug use; and

- is violated because the denial of PNSPs has a disproportionate impact on women. Though women constitute a minority of those incarcerated in Canada, a significant percentage of women in Canadian prisons were incarcerated for offences related to drug use, often linked to underlying factors such as experiences of sexual or physical abuse or violence.[100] Moreover, a 2003 study of federally incarcerated women found that 19 percent reported injecting drugs while in prison[101] and a previous history of injection drug use is consistently found more frequently among women than men in Canadian prisons.[102] In a number of studies, HIV and/or HCV prevalence has also been shown to be higher among incarcerated women than among incarcerated men in Canada.[103] As the Canadian Human Rights Commission has concluded, "[a]lthough sharing dirty needles poses risks for any inmate, the impact on women is greater because of the higher rate of drug use and HIV infection in this population," an impact that "may be particularly acute for federally sentenced Aboriginal women."[104]

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[97] PHAC, *HIV/AIDS: Populations at Risk*, 2006. A subsequent report by the CSC Review Panel states that "[a]bout 4 out of 5 offenders arrive with a serious substance abuse problem, with 1 out of 2 having committed their crime while under the influence": *A Roadmap to Strengthening Public Safety*, Report of the CSC Review Panel, 2007, p. v.

[98] Under the *Canadian Human Rights Act*, for example, disability is defined as including previous or existing dependence on alcohol or a drug: *Canadian Human Rights Act* (CHRA), R.S.C. 1985, c. H-6, s. 25. See also, *Employment Equity Act*, S.C. 1995, c. 44, in conjunction with Human Resources Development Canada, *Defining Disability: A Complex Issue*, 2003, p. 16.

[99] See, for example, cases cited in footnote 227 of S. Chu and R. Elliott, *Clean Switch* (supra).

[100] J. Csete, *Do Not Cross: Policing and HIV Risk Faced by People Who Use Drugs*, Canadian HIV/AIDS Legal Network, 2007, pp. 36–37; and S. Boyd and K. Faith, "Women, illegal drugs and prison: views from Canada," *International Journal of Drug Policy* 10 (1999): 195–207 at 199.

[101] A. DiCenso et al, *Unlocking Our Futures* (supra).

[102] PHAC, *Final Report: Estimating the Number of Persons Co-Infected with Hepatitis C Virus and Human Immunodeficiency Virus in Canada*, 2001.

[103] See, for example L. Calzavara et al, "Prevalence of HIV and hepatitis C virus infections among inmates of Ontario remand facilities," *Canadian Medical Association Journal* 177 (3) (2007): 257–261; C. Poulin et al, "Prevalence of HIV and hepatitis C virus infections among inmates of Quebec provincial prisons" (supra); CSC, *1995 National Inmate Survey* (supra); and CSC, *Infectious disease prevention and control in Canadian federal penitentiaries 2002-01*, 2003.

[104] CHRC, *Protecting Their Rights* (supra) at 37.

5. Conclusions and recommendations

In Canada's federal prison system, the number of reported cases of HIV rose from 25 in 1989 to 170 in 1996 to 204 in 2005, and the actual number of HIV-positive people in federal prisons is likely to be even higher as not all people will have reported their status to CSC or be aware of it themselves.[105] Forcing people who suffer from addiction to share dirty needles or syringes, in a setting where blood-borne infections are rampant and drugs are available but sterile injection equipment is not, is a recipe for a public health disaster. Many people suffering from addiction also suffer from mental health issues and in some cases, people may have resorted to drugs to cope with their mental illness. In the Legal Network's interviews with people formerly incarcerated in federal institutions, some described their personal experiences with mental illness and addiction, and many described observing depression among fellow prisoners, who used drugs to numb those feelings.

People in prison retain their right to health and their right to programs, such as PNSPs, which help protect them from disease. Contrary to what CSC may contend, PNSPs do not enable the addiction of people in prison, but actually facilitate referrals of users to drug addiction treatment programs. Viewed in light of (a) the reality of HIV, HCV and injection drug use in prisons, (b) the well-established legal principles that people in prison retain all human rights and are entitled to health care equivalent to that available in the community, (c) the availability and general acceptance of NSPs in the community as a vital harm reduction measure, and (d) CSC's obligations to take effective measures to prevent the spread of infectious diseases among people in prison, CSC's failure to provide PNSPs in Canadian prisons does not meet Canada's commitments under international human rights law, its mandate under Canadian correctional legislation, or its obligations under the Charter.

With increasing HIV and HCV prevalence in Canadian prisons, the urgency for action is mounting: people's lives, both inside and outside prisons, are dramatically affected by the lack of clean needles every passing day. Given the significant benefits to be gained from implementing PNSPs and the very real adverse consequences of continuing to reject such programs, the Canadian HIV/AIDS Legal Network urges that PNSPs be implemented in federal prisons immediately.

[105] Canadian HIV/AIDS Legal Network, *HIV and Hepatitis C in Prisons, Fact Sheet #1: "HIV and hepatitis C in prisons: the facts,"* 2008.