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21 March 1994

Dear Dr. Gebbie:

In October of 1993, Ben Merrill requested a copy of the Working Paper on HIV/AIDS in Prisons that I had prepared for the Canadian Expert Committee on AIDS and Prisons. Ben was sent a copy, and we subsequently met at the National AIDS/HIV in Prisons Roundtable in San Francisco and had a few phone conversations regarding the work undertaken by the Canadian Committee. I understand that Ben has since left your office.

For your information, I would like to let you know that the Expert Committee will release its Final Report on March 24th. This report will consist of three volumes: the Final Report itself, a Summary Report, and a volume of background materials, which contains, among others, a section on AIDS in prisons in the United States. A copy of the report will be sent to your office. I hope that you will find the report interesting and will be happy to respond to any questions or requests for information that you may have.

Sincerely,

Ralf Jürgens, LL.M., Dr.iur.
ECAP Project Coordinator

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HIV/AIDS in Prisons:

**A Working Paper
of
The Expert Committee on AIDS and Prisons**

June 1993

HIV/AIDS in Prisons:

A Working Paper of The Expert Committee on AIDS and Prisons

Prepared for the Committee by
Ralf Jürgens, LL.M., Dr.iur.
Project Coordinator
The Expert Committee on AIDS and Prisons

This Working Paper is being distributed for consultation. The parts of the Working Paper entitled "ECAP's Assessment" and "Conclusions" have been approved by the Expert Committee on AIDS and Prisons. All other statements or opinions expressed in the Working Paper do not necessarily represent the views of the Committee. Furthermore, statements or conclusions in this Paper do not necessarily reflect the views or the policies of the Correctional Service of Canada.

June 1993

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ACKNOWLEDGMENTS

The Expert Committee on AIDS and Prisons wishes to thank many people for their contributions to and support of the Committee's work.

First, the Committee wishes to acknowledge the contributions of the staff of Correctional Service Canada and of inmates with whom the Committee met and who provided ECAP with information necessary to its work. ECAP also wishes to thank the many people and the governmental and nongovernmental organizations who responded to our solicitations and enquiries. Their input has been invaluable in identifying issues and formulating responses to them. Many of these individuals and organizations are not mentioned by name in the ECAP Working Paper but they will be listed in ECAP's final report.

ECAP also wishes to acknowledge the organizations, committees and individuals who have worked on issues related to HIV/AIDS and drug use in prisons in Canada. Their dedication to resolving the issues raised by HIV/AIDS and drug use in Canadian prisons has been an inspiration and an invaluable resource for the Committee. They include Gerald Benoit, Michael Linhart and the many other inmates who have established self-help peer groups in federal institutions; the Canadian AIDS Society; Dr. Catherine Hankins of the Centre for AIDS Studies of the Community Health Department of the Montreal General Hospital; the National Advisory Committee on AIDS; the Ontario Regional HIV/AIDS Advisory Committee; the Parliamentary Ad Hoc Committee on AIDS; Dr. Jacques Roy and the staff of Health Care Services, Correctional Programs and Operations, CSC; the Royal Society of Canada; Xavier Sanchez Horno; Ron Shore and the Kingston AIDS Project; Andrea Riesch Toepell and the John Howard Society of Metropolitan Toronto; and the Prisoners with AIDS/HIV Support Action Network (PASAN).

Three people who have worked closely with the Committee deserve special thanks. Their efforts have helped to make ECAP a success. They are the Committee's three observers: Mr. Rob Adlard of Correctional Service Canada; Mr. Wayne Stryde, formerly of Health and Welfare Canada and now with Correctional Service Canada; and Ms. Margaret Gillis of Health and Welfare Canada.

Finally, the Committee wishes to thank Garry Bowers for his help in editing this Working Paper.

Ce document est également disponible en français.

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I. INTRODUCTION

Issues raised by HIV/AIDS and drug use in prisons have been the subject of considerable concern among prisoners, prison authorities and the public. Many of these issues are controversial, and they have elicited significant media attention, community discussion and political debate. In an effort to resolve these issues, the Solicitor General of Canada created an Expert Committee on AIDS and Prisons ("ECAP") on 15 June 1992. The Committee's goal is to assist the federal government in promoting and protecting the health of inmates and of staff, and preventing the transmission of HIV and other infectious agents in federal correctional facilities. It has consulted on, reviewed and analyzed issues raised by HIV infection, AIDS and drug use in these facilities. During the past eight months, ECAP visited correctional facilities in British Columbia, Ontario and Quebec, reviewed and analyzed relevant national and international policies, reports and documentation, and solicited information and submissions from inmates, prison staff, and groups or individuals with an interest in HIV/AIDS and prisons.

As part of its work, ECAP has prepared this Working Paper. It addresses many of the issues that HIV/AIDS and drug use raise in federal penitentiaries. However, it is far from complete and may properly be considered a "first draft" of a discussion of these issues and of what might be done to address them. The Working Paper contains conclusions of ECAP's deliberations and suggestions for action rather than recommendations.

It is hoped that the Working Paper will help to prepare the way for changes that ECAP believes are necessary. It is being widely circulated to stimulate discussion and to give people interested in the issues raised by HIV/AIDS and drug use in prisons an opportunity to review the Committee's work and proposals and to provide further input into the Committee's final report. When this input has been assessed, recommendations will be formulated and a final report prepared for release in the fall of 1993.

Making Necessary Changes Possible

Although members of ECAP were already familiar with many of the issues raised by infectious diseases and drug use in Canadian penitentiaries, in the course of its work the Committee learned a great deal more about Canadian penitentiaries and some of the problems they face. The Committee has come to appreciate the exceedingly complex environment of correctional facilities and the problems that HIV infection, AIDS and drug use create in this particular environment. In its search for ways for the Correctional Service of Canada ("CSC") to better promote and protect the health of staff and inmates and to prevent the spread of infections in penitentiaries, the Committee reached numerous conclusions. Seldom were they reached easily, but when they were reached, acceptance and support of them was unanimous. Attaining this unanimity was one of the most arduous but gratifying experiences for the Committee, and it emphasizes ECAP's commitment to what needs to be done.

ECAP often found that what needed to be done to resolve many of the problems raised by HIV/AIDS and by drug use in prisons was obvious and had in many cases already been articulated by others, but that how to implement these changes was seldom evident. As a result, ECAP focused on strategies for making necessary changes possible. The Working Paper reflects this approach, emphasizing not only what may be changed but how to make changes possible in federal correctional facilities.

Correctional facilities and the communities within them are not static organizations, but dynamic ones. The dynamics are exceedingly complex and not always readily apparent. They are further complicated by a variety of factors, including: (1) the sometimes divergent goals,

aspirations, needs and perceptions of inmates, health-care staff, corrections officers, administration, communities outside prisons, politicians and the public; (2) the unique environment of penitentiaries; (3) the problem of constrained resources and competing demands concerning their allocation; and (4) incomplete knowledge about the prevalence and likely impact of HIV infection in penitentiaries. In such an environment, change, or even the possibility of change, often elicits strong or divisive opinions and favours entrenchment of the status quo. This applies as much to personal behaviour as to operations and social interactions. ECAP recognizes that the challenges for CSC and for both staff and inmates to implement changes in this milieu are formidable.

Many of the complex problems HIV/AIDS raises in prisons derive from what Harding has called "an underlying conflict of values between the penal system (based on the principles of 'just deserts,' retribution, and dissuasion) and medical care (based on promoting health and limiting suffering)."¹ Correction is a public safety or law enforcement activity rather than a public health activity.² Prison life is organized not on the basis of care but of security and coercion. It has been found that, outside the prison setting, coercive interventions are often ineffective and may be counterproductive to the control of HIV transmission and its consequences³ and that the most effective interventions are those based on respect for persons, their rights and dignity, and which promote and encourage personal responsibility and provide realistic opportunities for behaving safely. In prisons, however, preventing disease and delivering medical care requires reconciling or balancing a medical model based on prevention, diagnosis, care and treatment with the correctional requirements of custody, control and punishment.⁴ Security concerns and the notion of punishment inherent in the prison system can be serious obstacles to effective prevention of HIV/AIDS in prisons. In this setting, populations engaging in risk-producing activities are often "hidden" and their activities covert or furtive, access to the means necessary to prevent HIV transmission are often severely limited, and both discourse about and interventions to improve this situation are rendered more difficult.

For all these reasons, responding to the threat of HIV/AIDS in prisons is more difficult than outside. At the same time, prisons represent a window of opportunity for the prevention of HIV transmission because a significant proportion of people engaging in high-risk activities, injection drug use in particular, pass through these facilities.⁵

Presumptions and Principles

The following are some of the presumptions and principles that have guided ECAP's work.

First of these are the "core values" expressed in the *Mission of the Correctional Service of Canada*.⁶ These include the presumption that the goal of imprisonment is rehabilitation, not punishment, and the recognition that offenders, as members of society, retain their rights and privileges "except those necessarily removed or restricted by the fact of their incarceration."⁷ A corollary is the principle that the same standards of health care and protection that apply to people outside prisons should also apply to offenders ("community equivalence").

Second, behaviour change is necessary to prevent or reduce transmission of infectious diseases in prisons. Importantly, this necessitates giving everyone in penitentiaries realistic opportunities to change their behaviour in such a way that exposure to infectious diseases will be avoided or reduced. Efforts to reduce the transmission of infections inside prisons, as outside, must be persistent and sustained, since it is unrealistic to believe that everyone will behave in such a way that the spread of infectious diseases, in particular HIV, will stop completely.

Third, prohibiting or suppressing behaviour that can transmit infectious diseases is often ineffective and may be counterproductive. Efforts to prevent the transmission of infectious diseases in correctional facilities should promote safe behaviour, enlist the cooperation of people in avoiding or reducing exposure, and emphasize respect for the rights and dignity of people.

Fourth, whatever prevents infections in prisons will protect both inmates and staff. Lowering the prevalence of infections in correctional facilities means that the risk of exposure to these infections will also be lowered. Efforts to prevent infection should not be viewed as favouring either inmates or staff, and efforts that protect inmates do not conflict with those that protect staff: these efforts benefit both inmates and staff.

Fifth, several of the conclusions the Committee reached may appear to conflict with established penitentiary policy. For example, distributing condoms, making bleach available for cleaning injection equipment, educating prisoners about how to inject drugs safely, and providing explicit educational materials would appear to conflict with laws, policies or standards according to which sexual activity is an institutional offence, drug possession (and use) a criminal offence, and the provision of graphic literature considered as offensive to the prison community and the public. However, such measures may be necessary to protect inmates, staff and the public from the much greater harm that HIV infection represents, and may be seen as part of a "health model" or harm-reduction model for dealing with HIV/AIDS and drug use. In the context of drug use, such a model has been defined as follows:

Harm reduction is a relatively new social policy with respect to drugs.... Although harm-reduction approaches seek to reduce the use of drugs, harm-reduction has as its first priority a decrease in the negative consequences of drug use.... According to a harm-reduction approach a strategy which is aimed exclusively at decreasing the prevalence of drug use may only serve to increase the level of various drug-related harms.

Harm reduction tries to reduce problems from drug use and recognizes that abstinence may be neither a realistic nor a desirable goal for some, especially in the short term. This is not to say that harm reduction and abstinence are mutually exclusive but only that it is not the only acceptable and important goal. Harm reduction involves setting up a hierarchy of goals, with the more immediate and realistic ones to be achieved in steps on the way to risk-free use or, if appropriate, abstinence. Harm reduction is consequently an approach which is characterized by pragmatism. ...

Such strategies have been developed in a number of countries in response to the realization that the spread of AIDS is a greater danger to individual and public health than is drug misuse.⁸

The Solicitor General's decision in January 1992 to make condoms available in federal penitentiaries is an example of this "lesser harm" approach to the threat posed by HIV infection in federal correctional institutions. Implementing condom distribution in penitentiaries has not resulted in any documented negative or adverse impact; indeed, it appears to have had a beneficial impact. It has opened discussions about sexual activity and about preventing disease in

penitentiaries. In addition, it has signaled how seriously CSC is taking the threat of HIV transmission, and its commitment to promote and protect the health of inmates and prevent infection among them.

Responding to HIV Infection and Drug Use in Prisons: Specific Issues

At its first meeting, ECAP identified 14 major issues it considered needed to be addressed by the Committee. ECAP concluded that responding to each of these issues would be necessary if HIV transmission and its adverse consequences in federal correctional facilities are to be prevented. The issues are:

1. Seroprevalence Studies
2. Testing for HIV Infection
3. Offender Medical Information
4. Housing and Activities
5. Educational Programs for Inmates
 - 5.1 Education about HIV/AIDS
 - 5.2 Education about Drug Use
6. Preventive Measures for Inmates
 - 6.1.1 Consensual Sexual Activity
 - 6.1.2 Status of Consensual Sexual Activity
 - 6.2 Nonconsensual Sexual Activity
 - 6.3 Preventing the Harms from Injection Drug Use
 - 6.4 Preventing the Harms from Tattooing
 - 6.5 Preventing the Harms from Piercing
7. Protective Measures for Staff
8. Health Care
9. Tuberculosis
10. Prison Health Services
11. Compassionate Release
12. Aftercare
13. Women Inmates
14. Aboriginal Inmates

ECAP has examined each of these issues, and the Committee's conclusions relating to each of them are presented in this Working Paper. For each issue, the Working Paper briefly reviews CSC policy and practice pertaining to that issue ("Current Situation"), what others have commented on regarding the issue ("Debate"), the Committee's assessment of it ("ECAP's Assessment"), and conclusions about what might be done in response to it ("Conclusions"). The "Debate" sections do not necessarily reflect the views of the Committee; the "Assessment" sections and "Conclusions" were adopted by the Committee at a meeting held on 11 May 1993.

Responding to HIV Infection and Drug Use in Prisons: Broader Issues

Although ECAP has addressed the specific issues listed above, there are several issues the Committee could not address. These are the broader social issues that underlie many of the specific issues ECAP has examined. They include Canada's views on and responses to the use of

drugs, intimate or private behaviour, vulnerability, aggression, violence and crime, and the status of women and Aboriginal populations. The Committee could not address these broader issues in greater detail because their magnitude and complexity would require more time and resources than were realistically available to ECAP. Nonetheless, these issues are briefly discussed here. Although the Committee found that there is much that can be done immediately to prevent HIV transmission in prisons, sooner or later these broader issues will have to be addressed in the context of Canadian prisons; otherwise, efforts to promote and protect the health of staff and inmates and to prevent infections in Canadian prisons will be limited.

- **Drug Use**

Throughout history people have used drugs to "receive pleasure or to achieve new experiences."⁹ It has even been said that drug use is a basic "human trait" and that the desire to alter consciousness is as deep as the need for food, shelter and love.¹⁰

Drug use among prisoners is a universal problem in Canada as elsewhere. Riley recently stated:

In Canada, many of the inmates of federal penitentiaries and provincial gaols as well as those on parole use drugs as part of their lifestyle. There are no strong deterrents to substance abuse in prison because cases take too long to go through and withholding privileges has little effect compared to the high positive reward value of drugs. In 1989, 53.7% of all federal inmates were classified as having a serious substance abuse problem (Correctional Services Canada, 1990 [Correctional Service Canada. Research and Statistics Branch. *Forum on Corrections Research* 1990;2(4). Ottawa: Correctional Service Canada]).

In prison offenders may be involved in an active drug trade that defies all barriers and sets up conflicts involving debts and coercions. Inmates can make a great deal of money selling drugs and the price of drugs can increase from 200-500% over street value. The drug trade is a major source of violence in federal prisons. Between 1985 and 1986 there were 6 murders, 69 major assaults and 3 suicides linked to alcohol or other drug use (Correctional Services Canada, 1988, 1990 [Correctional Service Canada. *Study to determine the incidence of psychiatric and behavioural disturbance among federally incarcerated offenders: Appendices A through H*. 1988. Ottawa: Correctional Service Canada])."

Inmates who enter the institution with no history of drug use often become drug users in prison. The extent of injection drug use in prisons is difficult to determine for obvious reasons, but what is clear is that when drugs are injected, clean needles and syringes are not available. Data from a recent Toronto report suggest that a significant number of inmates share injecting equipment for the first time when they are in prison (Milson, 1991 [Milson P. Evaluation of a programme to prevent HIV transmission in injection drug users in Toronto. 1991. Toronto Board of Health]). ...

The impression is often given that prisons are a separate world. In fact, of course, the opposite is true: prisons experience the problems experienced outside as well as their own unique problems, and there is a constant flow of people between prisons and the general population.¹¹

Among the many issues that ECAP considered, drug use is perhaps the most complex and problematic. CSC has diligently tried to prevent drug use in its institutions. Despite these efforts, drug use, including the injection of drugs, continues to occur. The Committee heard repeatedly that inmates would share their injection equipment, and would often do so without cleaning it between uses. As is the case outside prisons, efforts to prohibit drug use are costly and not always successful. Such efforts include interdiction of drugs and the penalization of possession (and use), education, and treatment programs. Since it is unrealistic to believe that all inmates will stop their drug-injecting behaviour, HIV is likely to spread relentlessly among injection drug users until they stop sharing their equipment or always clean it between uses. Other alternatives with which to respond to this problem appear unacceptable. Permitting drug use in penitentiaries in such a way that it can be done safely is unrealistic, given the legal prohibitions and public attitudes against drug use. On the other hand, allocating even greater resources to eradicating drug use is unlikely to be successful and would probably only drive drug users further underground and reinforce unsafe injecting practices.

Since efforts to suppress drug use are unlikely to eliminate the risk of HIV transmission and since drug-injecting behaviour is likely to persist, the only realistic option to successfully prevent infections is to encourage drug users to always use clean injection equipment and to provide them with the means to do so. There is accumulating evidence that injection drug users can and do change their behaviour in the face of HIV infection.¹² They will clean their injection equipment or not share it if sufficient equipment is accessible. Importantly, making these materials accessible has not increased the prevalence of injection drug use. In order to reduce the harms from drug use in prisons and, in particular, to prevent or reduce transmission of HIV and other infectious diseases, inmates need to be able to always use clean injection equipment. This harm-reduction approach should in no way be interpreted as condoning drug use. Rather, it should be seen as discouraging unsafe injecting behaviour. Other interventions that may be implemented include making methadone programs available to offenders and giving offenders the option of detention in so-called drug-free areas.^[1] However, these interventions may be considered to be band-aid solutions until the underlying issues are resolved. In the context of prisons, the two most prominent of these issues are preventing HIV infection among drug users outside prison, and reducing the number of drug users who are incarcerated.

Worldwide, the prevalence of HIV infection in prisons has been found to be closely related to the proportion of inmates who injected drugs prior to their imprisonment, and to the prevalence of HIV infection in their community.¹³ This means that some inmates will enter prisons already infected; for those not infected when they enter prison, persistent injection drug use in prison

[1] Drug-free detention units have been available in a number of prisons in the Netherlands since 1983. Prisoners who apply to be housed in such units must refrain from using drugs and submit to regular urine tests. They have no contact with the rest of the prison population and participate in special programs.

without access to clean injection equipment means that HIV infection will be unavoidable. And some offenders will begin using drugs when they are incarcerated.

When people using drugs are sent to prison, responsibility for dealing with their drug use and the harms deriving from it, including HIV/AIDS, is shifted to the correctional system. As the number of drug users who are incarcerated increases, this will only augment the problem. As Harding has stated, "prisons are the single largest response to the drug problem in most European countries" and "more resources are used in moving drug users through the criminal justice system in Europe than any other form of management, medical or social."¹⁴ Reducing the number of drug users who are incarcerated in federal penitentiaries is one possible way that HIV transmission in prisons may be lessened. Many of the problems created by HIV infection and by drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available. As WHO has stated, "[g]overnments may ... wish to review their penal admission policies, particularly where drug abusers are concerned, in the light of the AIDS epidemic and its impact on prisons."¹⁵

- **Health Care and Confidentiality**

One of CSC's norms is that there should be community equivalence in the health care and support services available to inmates; in other words, these services should not differ from those available to people outside of prisons.¹⁶ However, one of the major concerns repeatedly expressed by inmates is their lack of confidence in prison health services, in particular the confidentiality of personal medical information. They are often reluctant to use these services, and have expressed a desire for access to some services outside penitentiaries. These concerns have sometimes been difficult to evaluate and the provision of health care presents formidable logistical problems for CSC: the Working Paper discusses these issues at some length. However, HIV infection presents additional problems for prison health services, in particular the emerging specialty nature of the expertise needed to diagnose and treat it. Another issue is that of testing for HIV infection in penitentiaries. Testing raises exceedingly sensitive issues relating to the benefits, risks and harms from testing, disclosure of test results to others, and the possibility of abuse of this information. The fact that prisons are closed communities compounds these risks and harms. Again, the Working Paper addresses these issues.

Underlying all these issues is the lack of confidence of inmates in prison health services. There are a number of reasons for this, and addressing many of them goes beyond ECAP's mandate. However, until they are dealt with many of the problems created by infectious diseases and drug use in penitentiaries will not be resolved easily or effectively. Nonetheless, the Committee has sought to formulate implementable interim measures.

One of the major concerns is that inmates often do not trust prison health-care personnel. Outside prisons, people are free to choose a professional who can meet their individual health needs. When they find such a person, trust between patient and professional is reinforced, impediments to care are lessened, compliance is increased, and disclosure of personal—often intimate or sensitive—information is facilitated. This is not feasible in prisons because of the restricted liberty of inmates and concerns about security. However, a novel approach that has been developed in provincial correctional institutions in Quebec provides a potential solution to this problem through the provision of services by outside community clinics independent of prisons. The provision of such services has both merit and appeal. It would increase inmates' confidence in these services, increase their use of them—leading to earlier interventions relating

to disease—encourage discussion, counselling and testing for infectious diseases, and serve to demarcate personal medical information from other personal information in the institution's possession. ECAP considers that CSC's Health Care Advisory Committee should further study this issue.

- **Staff Health and Safety**

Another very complex issue is that of promoting and protecting the health of staff, in particular staff potentially exposed to violent or aggressive inmates. It was apparent to ECAP that infectious diseases, and HIV infection in particular, are perceived to be a serious threat to staff health and safety. This has often led to claims that staff "need to know" the HIV status of infected offenders and to demands that staff be provided with more and better protective clothing. ECAP has examined these claims. However, although ECAP recognizes staff's concerns about the need for protective equipment, the Committee could not study the issue extensively. The Committee therefore encourages the steering committee established to consider the issue of protective clothing and equipment to continue its efforts to provide CSC with proposals concerning improved protective equipment. At the same time, ECAP felt that improving staff understanding about HIV infection and AIDS is more important than knowledge about an individual's HIV status or the provision of protective equipment. There is extensive experience in managing HIV infection in health-care institutions, in particular preventing exposure to potentially infectious materials such as blood. Despite efforts by CSC to educate staff about the issue, this experience has not been effectively transferred to the prison setting, or has not had the educational and behavioural impact it merits.

Preventing workplace injuries has been an infection-control priority in health-care settings. In the prison setting, avoiding injuries will not always be possible. However, reducing the number of injuries from direct confrontation, and thus the risk of exposure to infectious diseases, should be a priority for CSC staff. Otherwise, efforts to protect staff from exposure will lead to excessive emphasis on protective clothing rather than on reducing exposure. Carried to its logical conclusion, such an approach would find staff in "space suits," and infected inmates isolated. A preferable approach would be first to handle aggressive or violent behaviour so that accidents would be reduced, and then to handle the inmate. Consequently, there is a need for a reassessment of the management of aggressive or violent behaviour that can lead to risk-producing situations in prisons.

- **Women Inmates and Aboriginal Inmates**

Many of the issues relating to HIV/AIDS and drug use in prison are similar for all inmates, but sometimes preventing HIV infection among female inmates and Aboriginal inmates and caring for them presents different challenges than among non-Aboriginal male inmates.

Women constituted only 2.3 percent of the on-register offender population in 1991.¹⁷ However, a seroprevalence study undertaken in a provincial medium-security prison for women in Montreal¹⁸ and a series of studies undertaken in prison systems in other countries have shown high rates of HIV infection among women prisoners, in particular those who have a history of injection drug use. Women generally experience HIV infection and AIDS differently than men, both socially and physically, and the problems they encounter in the correctional environment often reflect, and are augmented by, their vulnerability and the abuse many of them have suffered outside prison. Many female inmates suffer from chronic health conditions resulting from lives

of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition, and poor preventive health care.

ECAP has attempted to address some of these problems, but it could not address the broader social issues that give rise to or underlie many of them. ECAP concluded, among other things, that there is a need for greater sensitivity to the special concerns and needs of women in prison, for educational and prevention efforts that reflect this sensitivity and are specifically targeted at women inmates, and for increased efforts to empower women inmates so as to decrease their vulnerability to abuse in general and to HIV infection and drug use in particular. What ECAP was unable to do, and what so urgently needs to be done, is to address the vulnerability and the abuse many female offenders suffer outside prison.

Aboriginal inmates are another vulnerable population in federal penitentiaries. Compared with other Canadians, Aboriginal people are vastly overrepresented in the country's penitentiaries. In 1990-91, Aboriginal offenders accounted for 11.2 percent of the male and 15.4 percent of the female federal inmate population.¹⁹ In some institutions the percentage is much higher. For example, in the Prairie Region, Aboriginal offenders accounted for 36.4 percent of the male and 47.2 percent of the female federal offender populations.²⁰ The problems causing this overrepresentation could not be addressed by ECAP. However, ECAP has studied some of the special concerns and needs of Aboriginal inmates in prisons. The Committee's conclusions regarding these issues are included in this Working Paper. ECAP found that there was much that could be done to improve the health and welfare of Aboriginal people who are incarcerated.

The predominant culture in penitentiaries is not an aboriginal one. As a result, Aboriginal inmates must reconcile living in what may be considered an "alien" culture. For them, many of the problems that have led to their imprisonment, to drug use and to exposure to HIV, or that result from imprisonment, from drug use and from HIV infection, cannot be addressed effectively or efficiently without an understanding of the "cultural meaning" of their behaviour.²¹ It was clear to ECAP that CSC both understands the problem and is trying to respond to it. However, HIV infection imposes new demands on CSC and the prison community to respond to the pandemic and therefore to respond to these underlying cultural issues. With regard to Aboriginal offenders, this requires even greater efforts to overcome cultural barriers so that interventions to prevent HIV infection among Aboriginal offenders, care for those who are infected, and protect them from even greater vulnerability and abuse, are effective. Such interventions include providing for access to and use of traditional medicines, healers and healing ceremonies; culturally sensitive and specific communication and educational programs; and efforts to reinforce respect for social and religious values. This challenge is not unique to prisons, and to respond to this issue only in prisons would be a partial response. Many of the problems that arise for Aboriginal offenders in prisons have their roots outside prison and need to be addressed within a much broader context.

II. METHODS

1. MEETINGS

The Committee met five times:

- 4 September 1992 (Ottawa);
- 31 October 1992 (Abbotsford);
- 4 December 1992 (Montreal);
- 4 February 1993 (Kingston);
- 26 February 1993 (Ottawa).

In addition, members of the Committee met with:

- Ron Shore, Kingston AIDS Project (19 November 1992);
- Joan Anderson, Chair, Board of Directors, Canadian AIDS Society (22 January 1993);
- Representatives of the Union of Solicitor General Employees (11 February and 8 March 1993);
- Irving Kulik, John Rama, Willie Gibbs, Assistant Commissioners of the Correctional Service of Canada (23 February 1993);
- John Edwards, Commissioner of the Correctional Service of Canada (26 February 1993);
- Susan Ohrt, Special Assistant to the Solicitor General of Canada (26 February 1993).

2. PRISON VISITS

The Committee visited federal penitentiaries in British Columbia, Ontario and Quebec. This provided an opportunity to tour the institutions and hear the concerns of prison authorities, staff and inmates regarding HIV/AIDS and drug use in the prison environment. The Committee sees this as an important aspect of its work.

- (1) British Columbia: Matsqui and Mission institutions (30 October 1992)
- (2) Ontario: Prison for Women, Kingston Penitentiary and the Regional Treatment Centre (19-20 November 1992)
- (3) Quebec: Regional Reception Centre, Ste. Anne de Plaines Institution; and the Federal Training Centre (3-4 December 1992)
- (4) Consultation with Aboriginal people: Consultation with the Native Sisterhood of the Prison for Women and representatives of the Native Brotherhoods of several federal penitentiaries at the Prison for Women (3-4 February 1993)

3. REVIEW OF POLICIES AND LITERATURE

The McGill Centre for Medicine, Ethics and Law collected and reviewed national and international policies, reports and documentation relating to HIV/AIDS and to drug use in prisons. Policies have been analyzed with respect to:

- (1) HIV-antibody testing;
- (2) confidentiality of medical records;
- (3) housing of prisoners with HIV infection or AIDS;
- (4) educational programs for staff and prisoners;
- (5) preventive measures for prisoners, including availability of condoms and clean needles/syringes or material to decontaminate them before re-use;
- (6) protective measures for staff;
- (7) availability of and access to health care.

Further, Canadian case law and precedents that have dealt expressly with HIV/AIDS in prisons, or could be applicable to situations raised by HIV/AIDS in prisons, have been analyzed to identify patterns of problems related to HIV/AIDS in Canadian prisons.

4. SUBMISSIONS AND CORRESPONDENCE

Letters were sent to selected national and international bodies, groups or individuals, requesting information and asking them to make submissions to ECAP. Among those to whom letters were sent are:

- provincial and territorial ministries of health;
- provincial and territorial ministries responsible for the provision of adult and young offenders correctional services;
- federal, provincial and territorial human rights commissions;
- provincial and territorial drug abuse commissions;
- individuals and groups in Canada with an interest in the issue;
- selected correspondents from the international HIV/AIDS in Prisons Information Exchange Network managed by the University Institute of Legal Medicine, Geneva.

5. QUESTIONNAIRES

A questionnaire about prisoners' opinions and concerns regarding education about HIV/AIDS and drug use, availability of condoms, clean needles and syringes or material to clean injection equipment, and testing and confidentiality, was sent to inmate committees in federal penitentiaries. Further, inmates were urged to contact the Committee with suggestions, recommendations or comments regarding HIV/AIDS and drug use in prisons.

A second questionnaire was sent to prison staff to obtain information regarding staff concerns about safety and the concerns of prison authorities with regard to the maintenance of safety and order in the prison environment.

6. CONFERENCES

- (1) A special session on "HIV/AIDS in Prisons," organized by the Project Coordinator, was held in Vancouver at the 6th Annual British Columbia AIDS Conference, called *Living with*

HIV/AIDS, on 2 November 1992. This session provided an opportunity to discuss the issues raised by HIV/AIDS in the provincial and federal prison systems, identify the concerns of prisoners and of prison staff and authorities, and solicit possible solutions to problems raised by HIV/AIDS. The speakers at the session and titles of their talks were:

- Michael Linhart, Prisoner, Mission Institution, *An HIV Positive Prisoner's View*;
- Roger Brock, Warden, Mission Institution, *A Warden's Perspective*;
- John Turvey, Downtown Eastside Youth Activities Society, *The Role of Community Groups*;
- Ray Sill, American Indian Metis Society, *Aboriginal Prison Populations and HIV/AIDS*;
- Barry Lynden, Programs Analyst, B.C. Ministry of the Solicitor General, and Ron Painter, Director, Surrey Pretrial Service Centre, *The Action of the B.C. Corrections Branch*;
- Robert Adlard, Director, Program Policy Division, Correctional Service Canada, *The Action of the Correctional Services of Canada*;
- Jim Elliot, Chief of Health Care, Mission Institution, *Health Care in Prisons*;
- Ralf Jürgens, ECAP Project Coordinator, *HIV/AIDS and Prisons: Analysis of Policies and Relevant Case Law*;
- Diane Riley, Senior Analyst, Canadian Centre on Substance Abuse, *Drug Use in Prisons*.

A summary of the texts of the presentations will be included in the final report of the Committee.

An indication of the success of this meeting is that the organizers of the British Columbia AIDS Conference have asked Dr. Jürgens to plan a session on HIV/AIDS in prisons for the next conference, to be held in Vancouver in October 1993.

(2) At the 4th International Conference on the Reduction of Drug Related Harm, which was held in Rotterdam on 14-18 March 1993, Dr. Jürgens presented a paper based on the abstract "Reducing the Harms from Drug Use and from HIV/AIDS in Prisons" by Drs. Jürgens, Gilmore and Somerville (see Appendix 4).

(3) An abstract on "HIV/AIDS in Prisons: Making Necessary Changes Possible" was submitted by Drs. Jürgens, Gilmore and Richard to the IXth International Conference on AIDS, which will be held in Berlin on 7-11 June 1993.

7. NEWSLETTER

The Project Coordinator produced four issues of the Committee's newsletter, *ECAP NEWS*.

- Issue 1 (September 1992): Summarizes ECAP's goal and mandate, presents the Committee members, and introduces the major issues that ECAP deals with.
- Issue 2 (November 1992): Provides a summary of the presentations at the session on HIV/AIDS in Prisons at the 6th Annual British Columbia AIDS Conference, and addresses the issues raised by drug use in correctional facilities.
- Issue 3 (February 1993): Addresses the challenges presented by the particular needs of female inmates and of Aboriginal inmates with regard to preventing HIV infection.
- Issue 4 (April 1993): Addresses staff concerns about health and safety in the workplace.

III. SURVEY OF RELEVANT MATERIALS

A. SURVEY OF POLICIES

1. Canadian Policies

A directive relating to the management of inmates with AIDS, ARC, or HIV infection in federal penitentiaries was issued by the CSC Commissioner on 1 January 1988.^[2] Policy directives setting out standards and guidelines for dealing with HIV infection in the provincial and territorial prison systems have also been issued by all provinces and the Northwest Territories. Yukon will announce its policy in the near future.²² These policies vary widely in content and also differ substantially from those of many other developed countries. Common to all Canadian policies is that they:

- do not authorize the involuntary testing of prisoners for HIV infection;
- require that attempts be made to house infected prisoners among the general prison population;
- stress the importance of maintaining the confidentiality of the HIV status of inmates;
- establish educational programs about HIV/AIDS for both inmates and staff;
- indicate protective measures to be taken by staff to avoid exposure to HIV.

The following is a brief review of Canadian prison policies on HIV/AIDS. It is based on information made available to ECAP in the fall of 1992.^[3] A more comprehensive review will be included in the Committee's final report.

1.1 HIV-antibody testing

No jurisdiction currently authorizes the involuntary testing of inmates for HIV infection. In this connection, the policy of Newfoundland and Labrador states:

2. No person may be forced to submit to an HIV Antibody test. Such a test may only be administered by a medical professional if the patient provides informed consent. Any attempt to coerce an inmate to submit to the test in the absence of consent may not only be a violation of fundamental human rights under the Charter of Rights (the right to "life, liberty and security of the person" and the right to be "secure against unreasonable search or seizure") but may also be regarded as an offence under the *Criminal Code*.²³

On the other hand, the policies generally contemplate the possibility that inmates may be voluntarily tested, often with an explicit requirement for informed consent, but this is often subject

[2] Commissioner's Directive 821, *Management of Inmates with Human Immunodeficiency Virus (HIV) Infections*. At the time of writing, approval of a revised version of this directive was pending.

[3] Parts of the following survey were published in Hamblin J, Somerville MA, Gilmore N et al. *Responding to HIV/AIDS in Canada*. Toronto: Carswell, 1990.

to the approval of the institutional physician.^[4] Newfoundland's and Nova Scotia's²⁴ policies and the Manitoba Interim Guidelines for Correctional and Detentional Facilities explicitly encourage inmates to be tested if they exhibit signs of the disease or if they belong to a "high-risk group."^[5] Except for those of Alberta and Saskatchewan, all policies explicitly provide for pre- and post-test counselling services. Only some policies provide for the voluntary testing of staff, but most require that personnel who have been exposed to body fluids report the exposure and that they be given medical attention.

Some policies explicitly require that, upon entrance into the correctional system, inmates be screened for signs of HIV infection or AIDS or that they be asked whether to their knowledge they have a communicable disease, including HIV/AIDS. Where a diagnosis of HIV/AIDS is suspected or confirmed, a health-care assessment will usually be made to determine the precautions that might be required for managing the inmate. In Newfoundland, a staff member who suspects that an inmate may be infected with HIV "because he/she exhibits certain symptoms or engages in high risk activities" must report this information to the medical officer.²⁵ In other provinces, policies do not address the issue and it is therefore unclear whether any effort is being made to screen inmates for HIV infection or AIDS either upon entrance or during incarceration.

1.2 *Confidentiality of medical records*

With the exception of that of Alberta, all policies stress the importance of maintaining the confidentiality of the HIV status of inmates, and medical officials are usually appointed as the guardians of this information. But there does exist a wide range of exceptions to this principle, exceptions that permit disclosure of such information without the affected prisoner's consent. Each policy is different in this respect, but it is most common to find an exception to confidentiality based on a "need to know" principle. This sometimes calls for staff who come into regular contact with an infected inmate to be informed (in more or less detail) of the inmate's

[4] The only provincial policy that makes no reference to testing for HIV antibodies is Manitoba's Adult Corrections Branch Policy of 3 July 1990. This does not mean that testing is not available to inmates of adult correctional facilities in Manitoba. In personal correspondence, dated 31 March 1992, Mr. Demers, Assistant Deputy Minister, Manitoba Justice - Corrections, stated that the Manitoba policy "is intended to provide directions and safeguards" and that it is not "a medical or security procedures manual." Mr. Demers continued by saying that "there is no reference to HIV/AIDS testing or counselling because those are assumed to be doctor-patient decisions." The Interim Policy of Manitoba Community and Youth Corrections of 9 January 1991 provides that "[t]esting for infectious diseases is left to the individual discretion of staff and offenders who believe they may be infected." Interim Guidelines for Correctional and Detentional Facilities on Workplace Prevention and Management of AIDS and HIV, which were drawn up in 1987 by the Manitoba Department of Health, state that "[i]nmates/residents should not be routinely tested for antibody to AIDS virus (HIV) upon entrance into the facility or during their stay" and that "antibody testing and counselling services should be available for any person who wishes to be tested."

[5] Nova Scotia's policy, as well as Manitoba's guidelines, continue to use the outdated language of "high-risk group." That this is both imprecise and over-encompassing is illustrated by Nova Scotia's blanket inclusion in the group of all homosexual and bisexual males with multiple partners, and IV drug users, regardless of whether or not they engage in unsafe practices (such as unprotected sex). It would be both more accurate and preferable to refer to "high-risk activities" that people engage in.

condition.^[6] Other policies mandate the disclosure of medical information when there is reason to believe that an inmate's conduct poses a danger to himself or to others.^[7] A more detailed provision can be found in British Columbia's policy:

11.05 While it is recognized that the standard approach for dealing with all inmates is to employ universal precautions ... there may, from time-to-time, be a need for specific handling information. Therefore, when a Health Care professional advises the institutional director that an inmate presents a medical risk, information that does not reveal the specific diagnosis may be shared with all staff who may have direct contact with an inmate.²⁶

1.3 *Housing of prisoners with HIV infection or AIDS*

As a general rule, policies direct that attempts must be made to house infected inmates among the general prison population. The standard exceptions to this rule fall under three headings: segregation is deemed acceptable if (1) an inmate's behaviour threatens transmission of HIV; (2) the reactions of other inmates require that an infected prisoner be put into protective custody; or (3) an inmate's medical condition warrants it. Nova Scotia broadens this exception to include inmates suspected of having HIV/AIDS.^[8] Decisions are made by prison officials, and in general the policies do not contain decision-making criteria. Alberta's policy, however, contains very specific provisions concerning the placement of offenders with HIV infection or AIDS.

[6] For example, this is the case in Manitoba's Adult Corrections Branch Policy, in Nova Scotia's Policy on AIDS and in Alberta's Policy on AIDS and HIV (Alberta Solicitor General, Correctional Services Division, No. 20.15.03).

[7] These are Commissioner's Directive 821; the Infection Control Manual, New Brunswick Department of the Solicitor General, Correctional Services Division (revised version, May 1991); and the policies of Newfoundland and Quebec (Politique relative aux maladies infectieuses en milieu carcéral, Gouvernement du Québec, Ministère de la Sécurité publique, Direction générale des Services correctionnels, avril 1992). In personal correspondence, dated 30 March 1992, Ms. Cheryl MacIntyre, Chairperson, AIDS Protocol Committee, New Brunswick Correctional Services Division, stated that only in rare circumstances, when an offender's behaviour constitutes a risk to others, would the Medical Advisor make a decision to have supervisory personnel informed of an inmate's seropositivity.

[8] Nova Scotia's policy states that inmates who are suspected of being infected but who refuse to provide consent to be tested "may be returned" to the general prison population. In personal correspondence, dated 26 March 1992, Ms. Nadine Cooper Mont, Deputy Solicitor General of Nova Scotia, stated that notwithstanding the language used in the policy, such inmates are "indeed returned to the general inmate population."

1.4 *Educational programs for staff and prisoners*

The policies generally stress the importance of establishing educational programs about HIV/AIDS for both inmates and staff. However, the policies do not usually describe these programs; it is therefore unclear whether or not they are mandatory, who will implement them, and through what medium the information will be disseminated.^[9] Specifics concerning content are also minimal, although some policies do state that information must be relayed about the nature of the disease, how it is transmitted, and how transmission may be prevented.^[10] Although most policies envisage education as an ongoing process, except for some indications concerning the structures of the orientation process no information is provided regarding the fora in which it will be carried out.

1.5 *Preventive measures for prisoners*

In federal penitentiaries, condoms were made available on 1 January 1992. Each penitentiary has established its own system for making them available. These range from distributing condoms to every prisoner and leaving supplies of them in living units, to restricting distribution of them to prison health-care services. Dental dams are also made available to female prisoners.

Some provinces, including Alberta, British Columbia and Quebec, also started distributing condoms in 1992. In the Northwest Territories and in Yukon, condoms have been made available to prisoners for several years. According to submissions sent to ECAP in the fall of 1992, Manitoba was considering the issue, and in Ontario an announcement that condoms would be made available to prisoners was expected soon. In Saskatchewan, they are made available to an inmate only when he or she is approved for conjugal visits and requests condoms. In Newfoundland, Nova Scotia, Prince Edward Island and New Brunswick condoms are not made available. These provinces argue that since the average length of stay in provincial institutions is only 30 days, prisoners are less likely to engage in sexual relations and that condom distribution is therefore not necessary.

The provision of bleach and of clean needles is not mentioned in any of the policies. However, bleach is made available to inmates as a general cleaning agent in some institutions, for

[9] The new policy of the British Columbia Corrections Branch addresses these issues. According to this policy, all centre directors shall implement a comprehensive educational program for staff and inmates in conjunction with local health professionals. The Corrections Academy will provide complementary information on transmission control and preventive measures as part of recruit training.

[10] Some provinces have developed or are in the process of developing training materials on HIV/AIDS. In personal correspondence dated 26 March 1992, Nadine Cooper Mont, Deputy Solicitor General of Nova Scotia, indicated that Nova Scotia Correctional Services' Staff Training has developed such materials. In his submission to ECAP of 9 September 1992, Bruce Smith, Solicitor General of New Brunswick, indicated that an educational package for training of staff and inmates will be developed. Quebec's policy of 1 April 1992 contains a detailed plan of action for educational measures for both staff and inmates.

example in British Columbia, Yukon, Nova Scotia, and the Newfoundland and Labrador Youth Corrections.^[11]

1.6 *Protective measures for staff*

Policies generally go into great detail concerning the protective measures to be taken by staff to avoid contracting HIV/AIDS. They dictate that staff be supplied with the necessary protective equipment, and contain instructions concerning the proper methods for handling blood and other body fluids and for engaging in searches of inmates. All policies stress that every inmate should be treated as a potential carrier of HIV and that the precautions should accordingly be applied universally.

1.7 *Availability of and access to health care*

Prison policies on HIV/AIDS are generally silent on the topic of medical care. Only Ontario's and Newfoundland's policies comment that prisoners have the right to receive adequate medical care.^[12] Alberta's policy specifically provides that HIV-positive offenders with opportunistic infections should be registered with and under clinical supervision of the local STD clinic or infectious disease unit of a hospital. No policy refers to the provision of drug-treatment programs or to access to experimental HIV/AIDS therapies.

2. **International Policies**

The international community has developed a number of recommendations concerning HIV/AIDS in prisons, recommendations that stress the importance of preventing further transmission of HIV infection.

2.1 *World Health Organization*

WHO convened a meeting on prevention and control of AIDS in prisons in November 1987 that resulted in a formal WHO statement.²⁷ WHO stressed that "[c]ontrol and prevention of HIV infection must be viewed in the context of the need to improve significantly overall hygiene and

[11] In personal correspondence, dated 4 May 1992, Barry Lynden, Acting Program Analyst, Adult Institutional Services, Ministry of the Attorney General, Province of British Columbia, stated that "[b]leach is issued on the living units to our inmates as a cleansing agent" and that it "is diluted on a one part bleach to ten parts water basis". Elisabeth Lane, Superintendent of Correctional Services, Yukon, in personal communication of 11 May 1992 stated that inmates in Yukon have "informal access" to bleach. In her submission to ECAP, Nadine Cooper Mont, Deputy Solicitor General of Nova Scotia, stated that "bleach is not available for distribution to offenders for hygienic purposes" but that it was "used for cleaning purposes." In the submission to ECAP by Eric Gullage, Minister of Social Services of Newfoundland and Labrador, it is said that bleach is available on all units within the Newfoundland and Labrador Youth Corrections.

[12] In personal correspondence of 31 March 1992, Mr. Demers, Assistant Deputy Minister, Manitoba Justice - Corrections, stated that much of the medical services in Manitoba correctional centres are provided through part-time contracts with community clinics and that "we [Manitoba Justice - Corrections] expect the same level of care will be provided to inmates as is provided to non-inmates."

health facilities in prisons." It recognized that in many countries there "may be substantial numbers of prison inmates who have a history of high-risk behaviours, such as intravenous drug use [and] prostitution" and that "situational homosexual behaviour may occur." According to WHO, these considerations impose upon prison authorities a "special responsibility" to inform all prisoners of the risk of HIV infection from such behaviours. Many of the persons making up the prison population were thought to be "unlikely to have received such education in the general community." This corresponds with the view that prisons offer a window of opportunity for prevention of HIV transmission because a very large proportion of high-risk populations pass through them.²⁸ Most importantly, WHO guidelines state that the general principles adopted by national AIDS programs should apply as much to prisons as to the general community. The WHO statement recommended the adoption of prison policies that include, among others, the following provisions:

- prisoners should be treated in a manner similar to other members of the community, and have the same right of access to educational programs designed to minimize the spread of HIV infection;
- HIV-antibody testing should be available to prisoners and should comply with the same conditions that apply to testing of persons at liberty, i.e., consent, confidentiality of results, and pre- and post-test counselling;
- medical, nursing, inpatient and outpatient services of the same quality as those for AIDS patients in the community at large should be available to prisoners;
- prisoners with AIDS should be considered for compassionate early release;
- prisoners should not be subjected to discriminatory practices relating to HIV/AIDS, such as involuntary testing, segregation or isolation, "except when required for the prisoner's own well-being";
- consideration should be given to making condoms available, and the practicability of making sterile needles available "is worthy of further study."

At the time of writing, the WHO recommendations were being updated.

2.2 *United Nations*

The Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders in 1990 adopted a resolution on HIV/AIDS in prisons, stressing the need to address problems relating to HIV/AIDS in prisons. It recommended that member states take steps toward the development of a policy on AIDS prevention and control in prisons based on the WHO Global AIDS Strategy, as part of their national AIDS prevention and control strategy.

At the Interregional Meeting and regional meetings held in preparation for the Eighth Congress, the problem of HIV/AIDS in prisons, and more generally of prison health services, received attention. The Interregional Meeting, held in Vienna in 1988, concluded that "[a]t the most general level, ... humiliating or dehumanizing conditions could be equated with denying the inmates their basic human rights and with endangering their lives by exposing them, more so than in regular prison conditions, to AIDS and other communicable diseases."²⁹ At the African Regional Preparatory Meeting it was recognized that prisoners with AIDS should be treated, to the maximum extent possible, in the same manner as other inmates, that prevention and information programs should be developed, and that prisoners' aid associations could be very useful in providing community support for released prisoners with AIDS.³⁰ The Latin American

and Caribbean Regional Preparatory Meeting proposed basic principles for the treatment of prisoners, which included a proposition that "[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."³¹ Finally, the European Preparatory Meeting adopted the Rome Declaration, which includes detailed provisions on health care in the context of HIV/AIDS, and invites States to put into practice the following principles:

(a) To arrange for multi-disciplinary treatment of sick prisoners and to employ the services of specialized professional personnel; (b) To consider the human immunodeficiency virus, the acquired immunodeficiency syndrome, hepatitis and similar transmissible diseases as a growing public health issue concerning not only the wider community, but also the prison population and, in consequence, to provide information and encouragement to prisoners and staff to take the necessary measures to avoid the transmission of these diseases and, in the event of infection, to take the necessary measures to ensure their proper treatment including counselling; (c) To ensure that there is no discrimination on the grounds of infection.³²

2.3 *Council of Europe*

The Council of Europe has developed a health policy regarding HIV/AIDS in prisons. It specifically acknowledges that the occurrence of homosexual activities and injection drug use in prisons must be accepted as realities, and recommended that steps should be taken:

- to provide written information about the modes and consequences of HIV infection to prisoners;
- to make voluntary testing available to them;
- to ensure that HIV-infected prisoners are not isolated or segregated, provided they do not act irresponsibly;
- to transfer prisoners who have developed AIDS to specialized hospitals, and to permit release of fatally ill prisoners on humanitarian grounds;
- to ensure that hygiene and food in prisons are of such a standard as not to increase the risk of prisoners who are already HIV-infected developing AIDS;
- to make condoms available to prisoners;
- to prevent the illicit introduction of drugs and injection equipment into prisons, to offer help to drug addicts and to allow, in the last resort, clean, one-way syringes and clean needles to be made available to intravenous drug abusers in prison.³³

In a 1989 recommendation of the Council, national authorities were asked "to ensure that compulsory screening is not introduced ... for any given population group such as 'captive' populations, e.g. prisoners."³⁴

In 1990 the Select Committee of Experts on Criminological and Prison Aspects of the Control of Transmissible Diseases restated most of the previous recommendations, but went even further and recommended, among other things: that prisoners should be provided with a 0.5 percent solution of bleach; that alternatives to imprisonment should be proposed to persons dependent on drugs, with a view to encouraging them to receive treatment in health-care

institutions; and that, in general, prisoners should receive the same medical and psychosocial treatment as that given to other members of the community.³⁵

3. Policies of Other Countries

Information on policies, reports or documentation relating to the issues raised by HIV/AIDS and drug use in prisons was sent to ECAP by experts in the area of HIV/AIDS in prisons, many of whom are correspondents from the HIV/AIDS in Prisons Information Exchange Network managed by the University Institute of Legal Medicine, Geneva. ECAP requested information on the following:

1. copies of prison policies relating to HIV/AIDS and/or communicable diseases, including draft policies (where draft policies are considered confidential, this should be indicated so that such documents are disclosed only to the Committee);
2. provision of health services to the prison population, including access to treatment for drug use and provision of drug-treatment programs and access to experimental HIV/AIDS therapies for prisoners with HIV infection or AIDS;
3. educational programs about HIV/AIDS for inmates and for staff, including whether participation in them is mandatory or voluntary, their format, duration, and who delivers them;
4. housing of prisoners with HIV infection or AIDS, in particular whether they are housed among the general prison population or are segregated;
5. availability of condoms, including how long they have been available and how they are made available; if condoms are not yet available, is it planned to make them available, and if so, when;
6. availability of bleach, including how long it has been available and the purposes for which it is made available;
7. availability of clean needles and syringes, including whether consideration is being given to making them available and how this would be implemented;
8. testing of prisoners for antibodies to HIV, including whether testing is voluntary or mandatory, whether there is an explicit requirement for informed consent, whether pre- and post-test counselling is provided, and whether testing for antibodies to HIV is available at the request of prisoners;
9. confidentiality of medical information, including whether positive HIV test results are disclosed and to whom;
10. statistics on the number of prisoners with HIV infection or AIDS, including whether anonymous unlinked seroprevalence studies of persons admitted to correctional facilities have been undertaken or are planned;
11. policies regarding conjugal visits;
12. provisions for the early release of prisoners with AIDS;
13. names and addresses of groups or organizations in your country working with prisoners, in particular, prisoners with HIV infection or AIDS, or who have a history of drug use.

At the time of writing, ECAP had obtained responses to its request for information from Australia, Austria, Finland, France, Germany, Iceland, Ireland, Italy, the Netherlands, Portugal, Spain, Switzerland, the United Kingdom and the United States. The information received is being

reviewed and analyzed and will be supplemented with data from a survey of available literature undertaken at the McGill Centre. This analysis of prison policies will be included in the Committee's final report.

B. SURVEY OF CANADIAN CASE LAW AND PRECEDENTS^[13]

1. Complaints to Human Rights Commissions

1.1 *Ontario Human Rights Commission*

Many of the early complaints to the Ontario Human Rights Commission filed on the subject of HIV/AIDS have alleged unequal treatment of inmates with HIV infection or AIDS in Ontario correctional facilities. The general allegation is that, as a result of testing positive for antibodies to HIV, individuals have been removed from the general prison population and denied equal opportunity to eat, socialize and recreate with fellow inmates. The complaints have also alleged that inmates with HIV infection or AIDS have been subjected to humiliating treatment and demands, including being approached by guards wearing gloves, and have been forced to scrub showers and phones after using them. In addition, many inmates have complained of being denied essential medical and dietary requirements.³⁶

Following the adoption of a new policy on communicable diseases by the Ontario Ministry of Correctional Services in 1989, the Ontario Human Rights Commission expressed its hope that such discriminatory treatment of inmates with HIV infection or AIDS in Ontario would be eliminated and that "through the spirit of this policy better trained staff and inmates will be less likely to respond to infected inmates with fear and anger...".³⁷ However, the Commission's database shows that in 1991-92 there were four new complaints in which prisoners with HIV infection or AIDS alleged that they were receiving unequal treatment because of their HIV status.³⁸

1.2 *Quebec Human Rights Commission*

In Quebec, the provincial human rights commission on two occasions explicitly recommended that the minister responsible for the provincial prison system act without delay to guarantee that all HIV-infected inmates be treated in a manner appropriate to their physical condition. A policy on HIV/AIDS in prisons was adopted only on 1 April 1992.

In the case of *Sylvain A.*³⁹ the complainant, an inmate in a Montreal institution, was transferred to the institution's health-care unit after testing positive for HIV antibodies. He alleged that the transfer constituted inhumane treatment. He further alleged that detention of HIV-infected inmates in the health-care unit of the institution violated their right to physical integrity and that the increased exposure to viruses and microbes in the unit represented a great risk for these inmates. The complainant also reported that staff distanced themselves from HIV-infected inmates and that they "pointed them out with their fingers," thus disclosing their identity to everyone. Finally, the complainant maintained that he was refused the right to work and that he

^[13] Parts of the following survey were published in Hamblin J, Somerville MA, Gilmore N et al. *Responding to HIV/AIDS in Canada*. Toronto: Carswell, 1990.

was accorded only one hour of "daily outing," during which he was identified as HIV-infected by fellow prisoners and staff. The Quebec Human Rights Commission held that the transfer to the institution's health-care unit did not in itself constitute inhumane treatment, but that the complainant's right under s. 26 of the *Quebec Charter of Rights and Freedoms* to "distinct treatment" appropriate to his sex, age and physical and mental condition while in detention had been violated by his having been unduly exposed to the risk of contracting other diseases in the institution's health-care unit. The Commission also held that results of HIV tests had to remain confidential and that no exceptions should be made to this rule.

In the case of *Pierre M.*,⁴⁰ the inmate alleged that confidentiality had not been respected by the staff of the institution because his seropositivity was apparently known to everybody before he even arrived at the institution, that he had been isolated in the health-care unit from the day of his arrival at the institution, and that this isolation had meant "more difficult detention conditions" for him. In this case also, the Quebec Human Rights Commission concluded that the complainant had not received inhumane treatment, but that he had not received treatment appropriate to his physical condition.

2. Court Cases

The following cases are representative of some of the major issues that have arisen.

(1) In 1989 the Ontario District Court, in the case of *R. v. Downey*,⁴¹ stated that detention centres in Toronto were generally

failing to come to grips with this problem [the detention of people with HIV infection or AIDS], from two aspects: (a) providing facilities where such detainees may obtain adequate treatment; and (b) of educating staff and, in particular, guards as to not only the nature and extent of this disease ... but [also] what dangers, if any, it poses to the rest of the population of the detention centre and of the staff of the detention centre.

The Court had to decide whether to grant bail to an accused who had previously been denied it on the grounds that he had a long record of serious offences and was likely to commit further offences. One of the reasons advanced to support an order that the accused be released was that, five weeks after he was detained, he tested positive for antibodies to HIV. Additional tests indicated that he had developed disease associated with HIV infection. The Court found that the accused was not receiving adequate treatment for his disease. In particular, he was locked up virtually 24 hours a day, was the target of threats, and was not provided with an appropriate diet. The Court held that the accused had been subjected to cruel and unusual treatment, in violation of s. 12 of the *Canadian Charter of Rights and Freedoms*, which provides that everyone has the right not to be subjected to any cruel and unusual treatment or punishment. The Court ruled that the detention order be set aside and that the applicant be released on his own recognizance.

(2) In the case of *Ratte v. Kingston Penitentiary*,⁴² Mr. Ratte, a prisoner with HIV infection who had been put in solitary confinement, applied to be returned to the general prison population. The Ontario Court of Justice dismissed the application. Although it recognized that segregation or isolation of prisoners because of positive HIV status is generally unjustified, the Court held that Mr. Ratte was in isolation not because he was infected but because he was potentially dangerous to good order and discipline. According to correctional staff, he had once

"attempted to incite the range to riot" and on three occasions threatened to kill, bite or stab staff members. In other words, the Court held that isolation might be warranted not because of a prisoner's HIV infection but because of individual behaviour that could expose others to HIV.

(3) In the case of *R. v. McAllister*,⁴³ the matter for decision was whether the British Columbia Court of Appeal was entitled to reduce a sentence due to the circumstance that the trial judge had not known that the accused had AIDS. The Court of Appeal held that it was not possible on ordinary sentencing principles to say that the original sentence was unfit. It continued, however, by saying that the trial judge might have imposed a different sentence had he been made aware of the fact that the accused "was suffering from the disease [AIDS] which ... is almost invariably fatal." The Court of Appeal concluded that it was justified in reducing the sentence from five to three years.

(4) In the case of *R. v. Johnston*,⁴⁴ the fact that the accused had AIDS was taken into account in mitigation of the sentence.

(5) In the case of *R. v. Lesieur*,⁴⁵ the accused was incarcerated at Donnacona Maximum Security Institution in March 1992 when he assaulted penitentiary staff who were trying to restrain him in his cell. The inmate, who knew that he was HIV-positive, tried to bite staff. He then sprayed them with his blood, saying he would in this way contaminate and kill them. The inmate was charged with a number of offences, including attempted murder. On 17 February 1993, a jury returned a guilty verdict on charges of assaulting a peace officer, uttering threats to cause death or serious bodily harm, and assault causing bodily harm. Importantly, the inmate was found not guilty on the charge of attempted murder. The accused was sentenced to four years in prison.^[14]

3. *Complaints to the Public Service Staff Relations Board of Canada*

In *Walton v. Treasury Board (Correctional Services Canada)*,⁴⁶ the applicant, a correctional officer, refused to work with "certain inmates suspected of suffering from AIDS or Hepatitis B" on the ground that working with these inmates constituted a "danger" to his health. The claim was dismissed by a safety officer who concluded that no danger existed. At the applicant's request, the decision was referred to the Public Service Staff Relations Board. The Board partly denied and partly affirmed the safety officer's decision. With respect to the applicant's fear of AIDS, the Board held that there was no evidence that contacts of the kind feared by the applicant, i.e., having feces, urine, or semen thrown at him, or being spat upon or bitten by an HIV-infected inmate, were capable of leading to transmission of infection. However, the evidence indicated that hepatitis B could be transmitted through "casual contact." The Board concluded that hepatitis B, but not AIDS, constituted a danger to correctional officers. The employer was directed to offer correctional officers vaccination against hepatitis B and to counsel all correctional officers on the danger of contracting the disease.

[14] Similarly, in November 1992 another federal HIV-positive inmate was convicted of assault and sentenced to six months' imprisonment after he bit a correctional officer at Port-Cartier Institution.

C. RESULTS OF INMATE QUESTIONNAIRE

A copy of the questionnaire sent to the inmate committees is included in this Working Paper as Appendix 2. Responses to the questionnaire are currently being analyzed, and the results of this analysis will be published in the Committee's final report.

D. RESULTS OF STAFF QUESTIONNAIRE

A copy of the staff questionnaire is included in this Working Paper as Appendix 3. ECAP is presently receiving responses to the questionnaire. They will be analyzed in May and the results will be published in the Committee's final report.

E. SUBMISSIONS AND CORRESPONDENCE

ECAP has received numerous submissions from agencies, groups and individuals, and has attempted to address many of the issues raised in these submissions in this Working Paper. However, a more comprehensive analysis of submissions received, including a list of them, will be included in the Committee's final report.

IV. ANALYSIS OF ISSUES AND POSSIBLE SOLUTIONS

1. SEROPREVALENCE STUDIES

A. Current Situation

The number of prisoners with HIV infection or AIDS in federal penitentiaries is unknown, since there has thus far been no widespread testing of prisoners for HIV infection.^[15] To date, only two studies have been carried out in Quebec provincial institutions to determine behavioural risk factors and levels of infection in inmate populations.

The first study was undertaken in a medium-security prison for women in Montreal.⁴⁷ Of 321 participants, 23 (7.2 percent) were HIV-positive and 160 (49.8 percent) reported injection drug use.⁴⁸ Of 130 participants, 108 (83.7 percent) had loaned or borrowed needles and 56 (51.9 percent) had done so with strangers. Thirteen (10.2 percent) reported having shared needles with an HIV-infected person.⁴⁹ Of 321 participants, 78 (24.4 percent) indicated prostitution as their main source of income just prior to incarceration, and 82 percent of the latter reported using injection drugs prior to incarceration. Among injection drug users who indicated prostitution as their main source of income, 10 of 60 (16.7 percent) were HIV-infected compared with 11 of 100 injection drug users who did not engage in prostitution. All prostitutes who were not injection drug users were found to be HIV-negative. Nonsterile injection drug-use practices and unprotected sexual activity with an injection drug user were found to be the strongest risk factors for HIV infection.

The second study, of risk factors for HIV infection among incarcerated men, has been underway in two provincial correctional institutions in Quebec since January 1990. Of 588 participants, 21 (3.6 percent) were HIV-positive. Of 490 participants, 237 had a history of injection drug use and of these 18 (7.6 percent) were HIV-infected. Of the 253 participants with no history of injection drug use, only one (0.4 percent) was HIV-infected.⁵⁰

The extent to which participants in these studies are representative of the total inmate population of the institutions is not known.^[16] It has also been claimed that there are

[15] At the time of writing (February 1993), an HIV seroprevalence surveillance research project was being implemented at Joyceville Penitentiary. "An Anonymous Unlinked Study of the Prevalence of HIV Infection by Screening Urine Samples Obtained from Persons Admitted to Ontario's Jails and Detention Centres" was proposed in 1992 by Dr. Liviana Calzavara, Department of Preventive Medicine and Biostatistics, Faculty of Medicine, University of Toronto, and was underway at the time of writing. The objective of this study is to screen approximately 13,000 urine specimens collected from prisoners for other purposes. The specimens are routinely collected as part of medical care when these individuals are admitted to Ontario jails and detention centres. The study proposes to measure the prevalence of HIV infection in a sample of female and male adults and adolescents admitted over a period of two to six months (correspondence from Dr. Calzavara, dated 14 September 1992). In April 1992 the British Columbia Corrections Branch conducted a short-term saliva-testing project at the Surrey Pretrial Services Centre. Participation was voluntary. At the time of writing, a voluntary testing program was being run at all regional correctional centres in the province. Results of the testing are expected to be available in 1993.

[16] In the women's study, however, analysis revealed no difference between participants and eligible non-participants with respect to age, educational level, language and length of sentence.

differences in seroprevalence between federal and provincial inmate populations and that it would be misleading to link the seroprevalence rates estimated from the Quebec study with any expected rates at the federal level.⁵¹ In particular, it has been said that the first study consisted of an "exclusively female inmate population in an area of Quebec, which ... is heavily overrepresented by prostitutes and drug addicts."⁵² To this, Dr. Hankins, who undertook the Quebec studies, replied by saying that "[i]t has not been established whether provincial or federal prisons are more likely to incarcerate individuals at higher risk for HIV infection" and that "[r]ecent studies in the U.S. indicate that seroprevalence rates do not differ significantly between jails and prisons based on same-state jail-prison comparisons."⁵³

Regardless of whether there are significant differences in seroprevalence between federal and provincial inmates, the Quebec studies suggest that the problem of HIV/AIDS in Canadian prisons, including federal penitentiaries and regardless of gender, may be more widespread than has previously been thought.⁵⁴

As of August 1992, 154 cases of HIV infection or AIDS had been identified in the federal prison system since 1985. During the month of August 1992, 65 federal prisoners among approximately 13,000 were known to be infected with HIV.⁵⁵ These official data suggest an infection rate of one in every 200 inmates (0.5 percent). However, it has been claimed that it is more likely that the number of individuals with HIV infection in federal penitentiaries is closer to one in 20 than to one in 200.⁵⁶ This would be consistent with the findings of the Parliamentary Ad Hoc Committee on AIDS. In a report issued in 1990, the Committee suggested that "the actual number [of inmates with HIV infection or AIDS] must be so vastly different [from the official statistics] as to make these statistics a mockery."⁵⁷ On the other hand, estimates that up to 15 percent of the inmate population of federal penitentiaries may be infected⁵⁸ are unproven.

Internationally, particularly high rates have been reported from countries in southern Europe; for example, 26 percent in Spain and 17 percent in Italy.⁵⁹ High figures have also been reported from France (13 percent; testing of 500 consecutive entries), Switzerland (11 percent; cross-sectional study in five prisons in the Canton of Berne) and the Netherlands (11 percent; screening of a sample of prisoners in Amsterdam).⁶⁰ In the United States, the geographic distribution of cases of HIV infection and AIDS is remarkably uneven. Many systems continue to have rates under one percent, while in a few, such as New York City or New York State, rates approach or exceed 20 percent.⁶¹ For example, in New York State an estimated 17 to 20 percent, or approximately 9,000 of the state's 54,000 inmates, are HIV-positive.⁶² In contrast, some European countries, including Belgium, Finland, Iceland and some Länder in Germany, report low levels of HIV prevalence.⁶³ Low rates of HIV prevalence, ranging from zero to 2.9 percent, were also reported from Australia.⁶⁴ In general, caution must be exercised in comparing and interpreting the data from different countries because of the different methodologies used (e.g., mandatory testing of the entire prison population, screening of only those inmates who have engaged in so-called high-risk activities, voluntary testing). However, these studies have consistently shown higher rates of HIV infection than in non-incarcerated populations.⁶⁵ Further, these studies have shown that the prevalence of HIV in the prison population is, in general, closely related to the proportion of those injecting drugs prior to imprisonment and to the rate of HIV infection among injection drug users in that community.⁶⁶ For example, a study in northern Italy that compared prisoners who were injection drug users with prisoners who had no known risk factors for HIV infection found that 36.3 percent of the injection drug users were HIV-positive, compared to 7.9 percent of the others.⁶⁷ A study of

prisoners in one prison in France who were injection drug users found that 61 percent were HIV-positive.⁶⁸ Similarly, the first study of HIV risk behaviour and HIV prevalence among ex-prisoners in England revealed an overall HIV prevalence rate of 5 percent, but among female injection drug users HIV prevalence was 15.5 percent and among male injection drug users 7.7 percent.⁶⁹ In the United States, the jurisdictions with the highest HIV prevalence in prisons are areas where HIV infection in the general community is "pervasive among IV drug users, who are dramatically over-represented in correctional institutions."⁷⁰ Commenting on this situation, the U.S. National Commission on AIDS stated:

By choosing mass imprisonment as the federal and state governments' response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection.⁷¹

In Canada, needle exchanges have been established in major cities at a time when in many cities rates of infection among injection drug users were still relatively low. They seem to have been successful in reducing the spread of HIV infection among this population and have also provided it with education and facilitated access to numerous support services. Since injection drug users constitute by far the largest group of infected inmates, the relatively lower rates of HIV prevalence among injection drug users in Canada, compared with some European countries and some jurisdictions in the United States, suggests that the prevalence of HIV infection among inmates will also be lower. It further suggests that the establishment of needle distribution schemes outside prisons has been one of the major contributions to preventing the spread of HIV infection in prisons. Funded by Health and Welfare Canada, evaluation of Canadian needle exchange programs is underway and results will be available in June 1993 (see also *infra*, chapter IV, section 6.3, at B(2)(iii)).

B. The Debate

The necessity of undertaking studies on the prevalence of HIV infection in prisons has been the subject of extensive debate in Canada. In 1990 the Parliamentary Ad Hoc Committee on AIDS recommended "that the Department of National Health and Welfare, in cooperation with the Correctional Service of Canada, immediately set up a pilot study, using unlinked seroprevalence survey techniques, and with appropriate ethical safeguards, to assess the level of HIV infection in federal prisons."⁷² At the time, the Commissioner of the Correctional Service acknowledged and lamented the lack of information on which to base an extensive HIV/AIDS prison policy, saying that he "did not have any hard information on the extent of HIV infection in the prisons."⁷³ However, he also suggested that it would not be possible to gather such information and that any attempt to do so would raise legal and ethical questions. To this the Ad Hoc Committee responded that "unlinked testing using left-over samples, which would bear no information identifying any particular inmate, would give us some reliable knowledge about the prevalence of HIV infection in the penal system" and that "[t]he same sort of testing using blood from incoming inmates, and from those being released, would give us a picture of how much infection was being incurred inside the prisons."⁷⁴ A study conducted in 1990 to assess the feasibility of scientifically estimating HIV prevalence and related risk behaviour among inmates found that this was not only technically but ethically feasible.⁷⁵

CSC has expressed the concern that conducting seroprevalence studies "might further stigmatize an already stigmatized population and, as well, raise contentious ethical considerations."⁷⁶ At the time of writing, a seroprevalence study was being undertaken at Joyceville Penitentiary. This is in accordance with the recommendation made by the Ontario Regional HIV/AIDS Advisory Committee to carry out a pilot study in a single penitentiary "to allow evaluation of the problems that might occur and to give an idea of the results that might be obtained in a larger study."⁷⁷

The Federal/Provincial/Territorial Advisory Committee on AIDS recommended that "[h]ealth departments and the Solicitor General consider cost-shared commissioned research, within the context of available resources, specifically in the areas of a) surveys of knowledge, attitudes and behaviour; and b) HIV-prevalence surveys."⁷⁸

Dr. Hankins, in her submission to ECAP, also strongly supports undertaking seroprevalence studies. She argues that "[u]ntil studies are done to determine the true prevalence of HIV-1 infection among individuals incarcerated in federal institutions in Canada, claims that there are differences in seroprevalence between federal and provincial inmate populations cannot be validated."⁷⁹ She further argues that, if seroprevalence studies are not undertaken, "no clear picture of the extent and seriousness of the HIV epidemic in federal prisons can be obtained" and that "[i]n the absence of this information, policy development, resource allocation, and the evaluation of effective interventions, both prison and community-based, are severely impeded."

However, this view is not universally accepted. In its brief to the Ontario Ministers of Correctional Services and of Health, the Prisoners with AIDS/HIV Support Action Network (PASAN) stated that "[w]e do not need HIV seroprevalence studies to know that HIV/AIDS is threatening prisoners' lives."⁸⁰ PASAN pointed out that "[t]he HIV/AIDS epidemic is known to be raging in prisons elsewhere"⁸¹ and that therefore Canadian authorities should be aware that there is at least a possibility of an HIV/AIDS epidemic among Canadian prisoners. PASAN concluded that although "[t]here are some legitimate reasons for HIV testing ... in these times of economic restraint, HIV sero-prevalence studies may not be the wisest use of severely limited funds."⁸² It added that "[t]horough HIV testing of inmates would be a very time-consuming and expensive procedure, using money that would be better spent improving the care of and services to prisoners with HIV/AIDS."⁸³ PASAN also expressed its concern that, given the problems with current testing programs in prisons, most HIV-seroprevalence studies would be unethical since the established ethical guidelines for such studies⁸⁴ require that universal access to confidential HIV-antibody testing be in place before a seroprevalence study is undertaken.⁸⁵

C. ECAP's Assessment

ECAP considers that the most important response to the problem of HIV infection and AIDS in Canadian penitentiaries is to increase efforts to protect inmates and staff, promote their health, and prevent transmission of HIV and other infectious agents within these institutions. These efforts may include, among others, increased and more effective education about HIV/AIDS and about drug use for both inmates and staff, better inmate access to condoms and to bleach, and increased efforts to provide staff with the ability to protect themselves from HIV transmission. These initiatives are discussed in detail below and, without exception, need to be undertaken regardless of HIV seroprevalence in correctional facilities. At the same time, ECAP acknowledges that resource allocation and evaluation of the effectiveness of interventions may be rendered more

difficult in the absence of seroprevalence studies. However, the benefits of repeated testing programs that would facilitate decision-making on resource allocation and allow better evaluation of the interventions that are undertaken would not seem to justify their relatively high costs. ECAP is concerned that seroprevalence studies may be expensive and may divert resources from, or delay efforts to, protect inmates and staff, and considers them unnecessary to the implementation of these efforts. Further, ECAP is concerned about the limitations of such studies. They provide point seroprevalence data (that is, a "snapshot" of the situation) and their usefulness may be limited because of confounding variables such as inmate turnover and differences among institutions. Keeping these limitations in mind, the results of the seroprevalence study currently underway at Joyceville Institution and careful evaluation of this project will help to establish whether additional studies need to be undertaken. If additional studies are undertaken, they should be cost-effective, carried out under strict adherence to established ethical guidelines,⁸⁶ and be preceded by extensive consultation with inmates, community groups and independent experts.

D. Conclusions

ECAP acknowledges the potential utility of HIV-seroprevalence studies of inmates in federal correctional institutions. However, such studies may be expensive, may divert resources from or delay efforts to prevent the transmission of HIV and other infectious agents in correctional institutions, and are not necessary for the implementation of these efforts.

ECAP considers that such studies should not be undertaken until the seroprevalence studies underway or planned in Canadian correctional institutions have been carefully evaluated, and then only when they are cost-effective, strictly adhere to established ethical guidelines, and are preceded by extensive consultation with inmates, community groups and independent experts.

2. TESTING FOR HIV INFECTION

A. Current Situation

Paragraphs 9 through 13 of Commissioner's Directive 821, Management of Inmates with Human Immunodeficiency Virus (HIV) Infections, read as follows:

9. Inmates, upon entrance into the correctional system or during incarceration, shall not be routinely screened for presence of antibodies to HIV.
10. HIV antibody testing shall be governed by the criteria for valid consent, as outlined in Commissioner's Directive No. 803, entitled Consent to Medical, Dental or Psychiatric Treatment.
11. Inmates wishing to be tested may make their request to the institutional physician. The institutional physician shall determine if testing is indicated, based on the need to confirm physical examination or laboratory studies suggestive of HIV infection. Requests for testing from inmates with a history of high risk activities associated with HIV infection shall be carried out at the discretion of the institutional physician.
12. All testing shall be preceded by a period of counselling by health care staff regarding the possible implications of the test and test results.
13. Following testing, HIV seropositive inmates shall receive counselling from medical staff and shall have access to the full range of available institutional and community counselling services.

In accordance with this policy, testing for HIV infection in Canadian penitentiaries is undertaken only voluntarily—that is, with the informed consent of the inmate. This is consistent with the general principle governing HIV-antibody testing in Canada, according to which "HIV antibody testing should only be done when voluntary, that is with informed consent ..."87[17] It is also consistent with provincial prison policies and practice. In contrast, mandatory testing is still widely practised in prisons in the United States—although, paradoxically, mainly in areas of low HIV prevalence.⁸⁸ Some states have recently abandoned such testing, whereas others limit

[17] However, this principle also requires that testing only be done when confidentiality of results or anonymity of testing can be guaranteed. The full text of the principle is as follows:

HIV antibody testing should only be done when voluntary, that is with informed consent, and when counselling and education before and following testing are available and offered, and when confidentiality of results or anonymity of testing can be guaranteed.

The issue of confidentiality of results is addressed below.

testing to so-called risk groups. In Europe, mandatory testing has now been abandoned in nearly all countries and steps have been taken to reinforce the confidentiality of voluntary test results.⁸⁹

In Canada, involuntary testing of inmates for HIV infection is deemed "unwarranted."⁹⁰ It is agreed that it would not be consistent with the provisions of the *Canadian Charter of Rights and Freedoms*. In this regard, the prison policy of Newfoundland and Labrador explicitly says:

No person may be forced to submit to an HIV Antibody test. Such a test may only be administered by a medical professional if the patient provides informed consent. Any attempt to coerce an inmate to submit to the test in the absence of consent may not only be a violation of fundamental human rights under the *Charter of Rights* (the right to "life, liberty and security of the person" and the right to be "secure against unreasonable search or seizure") but may also be regarded as an offence under the *Criminal Code*.⁹¹

It was in the prison setting that the *Charter* was first used to declare invalid a pilot project that involved mandatory drug testing. In *Re Dion and the Queen*⁹² it was found that random demands for urine samples to detect drug use violated the inmate's rights to life, liberty and security under section 7 of the *Charter*. Because there was no requirement that there be reasonable and probable grounds for demanding a sample, the power was held to be arbitrary and thus contrary to the principles of fundamental justice under section 1 of the *Charter*.⁹³ Similarly, in the case of *Jackson v. Joyceville Penitentiary*,⁹⁴ mandatory urine testing for drugs and alcohol in federal prisons was struck down by the Federal Court as a violation of sections 7 and 8 of the *Charter*.^[18] The principles underlying these decisions would also be relevant to an HIV-antibody testing program.⁹⁵

B. The Debate

At a seminar on HIV/AIDS in Prisons at the 6th Annual British Columbia AIDS Conference, Michael Linhart, a federal inmate with HIV infection, stated that "[m]any prisoners who have suspected they may be HIV positive have refused to be tested because they fear being isolated and ostracized."⁹⁶ Linhart summarized the questions prisoners have when they are considering being tested for antibodies to HIV as follows:

- 1) Would I be isolated and subjected to the same kind of inhumane treatment I had seen on W5 [a news-documentary television program]?
- 2) With a positive diagnosis would I be able to transfer to other institutions?

[18] According to ss. 54-56 of the recent *Corrections and Conditional Release Act*, CSC may carry out urinalysis when there are reasonable grounds to believe an offender has consumed drugs or alcohol. It is required for participation in a substance-abuse program or activity involving community contact and when an offender is on conditional release on condition that he or she abstain from alcohol or other drugs. Further, urinalysis may be carried out when it is part of a random check process in which every offender has an equal chance of being selected. The constitutional validity of this provision remains to be established.

- 3) How would I be received by other inmates if they knew I was positive? Would I be subjected to verbal or physical abuse, or both?
- 4) What about medical treatment? Would I be provided with knowledgeable doctors and have access to new treatments and medications being developed?
- 5) Was it really possible to keep my diagnosis confidential, or could I expect to hear from staff and inmates alike that they knew?
- 6) What kind of support would I be provided with?
- 7) What would happen to me if the virus was to become an immediate threat to my life?
- 8) Why doesn't the Correctional Service ensure that prisoners know what they can expect if they test positive for the HIV virus?
- 9) What will the Correctional Service do in the future to ensure that my needs will be met?

To encourage prisoners to be tested in prison and to ensure the confidentiality of test results, it has been widely recommended that testing be carried out by outside health services such as community clinics.⁹⁷ For example, PASAN stated that inmates would be "more likely to trust a counsellor from a community-based agency, with whom they would not have to worry about a breach of confidentiality" and that "[a] 'safe' testing environment would likely lead to more inmates choosing to be tested and would therefore allow inmates to avail themselves of information, counselling, and treatment to delay the onset of HIV-related illnesses."⁹⁸ In addition, PASAN argued that permitting "outside" workers to offer counselling and testing in prisons would increase prison security because "[s]taff would feel protected by an informed population who begin to change their behaviour voluntarily."⁹⁹ Similarly, the Federal/Provincial/Territorial Advisory Committee on AIDS recommended that all residents/inmates have access to "counselling and testing for HIV infection on resident/inmate request, with confidentiality of results and ongoing psychosocial support from appropriately trained persons acceptable to the resident/inmate."¹⁰⁰

It has further been recommended that offenders should have access to anonymous testing.¹⁰¹

[S]ome individuals at risk of HIV infection are reluctant to be tested. They are concerned that their names will be reported to the public health system, and they fear discrimination and loss of privacy. Anonymous testing is intended to remove these barriers and encourage people at risk of HIV infection to come forward for testing and receive the medical and social services they require.¹⁰²

Anonymous testing is available to people outside prisons in most provinces. It is also available to prisoners in some provincial prisons in Quebec. In the Toronto Jail, educational programs and screening for sexually transmitted diseases are provided by a community health clinic, the Hassle Free Clinic. Counsellors at the Clinic have stated that they are prepared to conduct anonymous HIV testing inside Toronto-area jails and suggested that "outside" workers go into prisons to schedule appointments, provide counselling, take blood samples and communicate test results.¹⁰³ The perceived advantages of, and the experiences in prisons with, testing that is not nominal have been summarized as follows:

Providing voluntary testing and counselling services can be cost effective and can simplify resource planning. Since the goal of testing is not to identify infected inmates for the purposes of segregation but rather to inform both non-infected and infected inmates of their results in order to assist them in adopting safer behaviours, the best programme will be the one which provides maximum encouragement to come forward for testing. In the Quebec experience, this has been a non-nominal testing service based on the principle that the control of information regarding serological status and the decision to initiate medical and psychological follow-up resides with the inmate himself or herself. The acceptability of this approach was evident from the continual demand for HIV antibody testing and counselling services from inmates as well as from correctional staff both during the study and after termination. ... The non-nominal approach, which has been so successful in Quebec, allows for serological results to be identified by a code number only. On presentation of their personal code number, consenting inmates can learn of their results but no information concerning either their risk behaviour or serostatus is provided to the prison health service or the administration. Prisoners have an option to learn of their results while incarcerated or just before release, or not at all. During post-test counselling, alternatives for medical and psychological follow-up can be discussed and appropriate referrals arranged upon request. This non-nominal testing approach is available to Canadians on the outside at anonymous testing sites.^{104[19]}

C. ECAP's Assessment

ECAP commends CSC for its policy and practice of undertaking testing for HIV infection only when it is voluntary—that is, with the informed consent of the inmate—and for providing pre- as well as post-test counselling. However, ECAP was frequently told that a considerable number of inmates do not seek to be tested while in prison. There may be three reasons for this:

(1) Inmates' access to testing

Whereas people outside prisons have universal access to testing, testing of inmates in federal penitentiaries was initially carried out at the discretion of the institutional physician, and this resulted in more limited access to testing. This concern has been addressed, at least in part, by making testing available at the inmate's request. This practice is reflected in a revised version of

[19] To avoid confusion between non-nominal and anonymous testing, the following definitions are reproduced here. Non-nominal testing is "testing in which results can be linked to the person being tested by a code (which does not include personal identification of the person being tested), known by the person being tested. The physician also knows the identity of the person being tested." Anonymous testing is "testing in which results can be linked to the patient by a code known only by the patient; the physician, etc. cannot know the identity of the person being tested." See Human Immunodeficiency Virus Antibody Testing in Canada. Recommendations of the National Advisory Committee on AIDS. *Canada Diseases Weekly Report* 1989; 15-8:37-47 at 43.

Commissioner's Directive 821 (pending approval). Paragraphs 9 through 12 of this Directive read as follows:

9. Inmates shall be offered testing for the presence of antibodies to HIV, but shall not be routinely screened.
10. HIV antibody testing shall be governed by the criteria for valid consent, as outlined in Commissioner's Directive No. 803, entitled Consent to Medical, Dental or Psychiatric Treatment.
11. All testing shall be preceded by a period of counselling by health care staff regarding the possible implications of the test and test results.
12. Following testing, HIV seropositive and seronegative inmates shall receive counselling from health care staff and shall have access to the full range of available institutional and community counselling services.

While in theory inmates now have better access to testing, ECAP found that in practice HIV testing on entry into the prison system is sometimes discussed only with inmates who acknowledge having engaged in so-called high-risk activities. As a result, some inmates may not be aware that HIV testing is available to them at their request on entry and while they are incarcerated. This situation could easily be corrected by discussing testing with all inmates on entry and informing them that testing is available, at their request, during incarceration.

(2) Confidentiality of test results

Many prisoners have expressed reluctance to be tested for antibodies to HIV in prison because of concern that test results will not remain confidential. This was confirmed by the preliminary results of the questionnaire that ECAP sent to inmate committees in federal institutions. It is also consistent with the findings of the Parliamentary Ad Hoc Committee on AIDS, which stated that the "most likely reason for the low number of inmates identified as HIV-positive in the federal prison system is the complete lack of confidence that most inmates appear to have in the confidentiality of prison health services" and that "many [inmates] have undoubtedly waited until they were released to be tested."¹⁰⁵

In view of the sensitive nature of personal information relating to HIV infection and of inmates' fear that such information may not remain confidential and their reluctance to seek HIV testing, ECAP feels that alternatives to HIV testing carried out by medical personnel belonging to prison health services would reassure inmates and reduce their fears while encouraging them to seek such testing. In particular, ECAP was impressed by the results of the anonymous testing program in some provincial prisons in Quebec, which is carried out by outside community health clinics. ECAP strongly believes that giving inmates access to HIV testing from such health-care personnel as primary-care or community clinic staff who are independent of CSC, will encourage inmates to be tested and will allow them to seek care, support and treatment. ECAP further believes that anonymous HIV testing should be accessible to all inmates. Studies have often shown higher rates of HIV infection among people seeking anonymous testing. This indicates that many people who consider themselves at risk of having contracted HIV infection prefer this

option, which guarantees the confidentiality of their medical information. Making anonymous testing accessible is also widely supported by the preliminary results of the questionnaire for inmate committees.

(3) *Discrimination*

ECAP feels that fear of discrimination by fellow inmates or by staff might be greatly reduced and that inmates would be encouraged to seek testing if testing were undertaken by health-care personnel independent of CSC, and if anonymous testing were accessible to inmates.

D. **Conclusions**

ECAP agrees that, as is the case with testing outside correctional institutions, testing should be readily accessible to all inmates in federal correctional institutions at their own request. Such testing should always be voluntary—with the express consent of the inmate—and should always be accompanied by counselling and education before and following testing. Further, ECAP considers

(1) that all inmates should be made aware that such testing is available, in particular on entry into prison, but also while in custody and regardless of whether they have or have not been exposed to HIV (i.e., have engaged in "high-risk activities");

(2) that all inmates should have access to HIV testing from CSC health-care personnel as well as from primary-care or community clinic personnel who are independent of CSC; and

(3) that all inmates should have access to anonymous HIV testing.

3. OFFENDER MEDICAL INFORMATION

A question closely related to that of testing of inmates for antibodies to HIV is that of confidentiality and disclosure of offender medical information.

A. Current Situation

(1) *Protecting confidentiality and preventing discrimination*

In the context of federal prisons, Commissioner's Directives expressly affirm the confidentiality of offender medical information. These Directives state:

Offenders have the same rights to confidentiality of information obtained by a health care professional as exists in the general community. [CD 835.12]

All diagnosis of HIV infection shall be noted on the problem sheet of the medical record. Once informed, health care staff shall comply with Commissioner's Directive No. 835 which governs the confidentiality and disclosure of any information obtained by a health professional. [CD 821.19]

Upon transfer to parole jurisdiction, health care staff shall, with the inmate's consent, ensure that arrangements have been made for follow-up with an appropriately qualified community physician. [CD 821.20]

The HIV status of an inmate is medical confidential [sic]. This information shall not be released to supervisory/agency staff without the inmate's consent. [CD 821.21]

(2) *Disclosure of medical information*

The confidentiality of offender medical information is not considered to be absolute. With regard to disclosure of this information, the Commissioner's Directives state:

[I]t is the responsibility of a health care professional, when there is reasonable cause to believe that the offender's intentions or possible actions may constitute a threat to the safety of him/herself or others, to provide information to the appropriate personnel without the offender's consent. [CD 835.12]

[I]f there is cause to believe that an offender's actions may constitute a danger to himself or others, and in accordance with the Privacy Act, health care staff shall provide information to the appropriate personnel without the offender's consent. [CD 821.21]

B. The Debate

From the foregoing, it is clear that a general principle of confidentiality of personal medical information—namely that such information is confidential between the person and the person's medical practitioner—applies to the personal medical information of offenders in the correctional

system. This means that disclosure of this information without the offender's consent is unwarranted unless it is authorized by law and is ethically justified.

The text that follows examines two aspects of the confidentiality of the personal medical information of offenders. First, because CSC Directives do not address this issue, what measures could be taken to protect this information? Second, recognizing that the right to confidentiality is not absolute and that disclosure of inmates' medical information may sometimes be justified, the issue of disclosure is also addressed. The issue of disclosure of personal medical information has been analyzed in detail by ECAP, and this analysis is included in the Working Paper as Appendix 1, "Disclosure of Offender Medical Information: A Legal and Ethical Analysis." "Disclosure of Offender Medical Information" examines, first, whether or not medical information pertaining to federal inmates—information that is considered confidential between inmate and medical staff—may be disclosed absent the inmate's consent. Second, it examines what conditions or criteria determine whether or not disclosure would be legally and ethically justifiable, and what conditions apply to disclosure when it is justified. Third, it examines specific situations in which a claim for disclosure may arise. Some of its findings are presented briefly in the following text.

(1) *Protecting confidentiality and preventing discrimination*

The National Advisory Committee on AIDS ("NAC-AIDS") recently recommended that the confidentiality of all HIV-related information in correctional facilities be strictly maintained, for two reasons. First, NAC-AIDS was concerned that, if the confidentiality of this information was violated, infected inmates would be placed at considerable risk of discrimination and would likely have to be removed from the general inmate population. Second, NAC-AIDS found that "there is no reason for this information to be made available either to other inmates or to the non-medical staff of the correctional facilities." Consequently, NAC-AIDS recommended that the Solicitor General implement additional measures to secure the confidentiality of all HIV-related information in correctional facilities. In particular, NAC-AIDS felt that it was necessary "to provide for disciplinary action against any employees found in violation of HIV-related confidentiality provisions."¹⁰⁶

The Federal/Provincial/Territorial Advisory Committee on AIDS recommended that all inmates in federal penitentiaries have access to "counselling and testing for HIV infection on ... inmate request, with confidentiality of results."¹⁰⁷

PASAN stated that "[t]he confidentiality of all prisoners' HIV-antibody status (whether positive or negative) must be respected" and that "[s]taff members who break the confidentiality of prisoners should be disciplined and/or fired."¹⁰⁸ PASAN further recommended:

Staff must be trained to protect the privacy of inmates' medical data. Work rules prohibiting release of HIV-related information must be strictly enforced. An HIV-positive prisoner should be consulted and his or her consent must be obtained before medical information is given to prison authorities or support workers. ... Prison administrators and staff should have access to the HIV-antibody status of prisoners only when it is absolutely necessary and with consent. When this information is shared, it must be held in the strictest confidence. This policy and the penalties for breaking it must be made widely known in the prison community, among both staff and inmates.¹⁰⁹

In Australia, the New South Wales Anti-Discrimination Board recommended that "[p]rocedures for the protection of confidentiality regarding the HIV status of any inmate should be established in every custodial institution, and breaches of confidentiality should be dealt with as breaches of discipline under the relevant legislation."¹¹⁰ One practical example of how confidential medical information is protected was given by Peter Harmsworth, Director-General of the Office of Corrections in Victoria:

It is difficult to maintain the community standard with respect to confidentiality and HIV infection within prisons. However, it is essential that the principle not be ignored. In Victoria, all HIV tests and the results are coded and the coded results are sent direct to the Medical Superintendent by Fairfield Hospital. The policy of moving prisoners to the Pentridge Hospital and then to K Division means that total confidentiality cannot be achieved. However all steps are taken to ensure that information relating to HIV positive status is restricted, and, as much as possible HIV positive prisoners are accorded the rights of confidentiality stipulated under legislation.¹¹¹

In the United States, the National Commission on AIDS recommended that staff should be trained to protect the privacy of inmate medical data and that work rules prohibiting release of HIV-related information should be strictly enforced.¹¹² Similarly, the proposed HIV Policy for the District of Columbia Department of Corrections establishes strict rules for the protection against disclosure of medical records. In particular, the policy states that "[a]ny unauthorized disclosure of medical records by DOC [District of Columbia] staff will result in immediate disciplinary proceedings," that "[p]ossession of prisoner medical records by unauthorized DOC staffpersons will result in an automatic unpaid suspension" and that "[d]isclosure of information contained in prisoner medical records to another unauthorized staffperson or to another prisoner will result in termination of employment."¹¹³ In addition, the policy states:

To protect prisoner records from unlawful disclosure, all information identifying a prisoner as HIV positive will be contained in the prisoner's medical files. All prisoner medical files will be immediately identifiable as medical files; they will be conspicuously colored and sealable. All such files will be stored in locked file cabinets, and access to any prisoner's file will be limited to the following categories of individuals:

The DOC medical, dental, or mental health staff person(s) directly responsible for providing care to that prisoner;

A consulting specialist or outside health care provider to whom the prisoner is referred for treatment or evaluation; or

Specifically identified individuals to whom the prisoner has permitted disclosure after providing written, informed consent.

Medical staff will not examine or question a prisoner about HIV-related issues or discuss the HIV-related health care status of a prisoner, without his or her consent, while in the presence or earshot of other prisoners or DOC staff who are not directly providing HIV-related care to the prisoner.

(2) *Disclosure of medical information*

Staff in federal penitentiaries have often claimed that they "need to know" the HIV status of infected inmates in order to take adequate precautions to protect themselves and their families. In particular, some staff have maintained that the use of "universal precautions" is not practical and that it is unrealistic to believe that protective measures that can prevent HIV transmission in penitentiaries can be applied universally. They have also argued that knowing a particular inmate is HIV-infected would protect them because they would then handle the known infected offender with increased caution. It has also been claimed that:

- health care staff may disclose medical information to a staff member or to an inmate who has suffered a significant exposure to bodily fluids or blood of an inmate who is HIV positive or infected with hepatitis B;
- health care staff may share information about an inmate's HIV or hepatitis B status with the warden of the institution, or may even be required to do so;
- the HIV status of an offender may be released to a case management officer or parole officer without the offender's consent; and that
- a parole officer may release information about an offender's HIV status to community authorities without the offender's consent.¹¹⁴

In the opinion of the Privacy Commissioner,

there may be a merit in a policy that allows disclosure where an infected inmate's conduct threatens others (for example, through unsafe sexual practices or the sharing of needles).¹¹⁵

In the Privacy Commissioner's report, *AIDS and the Privacy Act*, a distinction is made between disclosure of offender medical information in order to prevent HIV exposure among offenders and disclosure to prevent HIV exposure of prison staff. The report states that disclosure to staff "remains a question."¹¹⁶ In part, this reflects a concern of the Privacy Commissioner that corrections officers may negligently pass the information to other inmates. The report recognizes the risk to staff of being exposed to HIV, stating that "some corrections officers may fear that inmates will attempt to infect them, given the hostile relations between the two groups."¹¹⁷ However, it concludes that "[h]ow significant a risk this is must be assessed before a decision is made about informing corrections officers of an inmate's HIV infection."¹¹⁸

Claims that staff "need to know" an offender's medical information in order to be able to protect themselves against infection would seldom appear to be justifiable. As PASAN has stated:

It is an illusion to think that staff and inmates would be protected from AIDS by knowing every inmate's HIV status. In fact, it would be practically impossible to be certain of everyone's status, because the results of the HIV-antibody test are not always 100% accurate. Tests must be repeated after a period of approximately six months, during which time the individual must not have participated in any high risk activities ... The test measures the presence of antibodies to HIV, not the presence of the virus itself. People who have recently been infected (within the past six months) may not have developed antibodies to the virus yet, and thus may

test negative. There can be false negative and false positive results to the test. Because of this, public health campaigns argue that we can only assume that everyone, including staff, could be HIV positive. The proper use of universal precautions when dealing with anyone's potentially infectious bodily fluids is the only way to meet the concern of work place safety effectively.¹¹⁹

PASAN therefore recommended that "HIV-related information in the possession of medical providers should be released to prison authorities only under extraordinary circumstances and only with the consent of the prisoner."¹²⁰

At a workshop on HIV in the workplace held by CSC Ontario Region on 13 October 1992, one working group composed of members of the regional health-care staff discussed "the conundrum of confidentiality." The working group acknowledged that there is considerable pressure on health-care staff to let security staff know which inmates are HIV-positive, and found that the concept of universal precautions is not widely understood by security staff. What follows is the summary of the findings of this working group.

1. There is a great interest on the part of inmates to know which other inmates are HIV positive.
2. Likewise, there is considerable pressure on health care staff to let security staff know what inmates are HIV positive. The concept of universal precautions is not widely understood by security staff. Some badgering does go on of health care staff to release information on the HIV status of various inmates.
3. HIV testing appears to be readily available to some inmates who wish it.
4. Some concern was expressed as to who has access to HIV status and health records of the inmates.
5. It was felt by some health care staff that a certain "comfort level" will be provided by identifying which inmates are HIV positive and those which are not. This is at variance with the concepts of universal precautions.
6. It was acknowledged that universal precautions mandates that all health care providers use the same precautions in providing services to all patients.
7. It is important that the HIV status of an inmate be made available to the appropriate medical staff to implement the required medical therapy such as AZT and prophylaxis for Pneumocystis carinii etc.
8. Questions were raised as to how a health care worker would determine the HIV and Hepatitis B status of an inmate if that health care worker was exposed to the blood of that inmate. Who would have access to this information and by whose authority would serological testing be performed on the blood of that inmate? It was acknowledged that the consent of the inmate would be required.¹²¹

Internationally, as stated by Harding and Schaller, "[t]he superficially attractive doctrine of communicating the results to prison administrators on a need-to-know basis is being recognized ... as unrealistic,"¹²² and staff are informed of inmates' HIV status only in a minority of prison systems.¹²³ For example, in England and Wales the Viral Infectivity Restrictions according to

which prisoners with HIV infection had a red V.I.R. stamped on their personal records are now being phased out.¹²⁴ In the United States the National Commission on AIDS stated that "[t]est results should never be made available to any prison employee, even prison medical employees, without the specific, written informed consent of the prisoner."¹²⁵ The National Prison Project recommended that "[e]fforts should be made to ensure the highest degree of confidentiality concerning a prisoner's HIV status." It continued by saying that "need to know laws and other regulations are unnecessary and generally a response by miseducated corrections staff." The Project concluded:

A person's medical status should be a private matter between the prisoner and his or her medical doctor. It is not necessary for the parole board, future employers, judges or corrections staff to know a prisoners' HIV status. The general release of this confidential medical information routinely leads to discrimination and stigmatization of the HIV-infected prisoner.¹²⁶

C. ECAP'S Assessment

(1) *Protecting confidentiality and preventing discrimination*

Protecting confidentiality in the prison system raises very complex issues. Outside prisons, everybody assumes that information about themselves relating to medical treatment and their health status is confidential and that it will be made available to others only when they have consented to its disclosure. Moreover, outside prisons, information may be disclosed to some people without others knowing this information—in particular the community in which people live or with which they interact closely. In contrast, it has been stated that "[c]onfidentiality cannot be adequately guaranteed in prison (by both prisoners and staff)"¹²⁷ and that "when an HIV-positive person is in prison, her or his health status is usually circulated among both the guards and the prisoners."¹²⁸ There are many reasons for this. (1) Information about HIV status cannot at present be generated in penitentiaries in such a way that only the affected inmate controls its communication, since anonymous testing is currently unavailable in federal penitentiaries. (2) Self-disclosure of HIV status by infected inmates appears to be frequent, often made in order to obtain care, counselling or support that would not be available without such disclosure. (3) In the closed environment of the prison, personal information spreads easily and quickly, and any inmate whose HIV-antibody status is known to anyone within the system must anticipate that it will become common knowledge. (4) Although the Commissioner's Directive stresses the importance of maintaining the confidentiality of the HIV status of inmates, this information may sometimes be disclosed without the affected prisoner's consent.

ECAP commends CSC for recognizing that "offenders have the same rights to confidentiality of information obtained by a health professional as exists in the general community" (Directive 835, section 12). At the same time, as the British Columbia Civil Liberties Association stated:

We are aware that the prison "grapevine" system is an extremely efficient conduit for information. Little goes on in prisons which is not almost immediately known by almost all inmates and staff. This makes the confidentiality of an inmate's HIV

status difficult to maintain. However, strict guidelines for nondisclosure of HIV information at the source, the health unit, coupled with inmate and correctional staff education, should eradicate much of the problem.¹²⁹

In view of the possibilities for disclosure of personal medical information of inmates and the potential harms from such disclosure, and in order to prevent breaches of confidentiality, the Committee concluded that it is essential that CSC have specific policies and procedures that will restrict access to, and allow for better protection of, confidential medical information. These should provide that breaches of confidentiality by staff be dealt with as breaches of discipline.

In addition, because protecting confidentiality is more difficult in the closed environment of correctional institutions, ECAP concluded that efforts to protect confidentiality must be accompanied by efforts to protect inmates with HIV infection or AIDS against discrimination. ECAP found no evidence of systemic discrimination against inmates with HIV infection or AIDS in federal penitentiaries. In particular, HIV-positive inmates are usually housed in the general prison population, can participate in the same activities as any other inmates, and have the same access to health care as any other inmates. ECAP was often told that inmates' and staff's attitudes and behaviour toward HIV-positive inmates are changing, that some abuses which may have occurred early in the HIV pandemic no longer occur, and that acceptance and support are increasing. This is particularly true where staff and inmates have had contact with known HIV-positive inmates. However, ECAP sometimes heard that HIV-positive inmates have been discriminated against or have been afraid to seek testing, support and counselling because of fear that their HIV status would be disclosed and that they would be exposed to discrimination by fellow inmates and by staff. Although it commends CSC and especially staff for their efforts, ECAP believes that more could be done to reduce inmates' fears and to ensure that infected inmates will not be discriminated against. The primary effort for achieving this is education, so that inmates and staff may overcome the fears and prejudices that are often the basis of discrimination. Importantly, ECAP feels that inmates should be encouraged to reveal their HIV status to fellow inmates and to staff so that inmates can receive support, care and treatment. In order to allow them to "come out" as HIV-positive, measures should be undertaken to ensure that inmates who are HIV-infected will not be wrongfully discriminated against.

(2) Disclosure of medical information

The claim of staff that they "need to know" the HIV status of infected inmates raises many complex issues. There are two main situations in which claims for disclosure arise: (1) disclosure preceding exposure to HIV, in order to prevent exposure and possible HIV transmission; and (2) disclosure following exposure to HIV. ECAP has devoted much time to an examination of these issues, acknowledging that staff's concerns for their safety in the workplace have to be taken very seriously. At first, the claim that staff "need to know" an inmate's HIV status in order to be able to better protect themselves against HIV transmission seemed irreconcilable with demands for better protection of the confidentiality of personal medical information. However, ECAP soon realized that, although the prisoners' interest in maintaining their test results confidential and the interest of staff in protecting themselves from exposure to HIV are often perceived to conflict, they are in reality compatible. Further, whatever is done to reduce the prevalence of infections within an institution will protect everyone in the institution, both staff and inmates.

ECAP's examination of the legal and ethical issues raised by the disclosure of an inmate's personal medical information absent the inmate's consent revealed that such disclosure is rarely justifiable.¹³⁰ In most situations such disclosure cannot be considered necessary and its efficacy would appear to be questionable. Often, disclosure would appear to be counterproductive or harmful, in excess of any benefits or potential benefits that might result from it. This follows from the fact that most measures that can be undertaken to prevent exposure to and infection with HIV have to be undertaken regardless of whether an inmate or staff member is or is not known, to staff, wardens, or inmates, to be infected with HIV.

In order to protect themselves, prison staff have to apply precautions universally. Arguments that "extra precautions" could be taken with known HIV-positive inmates are misguided because the concept of universal precautions requires that the same precautions be taken for every inmate, whether or not the inmate is known to be seropositive. ECAP was often told by staff that applying precautions universally in the prison setting is impossible or impractical. However, experience in the health-care setting has shown that people can and must learn to apply precautions universally. For example, in hospitals, where the risk of exposure to HIV is much higher than in prisons, it has long been understood that disclosure of the HIV status of patients would not increase staff safety.¹³¹ Consequently, the HIV status of patients and doctors is not revealed to others, and strict adherence to universal precautions is enforced. ECAP believes that, were staff to be routinely informed about prisoners known to be HIV-infected, it would create a false sense of security; without all prisoners being tested repeatedly, staff would know of only a few of the infected prisoners. Further, ECAP is concerned that if the HIV status of seropositive offenders were disclosed to staff, fewer offenders would come forward for testing or self-disclose their positive HIV status. ECAP was told on numerous occasions that most seropositive offenders will sooner or later self-disclose their HIV status to fellow offenders and to staff. Such disclosure is voluntary, and offenders will wait until they feel "ready" to self-disclose. On the other side, were disclosure to staff to become an automatic byproduct of a positive test result for HIV, many offenders who now volunteer to be tested (and at some point self-disclose) would likely not choose to be tested in the first place. As the Krever Commission stated:

[T]he primary concern of physicians, hospitals, their employees and other health-care providers must be the care of their patients. It is not an unreasonable assumption to make that persons in need of health care might, in some circumstances, be deterred from seeking it if they believed that physicians, hospital employees and other health-care providers were obliged to disclose confidential health information to the police in those circumstances.¹³²

Similarly, it would not be an unreasonable assumption that inmates would be deterred from seeking testing were health-care staff obliged to disclose positive test results to other staff. In the end, staff would very likely know of fewer HIV-positive inmates than under the present policy. For all these reasons, ECAP agrees with a study on HIV/AIDS in Australian prisons which concluded:

While the desire of the custodial officers to know the identity of seropositive prisoners may be understandable, it can be argued that the knowledge may in fact be dangerous to the prison officers as well as detrimental to the prisoner.

Custodial officers may be lulled into a false sense of security with regard to prisoners believed to be HIV negative. Because of the unreliability of the test (the "window" period) and the possibility of recent infection there is a risk that such prisoners may be seropositive. Universal blood and body fluid precautions provide a much higher degree of protection for custodial staff.¹³³

ECAP also agrees with the policy of the Detention Branch of the Quebec provincial prison system, which states as follows:

[TRANSLATION]

5.7 The rules respecting the confidentiality of medical files apply in respect of every incarcerated person, in particular when that person has been tested for antibodies to HIV or hepatitis B.

However, two exceptions to this rule have been provided for:

- When an incarcerated person relieves a health professional of the patient-physician privilege.
- When a medical practitioner concludes that an incarcerated person known to be infected with the AIDS or hepatitis B virus constitutes a risk of infection because of dangerous or irresponsible behaviour toward staff and/or other incarcerated persons.

ECAP recognizes that there are some situations when disclosure that an inmate suffers from an infectious disease might be justifiable, such as when an infected inmate threatens to harm someone:

If there exists a significant or probable risk of serious physical harm to a person or if a serious crime has been committed, there may, in some circumstances, be a public interest that outweighs an individual's privacy interest and justifies the disclosure by a hospital employee, physician or other health-care provider of health information to the police without patient authorization.¹³⁴

ECAP believes that these considerations should also apply in the prison setting. Nonetheless, disclosure remains an exception to the principle of confidentiality. ECAP has examined some of the situations in which disclosure may be justifiable as an exception to respect of confidentiality (see Appendix 1). However, ECAP feels that there is an urgent need to clearly define these situations. In order to further this analysis, the Committee agreed to organize a workshop on the issue in the summer of 1993 that would bring together representatives of the unions, CSC, the Office of the Privacy Commissioner, the Canadian Human Rights Commission, and the Departments of Justice and National Health and Welfare, together with experts on privacy issues. An Interdepartmental Committee on Human Rights and AIDS met for the first time on 26 May 1993. Its proposed areas of study include issues relating to disclosure and confidentiality of test results.

D. Conclusions

(1) Protecting confidentiality and preventing discrimination

ECAP considers that procedures should be reviewed in every federal correctional institution to ensure that the confidentiality of medical information is protected, in particular information regarding the HIV status of inmates. ECAP agrees with CSC's policy according to which breaches of confidentiality by staff are breaches of discipline.

ECAP recognizes both the need for and potential benefits to inmates from disclosing their HIV status to other inmates and staff. In order to encourage them to disclose and to obtain the benefits from disclosure, any inmate or staff who wrongfully harms or discriminates against inmates with HIV infection or AIDS should be disciplined.

Commissioner's Directives should be revised to include a clear statement that any workplace behaviour that wrongfully discriminates against inmates with HIV infection or AIDS will not be tolerated and that those involved in such behaviour will be subject to disciplinary action.

(2) Disclosure of offender medical information

ECAP agrees that every inmate's personal medical information should remain confidential between medical personnel and the inmate and should not be disclosed without the inmate's consent. Only in exceptional cases will such disclosure be justifiable, and then only when it is clearly necessary, is likely to be effective, and is the least invasive and restrictive means available to prevent harms that cannot otherwise be prevented.

ECAP considers the most effective means of preventing HIV transmission in correctional institutions is reliance on the stringent and universal application of procedures and practices that can prevent HIV transmission, and not reliance on knowing who in a correctional institution may or may not be infected. For both staff and inmates, the universal application of precautions to prevent HIV transmission, and access to the means to do so, are essential.

4. HOUSING AND ACTIVITIES

A. Current Situation

With regard to the placement of inmates with HIV infection or AIDS, Commissioner's Directive 821 states that

5. Once an inmate has been placed in an institution he/she shall be housed as follows:

- a. if the inmate has antibodies to HIV or is diagnosed as having ARC, attempts shall be made to place him/her in the general population;
- b. if placement in the general population is not feasible, attempts shall be made to place the inmate in protective custody;
- c. if protective custody is not feasible, the inmate shall be placed in administrative segregation; and
- d. if the inmate has AIDS he/she shall be housed in the health care centre.

According to section 6 of the Directive,

case-by-case decisions regarding institutional placement may be necessary to accommodate the specific medical and non-medical characteristics of each particular case.

With regard to activities, sections 7 and 8 of the Directive read as follows:

7. Inmates with suspected HIV infections or diagnosed with HIV infection shall not be managed differently from other inmates unless medically indicated.

8. The Director may decide to isolate an inmate to maintain the security or good order of the institution.

This Directive, like most provincial prison policies, directs that attempts shall be made to house infected inmates among the general prison population and that they should be able to participate in all prison activities, but the exceptions to this rule are broadly phrased and there are no decision-making criteria.

A revised version of Directive 821 (pending approval) does not contain very specific provisions either, but it nevertheless constitutes a significant step in the right direction. In particular, sections 3 and 4 of this Directive state:

3. Inmates who have AIDS or who have antibodies to HIV shall be placed in an institution in the same manner as all other inmates who do not have indications of the disease.

4. Every attempt will be made to house inmates who have AIDS or have antibodies to HIV in the general population.

The revised Directive emphasizes that any placement other than in the general population will be an exception rather than the rule. In contrast, the current Directive states only that "attempts shall be made" to place infected inmates in the general population, and in principle it thus allows for other kinds of placement and gives prison authorities wide discretionary power.

With regard to inmates who have AIDS, the current Directive states that they shall be housed in the health-care centre. In contrast, under the revised Directive the same considerations that apply to inmates with HIV infection also apply to inmates with AIDS. In particular, section 6 states:

6. The inmate who has antibodies to HIV or has AIDS will not be transferred to the health care centre unless ordered by the institutional physician for medical reasons.

Thus, under the revised Directive the general approach is to place inmates with HIV infection or AIDS in the general population. However, this principle is limited by section 5 of the Directive, which states:

5. If placement in the general population is not feasible, protective custody or administrative segregation will be considered.

This exception is very broadly phrased and contains no decision-making criteria.

With regard to activities, the revised Directive reads as follows:

7. Inmates suspected or diagnosed with HIV infection shall be managed in the same way as other inmates unless medically indicated.

8. Where an inmate who has HIV infection cannot be maintained in the general population, every effort shall be made by staff to keep the inmate productively occupied.

In practice, inmates with HIV infection or AIDS have sometimes been segregated on the basis of their being infected. This has mostly occurred in provincial institutions. For example, the British Columbia Civil Liberties Association received a complaint from an inmate in a British Columbia remand centre who told prison officials that he might be HIV-positive:

He was placed in 24 hour lock-up for 16 days despite two negative HIV tests, was allowed visits only when separated by a plastic window from visitors, was accompanied by guards in rubber gloves when out of his cell, and friends claim they were denied visits "because he has AIDS."¹³⁵

It has been alleged that prisoners with HIV infection or AIDS were being isolated from the rest of the population in provincial remand centres as late as 1989.¹³⁶

There are sporadic reports of such isolations in federal penitentiaries. While PASAN stated that "[t]he isolation of HIV-positive prisoners has been an all-too-frequent reality, if not

official policy, of both provincial and federal prisons,"¹³⁷ the statistics provided by CSC on the location of known offenders with HIV infection or AIDS demonstrate that cases of segregation, disciplinary dissociation or protective custody of inmates with HIV infection or AIDS are rare. For example, in October 1992 a total of 59 inmates known to have HIV infection and three inmates with AIDS were incarcerated in federal institutions. Of the 59 inmates with HIV infection, 55 were housed in the general population, two in health-care centres, one in disciplinary dissociation, and one in protective custody. Of the three inmates with AIDS, two were housed in the general population and one in a health-care centre. From January to October 1992 there were never more than five inmates with HIV infection in federal correctional facilities who were not located in the general population.

A decision by the Ontario Court of Justice has reaffirmed that segregation of inmates with HIV infection is justified only in exceptional cases. In the case of *Ratte v. Kingston Penitentiary*,¹³⁸ Mr. Ratte, an inmate with HIV infection who had been put in solitary confinement, applied to be returned to the general prison population. The Court dismissed the application. While it recognized that segregation or isolation of inmates because of their positive HIV status is generally unjustified, the Court held that Mr. Ratte was in isolation not because he was infected but because he was potentially dangerous to the good order and discipline of the institution. According to correctional staff, he had once "attempted to incite the range to riot" and on three occasions he threatened to kill, bite or stab staff members. In other words, the Court held that isolation might be warranted not because of the inmate's HIV infection but because of behaviour that could expose others to HIV.

B. The Debate

In many countries the initial response to HIV/AIDS in prisons was to isolate and segregate prisoners with HIV infection. This was done at a time when there was misunderstanding and a lack of education about how HIV is and is not transmitted. Isolation and segregation continue in some prison systems—for example, in many systems in the United States. In contrast, a recent survey of selected prison systems revealed that 23 of 31 European prison systems and four of seven Australian states have clear "no segregation" and "normal housing" policies for HIV-infected prisoners.¹³⁹ Yet the survey also revealed that, even in the systems that have non-discriminatory housing policies, prisoners with HIV infection may still be excluded from certain activities such as working in kitchens or infirmaries.

As Harding and Schaller have pointed out, the debate about segregation and participation in work activities by HIV-infected prisoners has been complicated by two factors:

The first is the assertion that such prisoners require a protective environment in their own interests involving freedom from harassment by other prisoners and improved hygienic conditions, medical care, and nutrition. Thus, in some countries (e.g., Ireland) units with better than average conditions have been built to house HIV-infected prisoners. The second factor is the desire to protect the general prison population from violent or sexually predatory HIV-infected prisoners.¹⁴⁰

In Canada it is generally agreed that inmates with HIV infection or AIDS should normally be housed with the general inmate population. In practice, segregation or isolation is clearly the exception rather than the rule in federal institutions. Nevertheless, there have been examples of unwarranted segregation, and there is concern that segregation may be practised arbitrarily and that policies may be applied in a haphazard and inconsistent manner.

In response to this, the Federal/Provincial/Territorial Advisory Committee on AIDS recommended that all inmates should be housed with the general inmate population "unless [segregation is] required for the ... inmate's own well being."¹⁴¹ The Federal Centre for AIDS Working Group on HIV Infection and Mental Health suggests that, [w]henver possible, correctional facilities house inmates with HIV disease with the general prison population where they have access to the full range of programs and activities in the institutions."¹⁴² Similarly, PASAN stated that, as a matter of principle, "[p]risoners with HIV/AIDS should not be involuntarily isolated or segregated."¹⁴³ PASAN argues that involuntary isolation of inmates with HIV/AIDS is not justifiable, nor is it in the best interests of either the isolated inmate or the general population. In particular, PASAN emphasizes that special housing arrangements should be considered only when inmates themselves request them, such as when their health may be jeopardized by viruses or opportunistic infections transmitted by others in the population. As stated by PASAN, "[s]pecial housing ought to translate into supportive medical care, and not punishment or hardship."¹⁴⁴ PASAN added that "involuntary isolation serves no one's interests" and that "it presents to the prison population a false sense of security—that infectious people are removed from their lives and that therefore they need not take proper safe sex and safer drug precautions."¹⁴⁵

Similar recommendations were made in the United States, where the National Prison Project stated:

The only time that a prisoner should be isolated or segregated is when he or she exhibits predatory or violent behavior toward other prisoners or staff. Prisoners who are prone to violence whether HIV positive or negative should be isolated. HIV positive prisoners who are removed from the general population after engaging in "high risk" behavior should receive AIDS counseling and education and be given the same opportunity as non-HIV positive prisoners to return to the general prison population.¹⁴⁶

C. ECAP's Assessment

ECAP commends CSC for its practice of housing inmates with HIV infection or AIDS in the general prison population. However, more specific provisions in prison policies are possible that would minimize the risk of unwarranted segregation. In particular, the Directive could clearly state that decisions about the segregation of inmates with HIV infection or AIDS follow the same criteria as decisions about the segregation of any other inmate. For example, if inmates are violent or predatory, their actions may justify isolation or other disciplinary measures regardless of their HIV status. This would be consistent with the decision in *Ratte*. Such a change would reinforce the approach that CSC intends with its revision of the Commissioner's Directive, namely that being HIV-infected is not a basis on which to segregate inmates. It would also be consistent with the *Corrections and Conditional Release Act*,¹⁴⁷ which sets out guidelines concerning how and when

administrative segregation is to be applied. The legislation states that segregation is only permissible when:

- there is no other alternative; and
- the offenders pose a danger to themselves or others, jeopardize security, or would interfere with an investigation if left in the offender population.

ECAP considers that isolation of HIV-infected inmates should always be compatible with the guidelines contained in the *Corrections and Conditional Release Act* and should only be considered when an HIV-infected inmate requests it or when other means such as education and discipline of fellow inmates or corrections officers have failed to protect the infected inmate.

ECAP further considers that inmates with HIV infection or AIDS should be transferred to a health-care centre only when their medical condition clearly necessitates it and when the transfer is ordered by a physician.

Finally, ECAP considers that HIV-infected inmates should not be excluded from any educational, job or vocational program, and in particular from working in kitchens and infirmaries, by reason of their HIV status alone.

D. Conclusions

Housing:

ECAP agrees that inmates with HIV infection or AIDS should be housed with the general inmate population.

In order to minimize the risk of unwarranted segregation, Commissioner's Directive 821 and other applicable Directives should be revised to clearly state that decisions about housing of inmates with HIV infection or AIDS should follow the same criteria as those for any other inmate.

Activities:

The Commissioner's Directive should be revised to clearly state that inmates with HIV infection or AIDS should have the opportunity to participate in the same educational, job and vocational programs as any other inmate.

5. EDUCATIONAL PROGRAMS FOR INMATES

5.1 Education about HIV/AIDS

A. Current Situation

With regard to educational programs, Commissioner's Directive 821 reads as follows:

18. Regional Headquarters shall develop and coordinate a comprehensive educational effort directed at both staff and inmates. Specific components shall include:

- a. educational materials and opportunities to be provided as part of the orientation for staff and for an inmate entering the system, and to include information on how AIDS is transmitted, infection control measures and precautions to minimize the risk of transmission of HIV; and
- b. opportunities for periodic information updates to ensure staff and inmates are kept informed on developments relating to AIDS.

The revised Directive (pending approval) is very similar in wording and content, but would seem to emphasize "live" instead of written education:

16. Regional Headquarters shall develop and coordinate a comprehensive educational effort directed at both staff and inmates. Specific components shall include:

- a) information on how AIDS is transmitted, infection control measures and precautions to minimize the risk of transmission of HIV; and
- b) periodic information updates to ensure staff and inmates are kept informed on developments relating to HIV and AIDS.

CSC considers that providing inmates with information about the prevention and transmission of infectious diseases is of paramount importance. An educational program for inmates was initiated prior to 1985, when the first case of AIDS was identified in the federal prison system, and it has been in existence ever since. According to Dr. Jacques Roy, Director General of CSC's Health Care Services, "[t]he type, quality and quantity of material that has been made available has steadily improved as new information about AIDS and HIV has become available."¹⁴⁸ On entering an institution, inmates view the video "AIDS: A Bad Way to Die," and a nurse is available to answer any questions they might have. A variety of other audiovisual materials are also shown, and brochures and pamphlets, available in French and English, are used as part of the educational program. Other educational and preventive activities include counselling upon request, group discussions with an institutional physician, and seminars.¹⁴⁹

B. The Debate

The information programs concerning HIV/AIDS provided to inmates have been criticized as ineffective.¹⁵⁰ In particular, it has been said that "they are not likely to be effective in changing

behaviour, and that they are not mandatory or even pressed upon the inmates, although the prison setting would allow for this."¹⁵¹ It has also been pointed out that "information probably will not be of much use if inmates do not have the means to act on it."¹⁵² Inmates themselves have said that educational sessions are "simply frustrating" when they get information about how to protect themselves but the means to do so are not made available to them. Zoltan Lugosi

pointed out that "[w]hile there is a need for films to educate prison workers, general populations of all prisons need explicit HIV/AIDS education presented by recognized community educators" and that since "prisoners distrust prison authorities and are unlikely to discuss proscribed activities, peer groups and programs are the best approach."¹⁵³

The Federal/Provincial/Territorial Advisory Committee on AIDS recommended that all inmates have access to "culturally and linguistically appropriate educational programs designed to minimize spread of the infection and provide factual information about risks and preventive measures."¹⁵⁴

In its presentation to the Parliamentary Ad Hoc Committee on AIDS on 13 May 1992, the Canadian AIDS Society stated that "[n]ow is the time to develop a strategy on HIV/AIDS in prisons that will include ... effective education programs for both staff and inmates," and that both staff and inmates should be involved in the development and delivery of these programs.¹⁵⁵

PASAN has recommended that HIV/AIDS education: (1) be made compulsory for all inmates; (2) be comprehensive; (3) "recognize and respond to the needs of prisoners with disabilities, from different ethnic and linguistic backgrounds, with varying language skills, and of different races, sexes, and sexual orientations"; (4) be provided through group HIV/AIDS educational sessions, and also be made available to inmates individually upon their entering and exiting the correctional facility; and (5) be provided by external, community-based HIV/AIDS and health organizations.¹⁵⁶

Similar recommendations can be found in the AIDS education needs assessment study undertaken by the John Howard Society of Metropolitan Toronto,¹⁵⁷ which examined the level of HIV/AIDS awareness and knowledge in two provincial institutions in Ontario:

Given the inmates' preference to receiving education from non-Ministry officials, it is strongly recommended that training and education be provided by health/AIDS individuals and organizations external to the Ministry of Correctional Services. Continuous consultation with these organizations and community groups is critical to ensure that the program and information remains current, is unbiased, accurate, discouraging AIDS-phobic attitudes and false beliefs. The design, implementation and delivery of an AIDS educational program should be done by external health and/or AIDS experts and professionals. ... The Ministry should recognize and access the expertise and educational skills concerning HIV/AIDS which are available outside the field of corrections.¹⁵⁸

The study revealed that the surveyed offenders "were keen on receiving HIV/AIDS education while incarcerated, and strongly supported initiatives to develop such a program in prison."¹⁵⁹ This is confirmed by a preliminary analysis of the results of the questionnaire sent to the inmate committees. Responses to the questionnaire received to date reveal that most inmates believe there is a need for more education about HIV/AIDS.

A second study undertaken by the John Howard Society examined inmates' knowledge, attitudes and behaviours concerning HIV/AIDS. In particular, the study examined inmates' attitudes toward HIV-infected inmates, toward correctional staff and community groups, and toward HIV testing. Further, identified risk-producing behaviours prior to incarceration were explored. Surveyed inmates had a high level of awareness concerning HIV and AIDS. However, the study also revealed many gaps in inmates' knowledge that were due primarily to myths and misconceptions. Further, many inmates expressed "strong AIDS-phobic and homophobic attitudes," felt threatened if fellow inmates infected with HIV were in their units or ranges, and suggested separate living arrangements in the institution for infected offenders. With regard to risk-producing behaviours in which inmates had engaged prior to imprisonment, the study results have been summarized as follows:

Generally, prisoners only used condoms with sexual partners they did not know well, and stopped practising safer sex after an average of one month. Inmates who injected intravenous drugs tended to share their equipment, mostly with their sexual partners, and commonly cleaned the shared equipment. Prisoners with tattoos were generally unaware of the risks involved with HIV transmission when sharing tattoo guns, needles and/or inks.¹⁶⁰

The study concluded that "[a]n education program should target the gaps in prisoners' knowledge, emphasize risk-reduction intervention for life in prison and outside prison, and encourage healthy attitude changes which will ultimately decrease their phobic-laden opinions."¹⁶¹

In some prisons, HIV/AIDS educational and support services are already provided by community-based AIDS organizations:

- The Kingston AIDS Project's Prison Outreach Program, funded by the federal government, provides HIV/AIDS education, support, one-on-one counselling, and advocacy to prisoners living with HIV disease. Peer education and support groups made up of inmates and sponsored by the Kingston AIDS Project operate in two correctional facilities. At one of these facilities, Kingston Penitentiary, an inmate was recently appointed Peer Health Counsellor, and his position became a full-time paid position.¹⁶²
- In Dorchester Penitentiary, a federal institution in New Brunswick, a support group for prisoners with HIV infection or AIDS has been established with the help of the local community group SIDA/AIDS Moncton. Monthly meetings are held at the institution in an effort to disseminate information about infectious diseases, informational material has been distributed on the ranges, and seminars on HIV/AIDS have been held for inmates and for staff.
- At Matsqui Institution, a group was formed to "educate our fellow prisoners on the HIV/AIDS problem" and to "offer comfort and support to HIV/AIDS patients within the institution."¹⁶³ The group also initiated an HIV/AIDS workshop that took place at the institution in February 1993.

- At the time of writing, an HIV and Friends Resource Group was being formed at Mission Institution.¹⁶⁴ The objectives of this group were formulated as follows:
 - a) To advocate responsible behaviour by inmates and their families.
 - b) To provide information, education, and increase awareness of HIV/AIDS issues within the institution and community.
 - c) With the assistance of the [Vancouver] Persons with AIDS Society and AIDS Vancouver, provide Peer Counselling Training to interested group members.
 - d) To provide "On Call" support for newly diagnosed inmates, if required, to assist them in the initial adjustment phase, so long as operational requirements can be successfully addressed.
 - e) To work in conjunction with Health Care Service and the Institutional Psychologist in assisting inmates adjust to their diagnosis.
 - f) To assist HIV/AIDS inmates in accessing the various support/therapy services available in the community.
 - g) Arrange ongoing and updated seminars for staff, inmates and their families.
 - h) To develop a greater acceptance and understanding of HIV/AIDS within the institution.
 - i) Through their involvement in this Group, members would develop a greater awareness of the issues, themselves and others. In so doing, they would develop a greater sensitivity toward those learning to live with the effects of HIV/AIDS.¹⁶⁵

Former CSC Commissioner Ole Ingstrup has stated that "[t]he Correctional Service puts a high value on the information and support the various community AIDS groups ... can provide for offenders with HIV."¹⁶⁶ Further, he said:

It is our feeling that the inmates may be more likely to believe warnings that come from groups independent of the Correctional Service of Canada. We therefore count to a large extent on these external groups for help.¹⁶⁷

The importance of community support is also acknowledged in the revised version of Commissioner's Directive 821 (pending approval). A new section on community support reads as follows:

22. The Correctional Service of Canada will actively encourage community and self-help groups to provide, as appropriate, support and information to inmates with HIV infection or AIDS, and their families.

With regard to peer education, the Minister of National Health and Welfare, the Hon. Benoît Bouchard, in a letter addressed to the AIDS Prison Group at Dorchester Penitentiary, recently stated:

I commend your personal courage and conviction in addressing AIDS issues in correctional settings. Our experience dealing with AIDS in other settings clearly demonstrates the need for and effectiveness of peer-led efforts like yours. I am certain that many prisoners have benefitted from your program, whether through support and counselling, access to services, or preventive information.¹⁶⁸

Internationally, there is wide range of HIV/AIDS education and prevention programs in prisons.^[20]

In Australia, the New South Wales Anti-Discrimination Board stated that "[t]he most effective programs both of HIV education for prisoners generally, and support for HIV positive prisoners particularly are clearly those in which there is a maximum involvement of prisoners, supported by appropriately selected and adequately trained outside counsellors."¹⁶⁹ The Board continued by saying that, [g]iven both the long established sense of hostility between prisoners and prison officers, and the widespread (and largely accurate) perception that confidentiality does not exist within the prison system, the use of prison officers, or even prison staff more generally, in such programs would seem unlikely to be effective."¹⁷⁰ In their report, Heilpern and Egger proposed the following "key elements for an education program within the prisons":

- (1) Education should be timely. AIDS education should be instituted before there are significant numbers of HIV positive prisoners. Such pro-active programs are able to avert the development of serious concerns amongst staff and prisoners. ...
- (2) Education should be mandatory for inmates and staff. Whilst mandatory education is expensive and difficult to administer, the importance of AIDS education requires such measures.
- (3) AIDS training should be regularly presented and regularly up-dated to respond to changing information and the often misleading media coverage of AIDS. Mechanisms for obtaining the latest information and up-dating the message conveyed should be developed.
- (4) AIDS education should include mechanisms which involve inmates and staff in the development and presentation of the education programs. "The best AIDS program involves representatives of the target audiences in the development of AIDS education and training. Behavioural change, which is the primary goal of AIDS education, requires a whole range of new strategies that may include tailoring the format to the group; including the target group in the delivery of the information; using the informal but powerful prisoner hierarchy; making each gaol responsible for its own AIDS prevention strategies; devising an effective form of evaluation; and linking the education strategies with community programs."

[20] An overview of some of these programs and the steps that are being taken to maintain and enhance their effectiveness can be found in a report on *AIDS Education and Prevention Programs in Correctional Institutions Worldwide*, prepared by L. Fitzsimmons, University of Waterloo, for the AIDS Information and Education Services Unit, Health Promotion Directorate, Health Services & Promotion Branch, Health and Welfare Canada, 1992.

- (5) AIDS training and education should be live. "It is the single most effective format because it allows for interaction and feedback. It is also often recommended that a person with AIDS should be present because of the powerfully motivating influence of personal testimony."
- (6) The AIDS educators should be credible. The AIDS educator should understand the prison system and foster credibility. The message should be accurate and straightforward with no judgmental or hidden ideological content. The education program should be in appropriate language and as non-technical as possible.
- (7) Live training should be supplemented with video tapes and/or written informational materials.
- (8) AIDS education should be sensitive to the specific concerns of the institution. In addition to providing basic information on the disease, the education program should address the specific concerns current in the prison no matter how irrational such concerns may be. In prison, AIDS education should address the major risk factors—needle sharing, sexual activities, tattooing and the risks associated with fights and other situations where blood may be spilt.
- (9) There must be a high level of executive commitment. The importance of this is threefold:
 - it enhances the credibility of the program;
 - it emphatically demonstrates the content of the program by way of example;
 - it involves a pragmatic commitment at all levels in the administration of the prison."AIDS programs thrive in prisons because management will it."
- (10) The AIDS education program should be rigorously monitored and evaluated in order to ensure that the objectives are being met.¹⁷¹

In some prisons in Australia, peer education is a major component of efforts to prevent the further spread of HIV infection. In particular, the Centre for Education and Information on Drugs and Alcohol, in association with the Prison AIDS Project of the New South Wales Department of Corrective Services, developed a training manual for a National Prisons HIV Peer Education Program.¹⁷² The manual is designed to be used by noncustodial prison staff and community educators conducting HIV peer-education training with inmates in prisons. Specifically, it is designed to enable educators to

- (1) provide inmates with the knowledge and skills necessary to avoid HIV infection;
- (2) motivate selected prisoners to play an active role in HIV-prevention activities with other prisoners;
- (3) develop prisoner "peer educators" with the ability and the willingness to inform other prisoners about HIV transmission and about safe sexual and safe drug-use practices;
- (4) assist peer educators to develop the skills and willingness to actively support inmates who are HIV-positive;
- (5) establish a support infrastructure of prison management, custodial staff, noncustodial staff and prisoners who will work together to actively facilitate all HIV-prevention activities;

- (6) develop an understanding of and a sensitivity to the particular learning needs of diverse groups of prisoners, in particular those with a developmental disability, those from non-English speaking backgrounds, Aboriginal prisoners, and women prisoners;
- (7) access information, resources and support.

Overall, this HIV Peer Education Program "aims to prevent the spread of HIV amongst the inmate population by enabling prisoners to obtain the knowledge, skills and attitudes needed to avoid infection."¹⁷³ This is achieved by directly involving prisoners, so that they "own" the process of HIV/AIDS prevention within the prison system; establishing structures in prisons for providing long-term support to prisoners' self-management in preventing the spread of HIV/AIDS; and providing comprehensive HIV educational programs that are consistent with the traditions and cultures already established in the prison system. As stated in the manual,

[t]he Peer Education Approach to preventing the spread of HIV/AIDS aims to build and reinforce prisoners' ability and motivation to manage their own health and well being. This self management method has been shown to be a powerful way of achieving behaviour and attitude change where other methods have failed.¹⁷⁴

The document continues by saying:

The prison setting is special. It is necessary to recognize and then positively tap into the power of the prison culture. HIV education strategies are unlikely to succeed if they are imposed from a central authority. If they are going to become part of the culture of both inmates and staff, they need to evolve in a way that will be relevant and acceptable to the particular gaol.¹⁷⁵

Several reasons are given for why peer education is so effective.

- (1) Since HIV transmission in prison often involves illegal practices, the Peer Educator may be the only person able to speak candidly to other inmates about HIV transmission.
- (2) Peer Educators' input is not viewed with the same suspicion or as the "propaganda" from the prison hierarchy.
- (3) Peer Educators are more likely to be able to realistically discuss the alternatives to risk behavior that are available to inmates, acknowledging the real problems that people face.
- (4) They are more likely to be able to respond to issues as they arise and in an ongoing way, rather than providing a formal service within a limited time and setting.
- (5) They are able to judge which educational strategies would work within their prison and link HIV/AIDS prevention to the existing culture and informal power structure.

Prisoners' AIDS committees operating in prisons in New South Wales impart knowledge of HIV/AIDS prevention to other prisoners. Their methods include group sessions, pamphlets, posters, HIV/AIDS knowledge-based competitions, plays, video scriptwriting, and musical compositions.¹⁷⁶ Education officers facilitate the committees' work with up-to-date information, and their activities include allowing openly HIV-positive people from the outside community to talk to prisoners, using videos and medical literature, using professional scriptwriters to develop educational resource materials, and organising poster competitions. The education officers also liaise with prison staff and authorities and prisoners.

In the United States, the National Commission on AIDS examined existing educational programs, concluding that they "vary enormously from jurisdiction to jurisdiction."¹⁷⁷ Among the *Recommendations for AIDS Prevention Programs in Correctional Settings* endorsed by the Commission are the following:

1. All inmates should participate in a mandatory AIDS information and education session upon entry into the system. ...
4. Inmates should have the opportunity to participate in ongoing groups that provide information and support about risk reduction. ...
5. Peer educators can play an important role in prison AIDS prevention programs. ...
8. Prevention programs need to be closely linked to health and social services for inmates with HIV/AIDS. ...
10. Prisoners should be included in planning and implementing AIDS prevention programs. ...
12. Correctional systems, prison health services, AIDS organizations, prisoners' rights groups and public health professionals need to work together to create effective AIDS prevention programs in correctional settings.¹⁷⁸

The *Recommendations* conclude with the statement that

AIDS prevention programs remain the single most effective strategy for slowing the spread of HIV infection. Inmates, like others in society, have the right to be protected from life-threatening illnesses. For legal, moral and public health reasons, correctional and health officials should develop effective and comprehensive AIDS prevention programs in correctional settings.¹⁷⁹

The National Prison Project on Care and Treatment of HIV-infected Prisoners also acknowledged that "[a] comprehensive and quality education program is one of the most successful tools for controlling HIV infection in prison."¹⁸⁰ In particular, the Project recommended the following:

All prisoners on intake should be mandated to attend an AIDS education session that includes a live presentation by an AIDS educator, as well as the dissemination of simply written educational materials. We recommend these programs be conducted by outside non-correctional organizations such as the public health department or local AIDS service agencies. Prisoners are generally skeptical of

information received from Department of Corrections staff. We recommend periodic follow-up education sessions for prisoners who wish to receive further information. We also recommend that support groups be set up for HIV-infected prisoners, those with IV drug use history, the worried well and others. An essential educational component that has worked quite successfully in New York State and Massachusetts prisons is the peer education and counseling model. The training and utilization of prisoners as AIDS educators is essential to the success of any AIDS education program.¹⁸¹

C. ECAP's Assessment

In today's society we are constantly being bombarded with media hype and other people's unfounded fears and insecurities that we are actually less educated than we think about the issues and how HIV/AIDS is spread.¹⁸²

ECAP believes that education of inmates about HIV/AIDS is the most important effort that can be made to promote and protect their health, particularly since prisoners are often "the people previously missed by traditional and mainstream education and prevention ... [b]ecause they are usually out of school and may have low levels of literacy."¹⁸³ Prisons present extraordinary opportunities and challenges for HIV/AIDS prevention efforts:

On the one hand, no other institution in this society has a higher concentration of people at substantial risk of HIV infection. Moreover, the population in prisons and jails is unlikely to have been reached by other AIDS education programs. On the other hand, formidable obstacles impede effective programs in the correctional system. These include an authoritarian atmosphere, preoccupation with security, inmates' mistrust of public health professionals, violence, discrimination and a high turn over of inmates.¹⁸⁴

ECAP sometimes heard from inmates that they had received enough and did not need or want more education about HIV/AIDS. Other inmates told ECAP that they never received education about HIV/AIDS in prison or that it was limited to making pamphlets on HIV/AIDS available to them and to regular screening of an HIV/AIDS video on the internal TV channel. Criticism that the educational and information programs provided to inmates are ineffective was also often voiced. It quickly became obvious to ECAP that the quantity and, in particular, the quality of education on HIV/AIDS varies greatly among institutions, from live education sessions with the participation of outside community groups to the provision of printed and video materials. In general, both the results of the studies undertaken by the John Howard Society of Metropolitan Toronto and the preliminary results of the questionnaire that ECAP sent to the inmate committees in federal penitentiaries revealed that although inmates may have a relatively high level of knowledge and awareness about HIV/AIDS, they also have many misconceptions and unfounded fears. Further, most inmates indicated that they felt it would be useful to have more or better educational programs on HIV/AIDS than what was currently available to them.

Although ECAP commends CSC for making available and continuously upgrading educational materials on HIV/AIDS for inmates, it strongly believes that educational efforts should

shift from purely passive to more active and participatory forms of education. There are many reasons why current educational efforts are often perceived as being ineffective. Among these reasons are that information may not "engage" inmates, in particular when there is non-inmate authorship and content, that it does not meet the literacy requirements of inmates, and that peer reinforcement of educational efforts is lacking. ECAP believes that every inmate should be given informational materials on HIV/AIDS, such as brochures or the booklet *Get the Facts*, published by the John Howard Society, at the time of admission. However, the emphasis should be on small group-education sessions that encourage the participation of individual inmates and include role-plays and other interactive forms of communication. Whenever possible, these sessions should be delivered by external, community-based organizations which should be funded to develop and carry out such programs, or by peers who have developed expertise in doing so. ECAP believes that peer educators can play a vital role in educating other inmates and that peer education and educational sessions delivered by external organizations will be better received than education by CSC staff. ECAP was encouraged to see that CSC and the Minister of Health have both expressed support for education carried out by external organizations or by peers. In this context, CSC is to be congratulated for its very promising initiative of designating an inmate as a paid health counsellor.

ECAP further believes that education about HIV/AIDS should be ongoing. Inmates should have the opportunity and be encouraged to participate in ongoing groups that provide themselves with information and support about risk reduction. A single intervention, even if repeated on a regular basis, is unlikely to lead to significant changes in risk behaviour. Inmates therefore need the opportunity to raise questions, learn preventive skills, explore feelings, and gain support for harm reduction.¹⁸⁵ Such programs would best be developed by peers and integrated into a variety of existing programs.

Regarding the question of whether participation in educational sessions about HIV/AIDS should be mandatory, ECAP received mixed answers. Some inmates and groups like PASAN expressed the fear that inmates would not participate if participation was voluntary. It has also been argued that mandatory sessions would reduce the stigmatization that can occur if HIV/AIDS educational programs are voluntary. Others said that inmates would be "turned off" and unwilling to attend if participation was mandatory. ECAP believes that, in order to attract a large but interested audience, participation should not be mandatory but should be strongly encouraged. This could include providing incentives or payment for attending or participating in such activities. One inmate suggested that "outside seminar leaders" should be brought in to talk to the inmates at their workplace:

If outside seminar leaders were brought in and went to talk to the inmates where they work an easier atmosphere would be developed. Inmates would be in a group they are already relatively comfortable with. The groups would be relatively small and would encourage interaction in a familiar environment. Meeting at the inmates' place of employment would get away from the idea of mandatory attendance. This method would also reach the staff supervisors who are there. Small—1 or 2 person—shops or jobs could be amalgamated in a related area to keep the informality.¹⁸⁶

D. Conclusions

ECAP considers that education about HIV infection and AIDS is the most important effort to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in federal correctional institutions. ECAP recognizes that educational efforts are already in place in federal correctional institutions but it considers that these efforts may be improved by the following:

- (1) On entry into the institution, all inmates should receive written information about HIV infection and AIDS that is appropriate to their level of literacy. This could be in the form of pamphlets or of a booklet such as *Get the Facts*, published by the John Howard Society.
- (2) Soon after admission and as part of the reception program, every inmate should be offered educational sessions about HIV infection and AIDS.
- (3) External, community-based AIDS, health or prisoner organizations should be encouraged to deliver or supplement these sessions.
- (4) CSC in collaboration with Health and Welfare Canada and others should fund such organizations to provide this education.
- (5) Because peer education has been found to be one of the most effective means of educating people about HIV infection and AIDS, inmates should be encouraged to develop and assisted in delivering their own peer education, counselling and support programs.
- (6) CSC in collaboration with Health and Welfare Canada and others should provide the funding necessary to support such efforts.
- (7) In each institution, CSC should create or designate one or more inmate job positions as peer health counsellors, and provide for appropriate training, support and evaluation.

5.2 Education about Drug Use^[21]

A. Current Situation

CSC has made a strong commitment to providing programs and services for drug users. This is seen as "part of CSC's effort to successfully reintegrate offenders into the community, especially since close to 70 per cent of offenders exhibit substance abuse problems to some degree."¹⁸⁷ Although CSC acknowledges that it "cannot claim to have all the answers, we [CSC] feel we are heading in the right direction."¹⁸⁸ In the past, substance abuse programming within CSC was very fragmented, and it was felt that a process was needed "to bring everything together in a focused way and to co-ordinate the efforts of different departments."¹⁸⁹ This led to the creation in August 1989 of the Task Force on the Reduction of Substance Abuse. The Task Force subsequently developed a framework within which CSC could plan and implement programs, services and policies to reduce alcohol and drug-related problems among offenders. The 53 recommendations contained in the Task Force's report include several that deal with education for inmates about drug use.

Recommendations 15 through 17 deal with the development and delivery of a Substance Abuse Induction Module targeted to all newly admitted inmates. The goal is "to provide education and information on CSC policies and procedures in order to influence offender attitudes and intentions against abusing drugs and alcohol, and encourage participation in programs which address individual needs."¹⁹⁰ The Task Force suggested that, upon completion of the module, offenders should be able to:

1. Describe aspects in a person's life that are negatively affected by the abuse of drugs and alcohol;
2. Identify CSC policies and procedures that address the use of alcohol and drugs;

[21] Many terms are commonly used to describe or define the use, misuse or abuse of drugs, of which "drug abuse" or "substance abuse" may be the most widely accepted. However, the difficulty of defining the boundaries between what constitutes drug use, misuse or abuse, as well as the controversy surrounding these terms and their boundaries, have to be recognized. In its "Lexicon of Psychiatric and Mental Health Terms," WHO recognizes that the term "drug abuse," defined as "[t]he self-administration of a medicinal or pleasurable substance in a quantity or manner that impairs health or social functioning," has pejorative overtones, and advises "to restrict its use to indicate the malevolence of an individual, or of his or her behaviour." The terms "drug abuse" and "substance abuse" will therefore not be used in this Working Paper, except when they refer to CSC programs (where the term "substance abuse" is used) or to texts of other authors who use other similar terms. Rather, the neutral term "drug use" will be used. Any drug can be used in a harmful way, impair health, cause disease or lead to chronic consumption. Harms can result if too much of a certain drug is taken, if a drug is taken regularly over a long period of time, if it is taken for the wrong reason or without following instructions, or if it is taken in combination with certain other drugs. Rather than talk about "drug abuse," it is therefore more useful to talk about "drug use" without a priori judgment about whether the behaviour concerned is or is not a "problem" or "harmful." A two-stage analysis is often necessary, i.e., "an objective and empirical description of a society's pattern and determinants of drug use, and a social process which determines what part of the total spectrum of use is to be viewed as abuse." For a more detailed discussion, see Jürgens R, Gilmore N, Somerville MA. Drugs and Drug Use. In *Drug Use and Human Rights in Europe*. Edited by J Silvis, A Hendriks, N Gilmore. Report for the European Commission. Utrecht/Montreal: 1992, 7-31 at 11-12, with many references.

3. Discuss the links between substance abuse and criminality, violence in the institution, and re-integration into society;
4. Identify personal/social consequences of using/not using drugs and alcohol in prison; and
5. Describe program opportunities available to them, and how they will get involved.¹⁹¹

As a result of these recommendations, a half-day Drug and Alcohol Reception Induction Module has been developed for use with all offenders in reception programs. This module "is designed to encourage those individuals to think about the way alcohol and drug use, either their own or that of members of their family, has affected their lives."¹⁹² A video is being produced as part of the module. This will "portray a realistic story of a male offender and a female offender who have recently returned to a correctional facility as a result of substance abuse."

Further, a Computerized Lifestyle Assessment Instrument (CLAI) is operational in all CSC reception sites. CLAI was originally used in the community to screen health problems and was later adapted for use with offenders. CLAI's two primary uses have been described as follows:

to accurately identify the nature and seriousness of substance abuse problems among newly-admitted offenders, and to provide important statistical information about the offender population which will assist in the development of future programs.¹⁹³

Recommendations 18 through 21 deal with the delivery of educational programs on substance abuse within CSC. Education about substance abuse is seen as "an interactive process, which provides the offender with the knowledge and awareness to critically evaluate the impact of substance abuse on his/her life."

An Alcohol, Drugs and Personal Choice Program consisting of nine three-hour educational sessions is now being implemented on a national level. The primary objective of this educational program has been described as "[making] participants aware of the costs of substance abuse, both to themselves as individuals and to society." The program is intended to influence participants' attitudes toward substance abuse and to motivate them to change their behaviour.

Implementation of a program designed to meet the needs of those offenders who require a moderate level of intervention is also underway. The Offender Substance Abuse Pre-Release Program (OSAP) consists of 26 half-day sessions and is intended "to give offenders the basic skills they need to cope with situations involving drugs and alcohol." OSAP is based on the "social learning model of addiction" and contains eight main components: alcohol and drug education, self-management skills, social skills, job-skills refresher, leisure and lifestyle, pre-release planning, relapse prevention and management, and one-on-one counselling sessions.

The Reception Module and these two programs are part of CSC's effort "to explore new ways to provide the most effective programming for offenders." A data-collection system has recently been implemented to provide a summary of substance-abuse programming within CSC. Staff will report four times a year for each substance-abuse program available to offenders in the community and in the institutions. The data collected will assist CSC "in mapping future directions."¹⁹⁴

B. The Debate

Most of the issues that arise in any debate about education on drug use in prisons have already been discussed in section 5.1 of this Working Paper, which deals with education about HIV/AIDS. It is generally agreed that: (1) educational materials, whether on HIV/AIDS or on drug use, are likely to correspond better to the reality and needs of the populations targeted, and therefore be more credible and effective, if the populations to which they are targeted participate in their development; (2) that outside community-based or health organizations should deliver, or have input into, educational sessions; and (3) that peer education should also be a priority. This is reflected in the recommendations that have been made with regard to education on drug use in prisons. For example, PASAN recommended that "[c]ommunity-based workers should educate prisoners about substance use as a health issue."¹⁹⁵ PASAN views an educational component relating to drug use as an essential part of the health-care model the Network proposes for dealing with drug use in prisons. It points out that education is better received by inmates when provided through outside sources and through an inmate peer-support program, and suggests that educational programs be developed by "an appropriate pool of community resources." Similarly, Diane Riley in her submission to ECAP suggests that "[d]rug education programmes ... should be run by community based organizations brought into the prisons and peer education programmes should be encouraged."¹⁹⁶

On the questionnaire sent out, one inmate commented on CSC's substance-abuse programs as follows:

For those who do substance abuse programs, [these] are a general waste of time—dispensing of outdated or factually false information is the staple of the institutional programs CSC funds. Most of these programs are now taught by CSC personnel who have no personal experience with what they are talking about. Their information largely comes from books written by people who got their information from books.

C. ECAP's Assessment

ECAP commends CSC for its major effort to provide inmates with programs on drug use. In particular, ECAP agrees with a statement by John Eno, formerly a substance-abuse coordinator at Drumheller Institution and now co-responsible for substance-abuse programming within CSC at the national level. He stated that CSC's substance-abuse programming efforts "are now heading in the right direction" but that they "still have a long way to go."¹⁹⁷ ECAP was impressed by the programs available to inmates and by the fact that outside organizations are sometimes asked to supplement the information provided. However, ECAP believes that these efforts to educate inmates about drug use can be made more effective. The preliminary analysis of answers to the questionnaire sent to inmate committees reveals that the vast majority of inmates support the making available of information and educational programs about drug use to inmates. Inmates often told ECAP that they disbelieved or were sceptical of much of the information currently provided in the course of these programs.

Generally, ECAP was told that when community-based groups were invited to give presentations on drug use, the presentations were much better received by inmates. ECAP

believes that input by community groups into educational programs on drug use is essential. The focus of current CSC programming is on reduction of drug use rather than of the harms from drug use. While efforts to prevent or reduce drug use may be important, ECAP believes that education about how to reduce the harms from drug use is also essential. This includes education about safer injection drug use. As Heilpern and Egger have stated, "the importance of preventing the spread of the disease makes it essential that information on cleaning drug equipment must be provided."¹⁹⁸ Outside community groups would be particularly suited to provide inmates with such information and education. Further, in the context of education about how to reduce the harms from injection drug use, it will be important to not only provide relevant information but also to make accessible the means that will enable inmates to practice safer injection drug use. Finally, peer education should be promoted, and inmates should be assisted in developing their own educational programs.

D. Conclusions

ECAP considers that education about drug use is one of the most important efforts to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in federal correctional institutions. ECAP recognizes that educational efforts are already in place in federal correctional institutions but it also considers that these efforts may be improved by the following:

- (1) Revision of the Drug and Alcohol Reception Induction Module to include input by external, community-based organizations and by inmates.
- (2) Revision of the Alcohol and Drug Education Program to include input by external, community-based organizations and by inmates.
- (3) External, community-based drug-use, health or prisoner organizations should be encouraged to deliver or supplement these programs.
- (4) CSC in collaboration with Canada's Drug Strategy and others should fund such organizations to provide this education.
- (5) Because peer education has been found to be one of the most effective means of educating people about drug use, inmates should be encouraged to develop and assisted in delivering their own peer education, counselling and support programs.
- (6) CSC in collaboration with Canada's Drug Strategy and others should fund such efforts.

6. PREVENTIVE MEASURES FOR INMATES

6.1.1 Consensual Sexual Activity

A. Current Situation

(1) *Prevalence of consensual sexual activity*

There is no reliable data on the prevalence of consensual sexual activity in Canadian prisons. Nevertheless, there is no reason to presume that it does not occur or that it may not be widespread.

(2) *Dealing with consensual sexual activity in prisons*

One of the most important steps toward instituting effective measures to prevent HIV transmission in correctional settings was making condoms available in federal penitentiaries as of 1 January 1992. Each penitentiary has established its own system for making them available. These range from distributing condoms to every inmate and leaving supplies of them in living units in some prisons, to restricting their distribution to prison health-care services. Dental dams are also being made available to female prisoners.

B. The Debate

(1) *Prevalence of consensual sexual activity*

Homosexual activity occurs inside prisons, as it does outside, as a consequence of preferred sexual orientation. In addition, prison life produces conditions which encourage the establishment of homosexual relationships within the institution..."¹⁹⁹

Its prevalence is difficult to estimate. It is presumably based on such factors as whether the accommodation is single-cell or dormitory, the duration of the sentence, the security classification and the extent to which conjugal visits are permitted.²⁰⁰

Regarding the prevalence of sexual activity in Canadian prisons, the Parliamentary Ad Hoc Committee on AIDS stated that "[w]e know that there is sexual activity in prison"²⁰¹ and referred to several studies on the extent of sexual activity in prisons in the United States.²⁰² These studies suggest that between 10 and 30 percent of inmates engage in homosexual activity. "[H]omosexual activity among male prison inmates, including situational homosexuality, is a significant, widely-recognized behaviour pattern in prisons."²⁰³

(2) *Dealing with consensual sexual activity in prisons*

According to the latest figures from the World Health Organization's network on HIV/AIDS in prison, 23 of the 52 prison systems sampled allow condom distribution.²⁰⁴ Significantly, no country that has adopted a policy of making condoms available in prisons has reversed the policy. In some countries, however, making condoms available in prisons is still opposed on the grounds that sexual activity is illegal in public and that prisons are public spaces. Among the systems that

refuse to make condoms available are many in the United States, where the National Commission on AIDS stated in 1991 that it was "distressed to find that only a handful of prison systems distribute condoms."²⁰⁵

In Canada, many of the provincial prison systems have followed the decision of the Solicitor General of Canada and have made condoms available to prisoners in provincial prisons or are considering doing so in the near future. Some provinces, however, including New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island and Saskatchewan, had, at the time of their submissions to ECAP, no plans to make condoms available.

The decision by CSC to make condoms available has been widely praised. For example, the Canadian AIDS Society stated:

We wish to acknowledge that progress has been made on this very issue [HIV/AIDS in prisons]. We were very pleased by the Fall announcement by the Solicitor General of Canada to have condoms available in federal prisons. It is an important step and has acted as a catalyst for discussion in provincial ministries.²⁰⁶

However, in federal penitentiaries, as in other prison systems where condoms have been made available, "finding the best distribution channels and encouraging condom use remain problems, even when the principle of availability is accepted."²⁰⁷

The Ontario Regional HIV/AIDS Advisory Committee reviewed the adequacy and confidentiality of the condom distribution process and concluded that "[c]ondom dispensing should be readily available, anonymous, and not obsessed with the number of condoms per offender."²⁰⁸ In particular, the Committee recommended that condoms should be distributed in institutions in the following manner:

- (1) Free of charge;
- (2) Through the Health Care Centre (offenders SHOULD NOT HAVE TO ASK FOR THEM OR SIGN FOR THEM)[emphasis in the original];
- (3) Available in other locations to preserve anonymity;
- (4) Dispensers shall be open receptacles to ensure privacy; and,
- (5) Lubrication packets shall be available in the same location as the condoms.²⁰⁹

PASAN also expressed concern with the method of condom distribution and recommended that they should not only be distributed through health-care services but should also be available in showers and on ranges. In particular, PASAN emphasized that condoms should be available safely and confidentially, and that dental dams and lubricants should also be easily accessible and free of charge to both men and women.²¹⁰

The 1989 Australian National HIV/AIDS Strategy also emphasized that "condoms should be freely and anonymously available to all prisoners."²¹¹

C. ECAP's Assessment

ECAP commends the Solicitor General of Canada for his decision to make condoms available to inmates in federal penitentiaries. ECAP was constantly told by both staff and inmates that this decision has been well-accepted and has not created any documented problems in the institutions. This is consistent with the experience in other prison systems like that of New York City: years of experience have shown that condom availability has not resulted in security problems or other negative incidents.²¹²

In many federal institutions condoms are easily and discreetly available to inmates. In these institutions condoms are available not only in the health-care centres but also in other locations where inmates regularly meet, or which they pass through or have access to. Inmates in some institutions have complained to ECAP that they do not have discreet access to condoms. These inmates said they were afraid to pick up condoms at the institution's health-care centre for fear of being identified as engaging in homosexual activity and of being discriminated against. In their responses to the questionnaires sent to them, many of the inmate committees also expressed a wish that condoms be made available through mechanisms or channels other than those already used in their particular institution. Water-based lubricant is essential to the correct use of condoms and to other safer sex practices, but ECAP was informed that it is not always available to inmates or that, as is the case with condoms, access to it is not always easy or discreet.

ECAP has considered what the optimal mechanisms for condom distribution might be. The Committee also considered whether or not condoms should be given to prisoners at entry into prison, and to prisoners leaving prison, for example as a "health kit." These kits would include condoms, dental dams, lubricant, educational materials, band-aids, disinfectant, acetaminophen, and relevant information about drug use and health services.

ECAP believes that inmates in every institution should be able to obtain condoms easily and discreetly and that there should be no real or perceived barriers discouraging inmates from protecting themselves and their partners when engaging in sexual activity. This should also apply to access to dental dams and water-based lubricant.

ECAP favours distribution of a "health kit" to every inmate on entry into prison. ECAP believes that provision of such a kit is important for the following reasons. It would make available to inmates the materials necessary for them to protect themselves against HIV transmission, without their having to go and ask for them or having to pick them up where they might be seen by staff or fellow inmates. This would also contribute to the destigmatization of sexual activity in prison and encourage more open discussion about it. At the same time, inmates would be provided with basic medical supplies, and this would have the effect of emphasizing the importance of their looking after their health and well-being. Further, offering a "health kit" to inmates on exit from prison would be an acknowledgment that prison authorities not only have an obligation to prevent HIV transmission in prisons, but also that they are working to protect the community as a whole by ensuring that inmates who are released have the means to protect themselves and others from HIV transmission.

D. Conclusions

ECAP considers it essential that inmates have discreet and easy access to the means to prevent the sexual transmission of infectious diseases, including HIV, in federal correctional institutions.

In order to discourage unsafe sexual activities in correctional institutions and to reduce real or perceived obstacles to safer sexual practices,

(1) condoms, dental dams and water-based lubricant should be available to inmates in locations where they regularly meet, which they pass through or have access to, and not only in the health-care centres of the institutions;

(2) a "health kit" should be given to every inmate on entry into the institution and offered to every inmate on exit from the institution. This kit should contain condoms, dental dams, water-based lubricant, educational materials about sexually transmitted diseases, band-aids, disinfectant, acetaminophen and relevant information about drug use and health services;

(3) a "health kit" should always be available in each family visiting unit.

6.1.2 Status of Consensual Sexual Activity

A. Current Situation

Sodomy between consenting persons 21 years of age or older was decriminalized in Canada in 1969 (see *Criminal Code*, R.S.C. 1970, c. C-34, s. 158). On 1 January 1988 new sexual offences sections were brought into force. "Buggery" was eliminated as an offence and "anal intercourse" became legal between consenting persons aged 18 or over. A new system based on age and power between the partners was adopted in the defining of sexual offences (see *Criminal Code*, R.S.C. 1985, c. C-46, s. 159(2)). The age of consent for sexual acts other than anal intercourse, whether heterosexual or homosexual, was set at 14.

In federal penitentiaries, consensual sexual activity among inmates is still considered or perceived to be an activity "that is likely to jeopardize the security of the penitentiary" under s. 40 (m)(ii) of the *Corrections and Conditional Release Act*.

B. The Debate

Proponents of maintaining sexual activity between inmates as an institutional offence often argue that prisons are not private spaces and that sexual activity undertaken in prisons would constitute a criminal offence.²¹³ They also argue that removing sexual activity between inmates from the list of institutional offences would condone or even encourage homosexual activity.

Others, including some CSC personnel, have acknowledged the dichotomy between prohibiting sexual activity between inmates and making condoms available to them.²¹⁴ In

particular, the Ontario Regional HIV/AIDS Advisory Committee expressed its concern that implementation of condom distribution without a review of institutional rules about offender sexual activity may constitute entrapment. The Committee therefore recommended that "[e]ach institution shall review its rules and regulations regarding sexual activity among offenders."²¹⁵ Similarly, PASAN recommended that consensual sex between prisoners should not be an institutional offence. In particular, PASAN stated:

Sexual activity between inmates is a fact of prison life, a fact which CSC, with their condom distribution plan, has finally acknowledged. But consensual sex between prisoners remains prohibited. This means that when prisoners are having sex they will be less likely to have safer sex; the extra time required is time in which they may be discovered and penalized. In order to fight the transmission of HIV most effectively, there must be no penalties for consensual sex between prisoners.²¹⁶

PASAN added that consensual sexual activity should be allowed not only because this will increase the effectiveness of HIV prevention, but also because it considers that prohibiting sexual activity between prisoners "is a violation of human rights." PASAN continued by saying that the argument that sex must be prohibited to maintain order in the prison is unsound:

Sexual activity continues to take place in prisons, despite being banned, and there is no loss of order and control. In fact, the need to be furtive while engaging in sexual activity is more a source of disorder than the sex itself.

C. ECAP's Assessment

It is increasingly accepted that sexual activity occurs in prisons and that it is being more and more tolerated. For example, ECAP is not aware of any disciplinary procedures having been taken during the past three years against inmates engaging in consensual sexual activity in federal correctional facilities. However, inmates have expressed fear that they may be disciplined when discovered while engaging in consensual sexual activity. The Committee is concerned that, due to the fear of being discovered, inmates may engage in consensual sexual activity furtively and not take the extra time required to engage in safer sex. Therefore—and in the interest of discouraging unsafe sexual activity—ECAP believes that consensual sexual activity should not be considered an activity that would jeopardize the security of the penitentiary, and that it should be removed from the category of institutional offences. This should not be seen as encouraging sexual activity, but rather as discouraging unsafe behaviour. Further, ECAP believes that it would be consistent with, and in fact mandated by, the general principles guiding CSC, according to which the Service shall "use the least restrictive measures consistent with the protection of the public, staff members and offenders"; and offenders shall "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" (ss. 4(d) and (e) of the *Corrections and Conditional Release Act*).

It is important to make a clear distinction between consensual and non-consensual sexual activity. While the second cannot be tolerated and may jeopardize the security of the institution, the first may only indirectly cause "problems" because of potential negative or intolerant reactions of fellow inmates or staff toward people engaging in sexual activity. However, this would be more

a result of the prejudices of fellow inmates or staff than of the sexual activity in itself, and should therefore be dealt with through more open discussion of sexuality.

Further, the argument that prisons are considered public spaces and that sexual activity in a public space would constitute a criminal offence does not seem to withstand scrutiny. CSC has been allowing private family visits for years, and for this purpose family visiting units have tacitly been considered "private" spaces. The same could be done with cells.

Generally, ECAP believes that the health of the inmates and, in particular, efforts to protect them from HIV transmission, should be the overriding concern in any discussion about consensual sexual activity in prisons.

D. Conclusions

ECAP considers that, in order to discourage unsafe sexual activity in federal correctional institutions, consensual sexual activity between inmates should not be considered an activity that is likely to jeopardize the security of the institution.

6.2 Non-consensual Sexual Activity

A. Current Situation

(1) *Prevalence of non-consensual sexual activity*

There is no reliable data on the prevalence of non-consensual sexual activity in Canadian prisons. Nevertheless, there is no reason to presume that it does not occur.

(2) *Dealing with non-consensual sexual activity*

CSC has adopted a policy of sending predators, not their victims, into protective custody, and has taken numerous other steps to prevent sexual aggression in institutions.

B. The Debate

(1) *Prevalence of non-consensual sexual activity*

It has been said that "it is nearly impossible to get accurate data on the number of violent sexual encounters that happen within gaol systems."²¹⁷ Non-consensual sexual activity, including so-called "quasi-consensual" sexual activity (for example, submission based on intimidation, or submission in return for protection or other favours),^[22] is, however, held to be widely prevalent and underreported in prisons. Heilpern and Egger have stated:

[22] The term "quasi-consensual" sexual activity is misleading, since any "consent" obtained through intimidation cannot be considered as consent: sexual activity is either consensual or non-consensual.

Official reports seriously underestimate the extent of sexual assault. One US self report study found that 0.6% of prison inmates were forced to perform undesired sexual acts during incarceration. Another US study found that 28% of inmates had been victims of aggressive sexual approaches. In another US research [study] the estimates of the proportion of prisoners who are subject to sexual assault varies from 1% to 2.9%.^{218[23]}

(2) *Dealing with non-consensual sexual activity*

Hankins has suggested that in order to prevent HIV transmission associated with non-consensual activity, the prison environment must be changed.²¹⁹ In particular, she writes:

For a start there has to be a more careful inmate classification so that more vulnerable individuals are kept together and not mixed with more aggressive individuals. More extensive supervision or surveillance, more effective prosecution of inmate rapists, basic structural changes such as lighting and restricted access to certain areas in the prison may help facilitate a safer environment for all prisoners. Some individuals, especially those who are susceptible to victimization, may have to be placed in protective custody. The prevention of rape and other non-consensual sexual activity through which HIV infection may be transmitted must be a critical element of a correctional services AIDS policy.²²⁰

PASAN states that "non-consensual sex is unacceptable" and that "it is a crime and should be treated as such," but does not address the issue of how to prevent or reduce the incidence of non-consensual sex in prisons.²²¹

Heilpern and Egger acknowledge that the extent to which HIV-prevention policies are able to adequately address the problem of non-consensual intercourse is unknown.²²² They continue by saying that

"[w]hilst policies such as safe sex education, the distribution of condoms, the provision of conjugal visits, single cell accomodation and the segregation of proven predators may reduce the risk of HIV transmission, the complexity of male prison sexuality requires an approach which both understands and challenges the value system which creates sexual domination in the prison system.

They conclude by saying that educational programs in prisons need to be broad in scope and that they must come to terms with the complexity of prison sexuality and the role it plays in the culture:

[23] The authors caution that some of the US research has been criticized for the strong ideological bias inherent in both the methodology and the conclusions. They therefore state that caution should be exercised in interpreting these findings and that, furthermore, the distinction between consensual and quasi-consensual sexual activity is problematic because a proposition may be regarded as a threat, depending upon the circumstances.

The relationship between sexual domination, the assertion of masculinity and power and status in the prison should be recognised and programs developed which understand and challenge this value system.²²³

C. ECAP's Assessment

ECAP was concerned that one of the ways in which infectious diseases may be spread in institutions is through non-consensual sexual activity. While the Committee commends CSC for its policy of sending predators, not their victims, into protective custody, and for having taken steps to prevent sexual aggression in its institutions, it considers that reaffirming these measures is important. Such reaffirmation should include open discussion of sexual activity in penitentiaries and education of inmates, preferably by inmates, about sexual abuse.

D. Conclusions

ECAP agrees that preventing sexual assault and other non-consensual sexual activity between inmates should continue to be a priority for CSC. Measures to make the prison environment safer should include:

- (1) continued efforts to identify sexual predators and inmates who may be vulnerable to sexual abuse;
- (2) effective prosecution of inmate sexual predators, and their removal or segregation from the general inmate population;
- (3) close supervision and protection, including single-cell accommodation, for inmates who may be vulnerable to sexual abuse;
- (4) education of inmates, preferably by inmates, about sexual abuse and the fact that such abuse will not be tolerated in federal correctional institutions;
- (5) a long-term goal of providing all inmates with single-cell accommodation.

6.3 Preventing the Harms from Injection Drug Use

A. Current Situation

(1) *Prevalence of injection drug use*

There is no reliable data on the prevalence of injection or other drug use in Canadian prisons. The only available data is on the prevalence of drug use by prisoners prior to incarceration. A Computerized Lifestyle Screening Instrument developed by the Ministry of the Solicitor General and CSC in 1988 is being used to obtain information about the extent and nature of offenders'

drug and alcohol use. Of 371 inmates tested in 1989-90, more than ten percent admitted using drugs every day in the six months prior to incarceration, 17 percent had regular drinking binges and 64 percent said they had consumed alcohol or other drugs on the day of their crime.²²⁴ Further, 53.7 percent of all federal inmates were classified as having a serious substance abuse problem.²²⁵

(2) Reducing the harms from injection drug use

(i) *Measures to reduce drug use*

CSC has undertaken a variety of measures to reduce injection drug use in federal penitentiaries. These have been described as follows:

Recognizing the serious contribution to institutional violence made by the presence and use of alcohol and other drugs in penitentiaries, the significant effect of continuing alcohol and drug abuse on criminal activity after release, as well as the general debilitating effect of substance abuse on individual and family life, the CSC has undertaken formal prevention, education and treatment measures in recent years. Stress has been placed on interdiction and apprehension, education and the treatment of addicted offenders—an approach continued to the present.^{226[24]}

Sections 54-56 of the Corrections and Conditional Release Act, according to which CSC may carry out urinalysis under certain circumstances specified in the Act, are also part of CSC's effort to prevent drug use.

(ii) *Availability of bleach*

Bleach is not officially available to inmates in federal penitentiaries. It is classified as contraband, and possession of it is considered to be an institutional offence. Nevertheless, some inmates may have covert access to bleach in laundries or kitchens and it may be available to other inmates as a commodity. In contrast, bleach is made available to inmates as a general cleansing agent in some provincial institutions (see *supra*, chapter III, section A.1(1.5)).

(iii) *Availability of needles for injection drug use*

Injection equipment—needles and syringes in particular—is classified as contraband and possession is considered to be an institutional offence.

(iv) *Availability of methadone*

Treatment with methadone as a substitute for opiate use is not available in federal penitentiaries.

[24] For a detailed description of CSC's educational programs on drug use, see *supra* at chapter IV, section 5.2.

B. The Debate

(1) *Prevalence of injection drug use*

It has been said that drug use is more visible in prisons than outside and that "inside an often overflowing incarceration system where there is little treatment, drugs help contain a situation that would otherwise explode."²²⁷ It has been pointed out that

many of the inmates of federal penitentiaries and provincial jails as well as those on parole use drugs as a part of their lifestyle. Drugs relieve tension, boredom and hopelessness and it should be no surprise that they are popular among those caught up by the criminal justice system.²²⁸

Similarly, PASAN has stated that

those in our overcrowded correctional facilities often turn to substance use as a means to cope with the harsh reality of prison life. They end up being more concerned with their daily struggles than with health issues regarding HIV.²²⁹

Drugs enter prisons on a regular basis, and availability of drugs in prisons has significantly increased since the early 1970s, in part due to increased visiting rights in most prisons.²³⁰ It has been estimated that only five percent of all drugs entering Canadian prisons is apprehended by prison authorities.²³¹ Allegations that drug use in prisons is quietly tolerated by prison authorities were denied by a CSC spokesperson who maintained that "[l]ooking the other way is something penitentiary staff do on very few occasions."²³²

The Parliamentary Ad Hoc Committee heard evidence that "up to fifty per cent of inmates may be involved in drug use."²³³ According to other estimates, two-thirds of all prisoners use drugs while in prison.²³⁴ The 1991 *Task Force Report on the Reduction of Substance Abuse* acknowledged that "[t]he problem of drugs in prisons, including their contribution to prison violence, is ... significant."²³⁵ The Report continues by saying that consequently "a significant percentage of institutional security measures are devoted to drug detection and reducing illegal sales of drugs." Further, the Report states:

Prison violence often occurs to obtain drugs or to settle debts related to the sale of drugs. From 1981 to 1986, 49 persons were killed in Canadian penitentiaries; many of these crimes were a direct result of alcohol or drug use and trafficking in drugs. During 1985-1986 alone, 181 major violent incidents occurred, of which 106 (58%) were believed to be related to drug abuse.

Similarly, the CSC Contraband Control Study states that "it is commonly accepted that many offenders have significant problems with alcohol or drug abuse that relate to their criminal behaviour" and that "drugs and alcohol can be identified as the most important contraband problem."²³⁶ The Study continues by saying:

The incidence of substance abuse among offenders means that:

- 1) A significant number of offenders may continue to use substances during their incarceration which creates a heavy demand for drugs and alcohol within institutions; and
- 2) Many, or most of these offenders will be at high risk for re-offending if their substance use/abuse problems are not dealt with effectively.

With regard to injection drug use, a CSC spokesperson maintained that "[w]hen drugs are used ... they are mostly the non-injectable ones...."²³⁷ However, the Parliamentary Ad Hoc Committee heard evidence that "needle sharing for injection drug use is common, and that needles and other implements are also used for tattooing purposes."²³⁸ An ex-prisoner estimated that ten percent of the inmates in the Guelph Correctional Centre share needles,²³⁹ and a study on HIV transmission among injection drug users in Toronto found that "[o]ver eighty per cent [of the participating injection drug users] had been in jail overnight or longer since beginning to inject drugs, with twenty-five per cent of those sharing injecting equipment while in custody."²⁴⁰

While it is generally agreed that it is difficult to determine exactly how much injection drug use and needle sharing occurs in prisons, it is also agreed that, in Canada and elsewhere, injection drug use is prevalent in prisons and that the scarcity of needles often leads to needle sharing. With regard to the Canadian situation, PASAN stated:

Despite high levels of injection drug use, the presence of syringes used to inject illegal drugs is severely limited. Only a handful of needles will circulate in a population of 400-600 people. Accordingly, once incarcerated, with no access to clean needles or bleach, yet ongoing access to injectable drugs, inmates using injection drugs must share needles even though they may not have shared on the outside. Needle sharing usually occurs in bathrooms, cells, and hidden areas. Home-made and unsafe sharps (needle substitutes) are fashioned out of hardened plastic and ball-point pens, often causing damage to veins, scarring, infections, and blood poisoning.²⁴¹

In Australia, "[a]ll commentators agree that it [injection drug use] occurs and that needle sharing is almost always associated with IV drug use in prisons because of the lack of availability of syringes."²⁴² The following are some examples of estimates of the amount of drug use and needle sharing in Australian prisons:

One of the more extreme estimates was made by Frapè—80% of prisoners were using drugs in NSW [New South Wales] prisons and needles were shared with up to 20 others at a time. Matthews reported that prisoners in one NSW prison claimed that there were only 2 syringes in the entire prison. The AIDS Task Force Prison working party reported that in Long Bay no more than 14 needles were available for more than 200 prisoners using IV drugs.²⁴³

In the United Kingdom, the Home Office claimed that there is a low incidence of injection drug use in prisons. However, a number of surveys found that the use and availability of injectable drugs greatly exceeded official estimates and that needles and syringes are commonly shared out of necessity.²⁴⁴

(2) *Reducing the harms from injection drug use*

It is widely believed that injection drug use represents the biggest risk for transmitting HIV infection in prisons.²⁴⁵ Heilpern and Egger have identified four lines of reasoning to support this view:

Firstly, the geographic distribution of AIDS in prisons parallels the geographic distribution of AIDS cases for whom IV drug use is the primary risk factor. ...

Secondly, research has shown that a high proportion of AIDS cases in prisons nominate IV drug use as the sole or predominant risk factor. ...

Thirdly, the prevalence of HIV infection in prisons again crudely mirrors the geographic distribution of IV drug users in different jurisdictions.

Finally, the rates of seropositivity in prisons are closely related to the proportion of drug dependent prisoners.²⁴⁶

Heilpern and Egger concluded that "HIV infection in prisons will increase if there is an increase in the proportion of IV drug users imprisoned and if there is an increase in HIV infection amongst IV drug users in the general community."

Similarly, Tomaševski stated:

There is extensive data on the association between injecting drug use and HIV infection, particularly relating to prisoners. AIDS was diagnosed among prisoners early in the epidemic and immediately linked to injecting drug use. This link was confirmed by a survey carried out for the Council of Europe: "The proportion of HIV seropositive prisoners ... reflects directly the proportion of drug addicts in the prison population", and proven in most industrialized countries, including Europe, North America, and Australia. The problem is exacerbated by the continuation of injecting drug use within prisons.

Two features of the prison population determine the magnitude of this dual problem of HIV/AIDS and drug use: a high proportion of injecting drug users in the prison population is a consequence of penalizing possession or use of drugs by imprisonment, while a large proportion of the prison population are dependent on drugs, whether imprisoned for a drug-related offence or not.²⁴⁷

For all these reasons, reducing the harms from injection drug use is an essential part of any comprehensive effort to reduce or avoid the risk of contracting bloodborne infections in prisons. For example, the Canadian AIDS Society stated:

The reality of the drug issue has not yet been addressed. A range of strategies need to be examined and implemented and need to include effective drug education and rehabilitation programmes and provisions of bleach and needle exchange. All of this is more complex within a prison setting. However, the difficulties must not deter us from finding solutions. We believe collaboration will bring workable solutions.²⁴⁸

(i) *Measures to reduce drug use*

Implementation of effective drug education, including education about how to reduce the harms from injection drug use, has been widely recommended. This issue has been addressed above. Other measures to reduce drug use in correctional facilities are more controversial. In particular, there is concern that these measures may create risks or harms that outweigh the benefit being sought, namely the reduction of drug use. For example, it is feared that drug-testing programs may have a negative impact on efforts to reduce the harms from drug use. In his submission to ECAP, Oscapeila stated:

The federal *Corrections and Conditional Release Act*... gives federal corrections and parole officials broad powers to test inmates in prisons and during their release into the community under certain programs, such as parole. It is too early to tell if the drug testing provisions of the Act will be found to violate Charter privacy rights; for now, this paper assumes that the testing provisions are constitutional [emphasis in the original].

In theory, drug testing should reduce the amount of drug use in prisons [emphasis in original]. Persons should be dissuaded from using drugs through fear of disciplinary action.

If drug testing did reduce the frequency with which inmates injected drugs, this would be a positive benefit; it would reduce the risk of HIV infection. However, it is arguable that drug testing in prisons ... could in *practice* lead to an *increased* frequency of injecting drugs [emphasis in the original].

Most use of illegal drugs in general society and the military, and perhaps also in prisons, involves marijuana. Marijuana metabolites may sometimes be detectable in urine for up to a month. Other drugs, such as cocaine, heroin, PCP and LSD have much shorter windows of detection. Because prisoners are aware that they might be required to undergo urinalysis, it makes sense for them to use drugs with a very short window of detection. ... These "short window" drugs may also be much easier to hide, given their smaller volume than marijuana.

Shifting from marijuana (longer period of detectability) to heroin (shorter period) likely means that the user will go from smoking to injecting. Smoking poses no risk of HIV infection. ... Injecting does. Hence, the possibility that drug testing programs may increase the risk of HIV infection in prisons.

Data may not be available on the impact of drug testing programs on risk of HIV infection. Still, this issue clearly merits consideration. **Any policy or law that increases the chances that inmates will inject drugs—particularly in light of the unwillingness of prisons to facilitate safe injection practices—is highly dangerous. It is difficult to think of any situation where the benefits of such a policy or law would outweigh the deadly harm of increased HIV infections** [emphasis in the original].²⁴⁹

(ii) *Availability of bleach*

Whereas providing prisoners with information and education about drug use is widely accepted, the issue of whether bleach should be made available to prisoners is controversial. This is not surprising, since "[m]easures to prevent further spread of HIV infection among injecting drug users, such as needle exchange programmes or bleach, are controversial even for people at liberty."²⁵⁰

Worldwide, bleach is made available to inmates in many prison systems. As reported by Harding and Schaller, 16 of 52 systems surveyed late in 1991 made bleach available to prisoners, often accompanied by clear instructions on how to clean needles. For example, in Spain a bottle of bleach is included in the sanitary kit that inmates receive at entry into the prison system and monthly thereafter, "and more is provided whenever needed."²⁵¹ In Switzerland, "first-aid kits" containing small bottles of bleach have been given to inmates since June 1991.²⁵² Bleach is also available in some systems in Germany, France, Denmark and Australia, in prisons in Belgium, Luxembourg and the Netherlands, and in some African and at least one Central American prison system.²⁵³

Making bleach available to prisoners has been widely recommended in Canada and elsewhere.²⁵⁴ As early as 1988, the Royal Society of Canada recommended that "facilities for decontaminating needles be made readily available to inmates in correctional institutions."²⁵⁵ Two years later, in 1990, the Parliamentary Ad Hoc Committee on AIDS urged the Solicitor General to "take immediate steps to have bleach for needle decontamination purposes ... made available on a confidential basis to inmates."²⁵⁶ More recently, the Ontario Regional HIV/AIDS Advisory Committee stated that offenders at all institutions would benefit from the provision of bleach to disinfect sharp instruments used in tattooing, piercing, and injection drug use. The Committee recommended that bleach kits be made available to all offenders. The kits should contain "one plastic bottle of bleach with red lettering for the poison symbol and easy instructions; one plastic bottle of clean water with yellow lettering for the instructions; one instruction sheet with low literacy printing and pictures."²⁵⁷ PASAN recommended that bleach kits should be distributed universally, "possibly during the weekly provision of supplies."²⁵⁸

Others have opposed making bleach available to prisoners on the grounds that it may be perceived as condoning an illegal act that has contributed to many prisoners being incarcerated in the first place. It has further been argued that making bleach and information on how to clean injection equipment available may encourage non-users to experiment with injection drug use, and

that bleach could be used as a weapon against staff.²⁵⁹ However, bleach had been available for a long time in Canadian prisons without any suggestion of it being a threat to institutional security until it became associated with the sterilization of injection equipment. Further, in some institutions it is still informally available, and there is no evidence that this has created any problems. The National Advisory Committee on AIDS stated:

Such distribution [of bleach] has not been shown to seriously compromise security within correctional facilities, nor can it be interpreted as condoning or encouraging proscribed behaviour within the facility. Instead, such measures are essential in order to reduce the risk of HIV transmission in the facility. It is unconscionable to deny inmates access to the means necessary in order to permit them to protect themselves from HIV infection.²⁶⁰

That it is becoming increasingly difficult for prison administrators to ignore the issue of needle cleaning has been recognized in other countries. For example, at a conference on AIDS in Australia one commentator said:

In the light of the startling increase of HIV infection in the IV drug population both inside and outside jail, this controversial issue will soon be the most central issue on the agenda. ... We are engaged in an extraordinary war which demands extraordinary solutions.²⁶¹

(iii) Availability of needles for injection drug use

Although making bleach available to prisoners is increasingly being accepted as necessary to prevent transmission of HIV and other infectious agents in correctional institutions and has been implemented in some prisons systems, there is strong resistance from prison authorities against making clean drug-injection equipment available. Worldwide, no prison system has authorized the distribution or exchange of clean syringes or needles.²⁶² However, in one institution in Switzerland, a pilot project that includes the distribution of syringes is being planned.²⁶³

In Canada, in 1991, the Minister of National Health and Welfare suggested that clean needles or bleach to clean needles be made available to inmates in federal penitentiaries. However, at the time, the Solicitor General of Canada rejected this suggestion.

Outside prisons, needle exchanges have been established in many countries. In Canada, the first needle exchange program began in Vancouver in January 1989. In June 1989 the federal government announced a special initiative to cost-share with provinces to support two-year pilot programs that could include needle exchange. Five provinces (British Columbia, Alberta, Manitoba, Ontario and Quebec) participated in this initiative to support pilot projects in 12 communities. Final results from evaluation research that was federally funded in association with the pilot projects will be released in June 1993. Initial findings demonstrate that

pilot programs have accessed thousands of drug users (approximately 4,000 contacts per month in both Vancouver and Montreal, over 400 clients per month in Toronto), have not led to increased drug use, and have linked many clients to other health and social services for the first time.²⁶⁴

Well over one million needles/syringes have been exchanged through these programs. Federal funding of these pilot projects ended on 31 March 1993. Provinces have begun to fund needle exchanges as ongoing services and have greatly increased the number of sites. As of March 1993, Health and Welfare Canada was aware of 28 outreach programs that include needle exchange. Eleven additional sites were under development and expected to open in 1993. The following is a list of sites of needle exchanges in Canada and of the dates on which they started.²⁶⁵

British Columbia: Vancouver (January 1989), Victoria (August 1989), Kelowna (May 1991), Prince George (August 1991), Nanaimo (November 1991), Quesnel (November 1991), Williams Lake (November 1991), Surrey (December 1992); six more programs under development are to open in 1993.

Alberta: Edmonton (August 1990), Calgary (February 1990).

Saskatchewan: Regina (August 1992), Saskatoon (February 1993).

Manitoba: Winnipeg (October 1990).

Ontario: Toronto (June 1989), Ottawa (November 1990), Hamilton (January 1992), Kingston (November 1991), London (May 1992), Sudbury (May 1992), Etobicoke (May 1992), Windsor (July 1992), Niagara (October 1992).

Quebec: Montreal (July 1989), Montérégie (May 1990), Quebec City (March 1991), Victoriaville (June 1991), Chicoutimi (March 1992); five more programs under development are to open in 1993.

Nova Scotia: Halifax (May 1992).

Providing sterile needles in prisons is often rejected because it would appear, "in an environment designed to uphold the law, to condone illegal drug use: a contradiction in terms."²⁶⁶ There is also concern for the safety and security of fellow prisoners and staff because it is feared that needles could be used as weapons. Wayne Crawford, executive secretary-treasurer of the Union of Solicitor General Employees, said:

A needle is a weapon. I'd hate to even think about some prisoner coming up and stabbing me, or injecting me, with his blood if it's infected. ... Whether it [the needle] is rusty or new hardly matters. The whole idea is ridiculous. It would be the same as giving bank robbers normal bullets so they won't use dum-dums. People talking about this aren't in the real world.²⁶⁷

On the other side, prisoners'-rights activists have rejected the contention that clean needles pose a security risk, saying that "a prisoner wishing to use violence against a guard or another prisoner will likely utilize other already available methods, such as pencils, pens, razors, utensils, toothbrushes, etc."²⁶⁸ Making clean injection equipment available "would probably reduce the

risk by eliminating dangerous, handmade syringes that have to be hidden within the prison."²⁶⁹ Furthermore, "[i]f the issuing of needles was more open and protected, there would be less concern about violence and security."²⁷⁰

In Canada and internationally, making clean drug injection equipment available in prisons has been recommended by many individuals, groups and organizations. For example, the Canadian Association of Elizabeth Fry Societies passed a resolution at its 1991 annual general meeting supporting "free needle exchange ... inside and outside the criminal justice system."²⁷¹ PASAN recommended that "[a] confidential needle exchange program should be implemented" in prisons.²⁷² It suggested that needle exchange programs "should be modelled after existing outside exchange programs while simultaneously protecting prisoners from harassment from prison staff and fellow prisoners."²⁷³ According to PASAN, needles should be exchanged through the health service in a confidential one-for-one manner and prisoners should not be accountable to non-medical staff when obtaining needles. At the same time, PASAN rejected the provision of a needle exchange machine in prisons because such machines "can be faulty and are easily vandalized" and because using them "poses problems for prisoners who wish to maintain their confidentiality." PASAN further suggested that "[a] public relations campaign should be initiated to combat anticipated resistance by staff or the public to a needle exchange program."²⁷⁴ PASAN stated:

Needle exchange programs on the "outside" are becoming more common. Experience has shown us that the few opponents they encounter in the community can be overcome through consultation and education. Harm reduction is the framework in which we promote needle exchanges to the outside community. A similar strategy should be pursued in supporting a prison exchange program. Information regarding drug use in the prisons and the health risks it involves should be made public. The success of needle exchanges in halting the transmission of HIV should also be conveyed. It should be noted that keeping a prisoner free of HIV and AIDS is a massive cost saving.²⁷⁵

Importantly, PASAN claimed that "bleach provision to prisoners (in isolation from other programs around injection drug use, such as needle exchange) is not highly successful because prisoners who are injecting drugs usually feel the time and activity it takes to clean a syringe or home-made sharp could be time in which guards would detect the activity."²⁷⁶ There is therefore concern that inmates would not take the extra time to clean their injection equipment and would thus continue to share dirty needles.

Others do not advocate outright implementation of needle exchanges in prisons, but suggest that the feasibility of making clean needles available in prisons should be studied. For example, Dr. Hankins recommended that "[i]n order to further reduce HIV transmission ... the feasibility should be explored of providing inmates with confidential access to clean needles and syringes through a one-for-one needle exchange intended to reduce HIV transmission while not prompting drug use."²⁷⁷ Similarly, members of the Ontario Regional HIV/AIDS Advisory Committee recommended that, given the effectiveness of needle exchanges in reducing the spread of HIV infection among drug users, "[a] proposal for a needle exchange program shall be examined in the context of the institutional setting,"²⁷⁸ expressing their belief that needle sharing is an important means of HIV transmission within the institutional setting. In particular,

they emphasized that needle sharing between injection drug users is a very efficient mode of transmission of HIV, that worldwide studies have shown that HIV infection in this population can increase from two percent to 40 to 60 percent within three years, and that evaluation of needle exchange programs outside prisons has shown that they are an effective means of preventing transmission of HIV and hepatitis B among drug users and have not encouraged or increased drug use among non-users.²⁷⁹ At the same time, the Committee acknowledged that there was concern that advocating a needle exchange program within the institutional setting may be interpreted as condoning drug use, that needles may be used as weapons, and that there was a risk of institutional liability if an offender experiences adverse effects from the use of a needle supplied by the institution.

The Council of Europe has invited States "to allow, in the last resort, clean, one-way syringes and clean needles being made available to intravenous drug abusers in prison."²⁸⁰

(iv) *Availability of methadone*

As stated by Harding and Schaller, "methadone maintenance in prisons may also be effective in reducing the risk of infection, and it is being adopted in some jails and a few long-term penitentiaries."^{281[25]} For example, in New South Wales (Australia), "[m]ethadone slowly insinuated itself into gaols, developing as 'the best game in town' to prevent needle sharing in the prison setting."²⁸² The experience with methadone has been described as follows:

Five years ago, methadone was only an organisational irritant to the Prison Medical Service, requiring additional paper work and extra nursing input. About that time, AIDS raised its head, and testing for the related antibody became available. The situation is now remarkably changed, with methadone being the "tail that wags the PMS dog." ... The main reason PMS promotes methadone in New South Wales is as an AIDS prevention strategy whereby it is hoped that needle sharing will be limited.²⁸³

Heilpern and Egger stated that "[i]ncreasing the number of places available for methadone treatment in the prisons should also be considered as a matter of urgency for HIV positive drug dependent prisoners."²⁸⁴

In Canada, methadone is given to some persons under controlled conditions in community clinics, but rarely is it prescribed to anyone in prison. It has been argued that "methadone should be available within our prisons, especially to those with a long-term history of drug use associated with criminality" and that "[i]f methadone were available to these people it would not only eliminate their efforts to acquire illicit drugs while in prison, but it would also serve to accustom them to a lifestyle not centered around its acquisition."²⁸⁵

[25] However, Harding has also pointed out that problems may occur on release for inmates on maintenance if access to a community program cannot be guaranteed, or when such inmates have to be transferred to prisons without methadone maintenance programs. See Harding and Schaller, *infra*, endnote 63 at 16.

C. ECAP's Assessment

(1) *Prevalence of injection drug use*

On numerous occasions ECAP was told by inmates that drug use, including injection drug use, occurs in federal correctional facilities. More importantly, ECAP was told that needle sharing is frequent and that often 15 to 20 people will use one needle without cleaning it between each use. Coupled with evidence collected from other sources, this led ECAP to conclude that injection drug use occurs in many penitentiaries and is likely to be the highest risk factor for HIV transmission within the correctional setting.

(2) *Reducing the harms from injection drug use*

It is clear to ECAP that it is unrealistic to presume that drug use in prisons will stop or that drug injection will cease. Consequently, the Committee examined in great detail what might be done in federal penitentiaries to reduce the harms from drug use, and in particular what might be done to reduce the harms to inmates from their drug injection behaviour.

In many countries HIV has spread explosively among injection drug users. However, in some places, including some cities in Canada, the spread has been slowed dramatically. This is not attributable to efforts to suppress drug use, in particular injection drug use, nor is it attributable to the availability of drug treatment. It has occurred primarily because of a reduction in the sharing of uncleaned injection equipment. Prevention efforts have been directed toward educating drug users about HIV infection, about the importance of always using clean injection equipment, and in particular of not sharing equipment or else cleaning it before each use. These efforts have been accompanied by making bleach and clean needles and syringes available, and by providing drug users with support services.^[26] Importantly, these efforts have not increased

[26] Perhaps the most complete evidence for the effectiveness of AIDS prevention for injection drug users comes from the Skane province of southern Sweden. Des Jarlais et al., *supra*, note 12 at 1061, describe their programs as follows:

AIDS prevention programs, including syringe exchange, education, referrals to drug-abuse treatment, and HIV testing and counselling, were established in the area in late 1986, when only a few of the local IDU were HIV-infected. There are an estimated 3000 IDU in the province, and 90% or more have been tested. Testing is routine at drug-abuse treatment programs, and all HIV-seropositives are reported to health authorities. Individuals who die from drug-related deaths are tested at autopsy; this has not identified any HIV-seropositives who were not already known to the health authorities. The current HIV seroprevalence among IDU in Skane is 0.2%, of whom four-fifths are known to have been infected with HIV before moving into the province. The seroprevalence for locally acquired HIV infections is thus only 0.04%, in contrast to 13% in Stockholm and 15% in Copenhagen, which is only a 30-40 minute ferry ride from Malmo, the largest city in the Skane province.

Equally impressive are the achievements of the needle exchange program in Vancouver, which has been described as the city's most important AIDS prevention program (see, e.g., Krueger G. Needle Exchange Program a Success for B.C. Project. *The Medical Post*, 14 May 1991 at 42).

injection drug use,²⁸⁶ and they show that injection drug users can responsibly modify their behaviour to reduce the risks of HIV transmission.²⁸⁷

Efforts to implement a multitude of programs to prevent HIV infection among injection drug users have "led to the development of a philosophical perspective that informs much of the organized work."²⁸⁸ This perspective has been called "harm reduction" or "harm minimization" and has been defined by Des Jarlais et al. as follows:

The fundamental basis for the harm-reduction perspective is a pragmatic approach to the social and individual problems associated with the misuse of psychoactive drugs. That is, if drug misuse cannot be eliminated in the near term (or perhaps even in the long term), then at least some of the problems associated with the misuse of psychoactive drugs can themselves be reduced.²⁸⁹

As has been emphasized by Des Jarlais et al., "harm reduction" or a "health model" approach for dealing with drug use is "not necessarily liberal or conservative in conventional political terms," but should rather "be seen as a contrast between the utopian ideal of a 'drug-free society' versus a 'drug use without drug misuse' perspective."²⁹⁰

"Harm reduction" or "health model" approaches for dealing with drug use have been adopted in many countries, including Canada, in response to the realization that the spread of HIV infection is a greater danger to individual and public health than drug use. They have led to the establishment of needle exchange or distribution programs in many communities. However, even communities that have adopted wide-ranging harm-reduction policies have often not extended these policies to prisons, and much remains to be done to reduce harms in this environment.²⁹¹

ECAP considers that injection drug use is a serious danger to the health of inmates. In particular, it is a danger with regard to the transmission of infectious diseases such as HIV when uncleaned injection equipment is shared. In considering what might be done to prevent the transmission of HIV by injection drug use, ECAP confronted the following dilemma.

First, efforts by CSC to prevent drug use among inmates have to continue. Among the reasons for this are that possession of drugs is a criminal offence; that the use of drugs in penitentiaries is considered to be a threat to these institutions, in particular because of the association of drug use with violent, aggressive or other dangerous behaviour; and that public attitudes to drug use expect and demand these efforts. With regard to this last reason, ECAP repeatedly heard that staff and administration were adamant that drug use cannot and would not be tolerated in federal correctional institutions.

Second, ECAP found that it is unrealistic to presume that injection drug use can ever be fully suppressed in prisons, despite strong and persistent efforts by CSC to prevent drug use by preventing drugs from entering the institutions and through education about drug use and treatment of drug users. ECAP found that most administrators, staff and prisoners concur in this assessment.

In addition, ECAP observed that the risk of transmission of HIV and other blood-borne infectious diseases is directly related to the scarcity of clean injection equipment. This in turn is a consequence of the fact that possession of such equipment and of bleach is forbidden, which leads to efforts to confiscate injection equipment and bleach.

Since injection drug use in penitentiaries is unlikely to stop, ECAP found that the only way to prevent or reduce the transmission of HIV and other infectious diseases would be for inmates

to always use clean injection equipment when injecting drugs. ECAP considered two alternatives for making this possible: making clean needles and syringes available to inmates, and making bleach available to them. As discussed below, ECAP concluded that making clean needles and syringes available to inmates would not be implementable at this time. With regard to making bleach available, ECAP considered that making it accessible to all inmates in a discreet and easy manner is necessary in order to interrupt the spread of bloodborne infections in prisons. Therefore, ECAP concluded that bleach should be made immediately and widely available to inmates in federal penitentiaries.

(i) *Measures to reduce drug use*

ECAP agrees that CSC has a responsibility to prevent the use of illicit drugs in federal correctional institutions. This means that CSC must continue to employ the full range of options in dealing with drug use, including efforts to prevent drugs from entering the institutions, confiscation of drugs, education about drug use and the harms deriving from it, and provision of access to rehabilitation and treatment programs for federal offenders. Many of these efforts are already in place, and ECAP has made suggestions as to how some of them could be improved (see supra, section 5.2). With regard to drug-testing programs, ECAP believes that in any decision about the extent to which they should be implemented, consideration be given to concerns that they may lead to increased harms.

(ii) *Availability of bleach*

Making bleach available has been opposed on the grounds that it could be used as a weapon against staff. However, ECAP came to the conclusion that making bleach available should not be opposed on security grounds. ECAP is aware that many drug-injecting inmates covertly obtain bleach to clean their injection equipment and that this has not been associated with adverse consequences for staff or the good order of the institutions. This is consistent with the experience of those prison systems in which bleach has been made officially available, including that of British Columbia. Further, ECAP strongly believes that the use of clean equipment will not only prevent transmission of HIV infection among drug injectors but will also protect other inmates and staff by there being fewer infected inmates in institutions and less risk of exposure to HIV through injuries from blood-contaminated equipment.

Making bleach available has also been opposed because it could be misinterpreted as condoning injection drug use and eroding efforts to prohibit drug use in federal penitentiaries. Staff have often expressed to ECAP their resistance to making bleach available, saying that it would be seen as sending out conflicting messages: prohibiting drug use and making strong efforts to prevent drugs from entering the institutions on the one hand; and on the other, acknowledging that an illegal act that has contributed to many prisoners being incarcerated in the first place is happening, and encouraging drug users to clean their equipment. However, ECAP believes that making bleach available should not be seen as encouraging drug use, but rather as discouraging unsafe injection behaviour. Making bleach available in no way condones drug use but, rather, emphasizes that in correctional facilities as elsewhere, the overriding concern in any effort to deal with drug use needs to be the health of the persons involved. Outside prisons this has been widely accepted, for instance by Canadian police forces. For example, in a formal statement Vancouver police spokesman Constable Scott Driemel gave the city's needle exchange unqualified support:

The police recognizes the needle-exchange program is a vital necessity in safeguarding the health of those people using the program.²⁹²

Making bleach available is also mandated by the fact that, because prisoners have reduced possibilities of protecting their health, and because this results from state action, the state has special responsibility for their health:

As prisoner's rights as human persons are necessarily curtailed to some extent, they are also entitled to more protection.²⁹³

As has been argued by the Hon. Justice Kirby, President of the Court of Appeals of New South Wales in Australia, governments and prison administrators have the duty to face up to the risks of the spread of HIV infection, since "offenders are imprisoned as punishment and not for punishment."²⁹⁴

ECAP concluded that, in addition to making bleach available in federal penitentiaries, it will be important to review institutional policies concerning possession of bleach. This should be done in order to convince inmates that cleaning injection equipment must be a priority for them if they inject drugs, and to reassure them that they will not be punished for possessing bleach.

(iii) *Availability of needles and syringes for injection drug use*

ECAP shares the concern that some inmates will not clean their injection equipment even if bleach is made available to them because of fear that they might be discovered during the extra time it takes to clean the equipment. Consequently, ECAP examined the more controversial issue of whether or not inmates should have access to clean drug-injection equipment.

The scarcity of drug-injection equipment in correctional facilities almost guarantees that inmates who persist in drug-injecting behaviour will share their equipment. Some injection drug users have stated that the only time they ever shared needles was during imprisonment and that they would not otherwise have done so.²⁹⁵ Access to clean drug-injection equipment would ensure that inmates would not have to share their equipment.

However, making needles and syringes available in federal penitentiaries raises many contentious and potentially divisive issues and elicits fear among both inmates and staff. Because needles and syringes have not been made available in any prison system, data on the efficacy, benefits, risks, harms and cost-effectiveness of making them available are lacking. For example, it is not clear whether the model developed for needle exchange outside prisons could be adapted to prisons. Whereas the impact of needle distribution or exchange on levels of injection drug use outside prisons appears to be negligible, its impact in prisons is unknown. Safety and security issues also have to be examined, although there is no inherent reason to believe that the needles that would be made available would be more dangerous than those already present in penitentiaries. ECAP therefore concluded that while there are several reasons for making needles and syringes available in prisons, it would not be feasible to make them available at this time. The reason for this is not that making them available might be unacceptable to prison authorities, staff, inmates or the public, but that how to make them available in a safe and confidential manner is not known. Research is needed on this issue.

Many organizations, groups and individuals have called for or supported making needles and syringes available in prisons, but many have also recognized that more needs to be known

about how this might best be done. For example, Riley stated that "[t]he development of syringes that could not be used as weapons also has to be considered a priority," that "[a] community-style syringe exchange ... raises problems of confidentiality for inmates," and that "[o]ther solutions have to be worked out for both regular prisons and 'open' prisons...."²⁹⁶ PASAN pointed out that a needle exchange program "must guarantee confidentiality" and that "without such a guarantee, prisoners will not make use of the exchange and the intervention will fail."²⁹⁷ However, PASAN then suggests "that needles be exchanged through the health service" and that "prisoners should not be accountable to non-medical prison staff (including guards) when obtaining needles."²⁹⁸ Since ECAP was often told that inmates would not go to the prison health service to ask for condoms for fear of being identified as someone engaging in sexual activity, the Committee does not believe that making needles available through the health service would solve the problem of confidentiality. Further, PASAN suggested that needles be exchanged in a "one-for-one manner," meaning that only those who already have a needle would be able to get a new one through the exchange.²⁹⁹ This would ensure that the number of needles in the institutions would not be increased. However, it would also mean that inmates would still have to share injection equipment.

In conclusion, ECAP considers that, at this time, making needles and syringes available in penitentiaries is not implementable. However, studies need to be undertaken on the feasibility and potential impact of establishing needle and syringe exchange or distribution programs in prisons. These studies should be empirical, carried out by researchers independent of but in collaboration with CSC, and include scientifically valid pilot projects. They should include open consultation and public input from all interested parties—for example, inmates, staff, prisoner, health and community organizations, CSC, Health and Welfare Canada, and the public.

(iv) Availability of methadone

The Committee agrees with the statement of Harding and Schaller that "methadone maintenance in prisons may also be effective in reducing the risk of infection."³⁰⁰ The Committee therefore considers that the care and treatment of drug users should include confidential access to methadone. Studies should be undertaken to establish the most effective ways of implementing methadone maintenance programs in penitentiaries.

D. Conclusions

ECAP considers that bleach should be made available to inmates in federal correctional institutions as a general disinfectant. In particular,

- small quantities of bleach should be included in a "health kit" given to every inmate on entry into the institution and offered to every inmate on exit from the institution;
- bleach should be made available to inmates in a manner similar to that for condoms, dental dams and lubricant; that is, small quantities of bleach should be easily and discreetly accessible.

ECAP considers that in making bleach available in correctional institutions, CSC's policies should be revised as follows:

- until bleach is made available as a general disinfectant, and thereafter, possession of small quantities of bleach should not be classified as an institutional offence, nor should it be considered to be presumptive evidence of illicit drug use;
- making bleach available in correctional institutions should be accompanied by a clear warning to inmates that possession or use of illicit drugs will not be tolerated in correctional institutions.

ECAP considers that the options for the care and treatment of drug users should include confidential access to methadone.

ECAP considers that there is a need to assess CSC efforts to prevent or reduce drug use and the harms from drug use and to care for and treat drug users in federal correctional institutions. This includes:

- the evaluation of programs already in place;
- studies on the impact of making bleach and of making methadone maintenance available and following up on their implementation; and
- research that will identify and develop measures, including access to clean injection equipment, that will further reduce the risk of HIV transmission and other harms from injection drug use in the prison environment.

6.4 Preventing the Harms from Tattooing

A. Current Situation

Tattooing is a prohibited activity in federal penitentiaries. Although data on its prevalence is lacking, it is generally agreed that tattooing is a prevalent activity in most penitentiaries.

B. The Debate

It has been said that "[o]utside tattooing is not thought to present much of a risk of HIV transmission because the needles are sterilised, but in prison tattooing is a social activity and involves sharing needles which may make it risky."³⁰¹ Similarly, Heilpern and Egger stated:

It is difficult to estimate how much tattooing occurs in prisons although the visible evidence is often quite striking. Because the activity is illegal it is almost certainly conducted with non-sterile equipment. The evidence on the risk of transmission is also unclear. In 1988, HIV infection was reported in two ex-prisoners, and tattooing appeared to be the primary risk factor. ... Whilst this evidence is far from conclusive it does suggest that attention should be paid to non-sterile tattooing equipment in prisons.³⁰²

In Canada the following measures to reduce the harms from tattooing have been proposed. The Ontario Regional HIV/AIDS Advisory Committee recommended that each institution review its rules and regulations regarding tattooing and that tattooing be permitted but not encouraged in all institutions.³⁰³

PASAN stated that tattooing is "an art form in which many inmates engage" and that "[i]t can be practiced safely if new needles are used for each tattoo and if safety guidelines are followed."³⁰⁴ PASAN therefore recommended that tattoo equipment and supplies be covered under "hobby-craft" and that expert tattoo artists should be brought into the prisons to help inmates learn to tattoo safely.

Heilpern and Egger stated that in Australia "[t]attooing is an integral part of the prison culture and will not be easily eliminated" and affirmed that "social and aesthetic judgments as to the merits of tattooing have no place in a HIV infection prevention program."³⁰⁵ The authors presented the following three options for dealing with tattooing in prisons:

- (1) Increased surveillance and confiscation of equipment. According to the authors this option would probably have little impact, given current experience with syringes, and may increase the risk that non-sterile equipment is used.
- (2) The provision of sterilizing equipment for tattoo needles. The authors believe that this option would be simple to implement and could be accompanied by an appropriate educational campaign about the risks associated with tattooing and the need for sterile equipment.
- (3) Allowing prisoners to engage professional tattooists. The authors believe that this option could also be easily implemented and accompanied by appropriate education.

C. ECAP's Assessment

ECAP was told by inmates and by staff that in many penitentiaries tattooing is a prevalent activity. Because it is prohibited it is done covertly and often results in the sharing of needles. ECAP believes that it would be unrealistic to think that this activity will stop. The Committee therefore examined a variety of possible ways to reduce the risk of contracting infections through tattooing. ECAP found that authorizing tattoo equipment and supplies for use in the institutions was accepted, often reluctantly, by correctional authorities and staff, and was supported by inmates. Further, ECAP supports both making educational materials on how to safely tattoo available to inmates, and instructing inmates who would offer safe tattooing services to other inmates. ECAP does not see this as condoning or promoting tattooing in penitentiaries. The Committee believes that in dealing with the harms from tattooing, concern for the health of inmates needs to be the primary consideration. While continuing to discourage inmates from having tattoos in the first place, CSC should authorize clean equipment for use in the institutions so that those inmates who nevertheless choose to have a tattoo can avoid contracting infections, HIV in particular.

D. Conclusions

ECAP considers that tattooing is a serious risk for the transmission of infectious diseases, including HIV, among inmates in federal correctional institutions, and that the following would reduce this risk:

- (1) tattoo equipment and supplies should be authorized for use in the institutions;
- (2) educational materials on how to tattoo safely should be made available to inmates;
- (3) inmates who would offer tattooing services to other inmates should be instructed about how to use tattooing equipment safely, and be prohibited from tattooing until they are proficient in safer tattooing procedures;
- (4) in the absence of such proficiency, institutions should consider providing inmates with access to professional tattooists from outside the institution who can do this safely.

6.5 Preventing the Harms from Piercing

A. Current Situation

Piercing is another prohibited activity in federal penitentiaries. Although data on its prevalence is lacking, it is generally agreed that piercing is a prevalent activity in most penitentiaries.

B. The Debate

The Ontario Regional HIV/AIDS Advisory Committee recommended that each institution review its rules and regulations regarding piercing and that piercing be permitted but not encouraged in all institutions.³⁰⁶

C. ECAP's Assessment

For the same reasons as for tattooing, ECAP considers that measures should be undertaken by CSC to reduce the risk of transmission of infectious diseases resulting from piercing with unclean equipment and supplies.

D. Conclusions

ECAP considers that piercing is a serious risk for the transmission of infectious diseases, including HIV, among inmates in federal correctional institutions, and that the following would reduce this risk:

- (1) piercing equipment and supplies should be authorized for use in the institutions;**
- (2) educational materials on how to pierce safely should be made available to inmates;**
- (3) inmates who would offer piercing services to other inmates should be instructed about how to use piercing equipment safely, and be prohibited from piercing until they are proficient in safer piercing procedures;**
- (4) in the absence of such proficiency, institutions should consider providing inmates with access to persons from outside the institution who can do this safely.**

7. PROTECTIVE MEASURES FOR STAFF

A. Current Situation

CSC has implemented a variety of measures to protect staff from exposure to and transmission of HIV and other infectious agents in correctional facilities. These include education about infectious diseases, provision of protective equipment, and development of infection-control guidelines.

With regard to educational programs for staff, Commissioner's Directive 821 reads as follows:

18. Regional Headquarters shall develop and coordinate a comprehensive educational effort directed at correctional staff and inmates. Specific components shall include:

- a. education materials and opportunities to be provided as part of the orientation for staff and for an inmate entering the system, and to include information on how AIDS is transmitted, infection control measures and precautions to minimize the risk of transmission of HIV; and
- b. opportunities for periodic information updates to ensure staff and inmates are kept informed on developments relating to AIDS.

As a result of the implementation of this policy, most staff have received education about HIV/AIDS. At the time of writing, educational programs were ongoing.

With regard to infection control, the Commissioner's Directive states:

14. For known or suspected cases of HIV infection, blood and body fluid precautions shall be instituted. Institutional health care staff, as subject matter experts, shall advise other staff regarding specific precautions.

15. Disposable gloves and resuscitation equipment and gowns shall be readily accessible to all staff, to be used at their discretion. Staff should be encouraged to use these when contact with blood or body fluids is anticipated, regardless of HIV infection status.

Guidelines for Infection Control were developed for staff in 1989, and contain information about the general precautions to be observed by all staff to prevent the spread of infection, as well as institutional procedures for cleaning and disinfecting the environment, equipment and supplies, cleaning of cells, kitchen and laundry, and "precautions to be observed with inmates identified as having an infectious disease."³⁰⁷ These guidelines stress that blood and body fluid precautions need to be employed universally, "whether or not there is an identified risk" and that "[s]taff safety is enhanced by assuming that any individual may be infected by a communicable disease."³⁰⁸

Staff have been provided with protective clothing and equipment, and at the time of writing efforts were underway to further study the needs of staff in this regard.

B. The Debate

There is general agreement that staff should continue to receive education about infectious diseases in general and HIV/AIDS in particular. For example, the Federal/Provincial/Territorial Advisory Committee on AIDS recommended that "[h]ealth authorities and persons responsible for correctional facilities ensure adequate and ongoing education/training on HIV/AIDS issues for their employees."³⁰⁹

PASAN recommended that "HIV/AIDS education should be compulsory for all inmates (male and female) and all staff providing services for incarcerated individuals...."³¹⁰ PASAN suggested that to "enable ... CSC staff to address HIV/AIDS issues comfortably, staff education should be a distinct and separate part of their orientation program at the beginning of employment" and that "ongoing mandatory sessions should be offered yearly."³¹¹ Further, PASAN recommended that such education should be comprehensive and should include, among other things, a review of how HIV is and is not transmitted, means of protection against HIV infection, community resources available to people with HIV/AIDS in the institutions and upon release, and universal precautions "reinforcing for staff and inmates that if these precautions are followed by everyone, there is no need to know a person's HIV status."³¹² According to PASAN, education of staff should be done by external organizations and community groups "to ensure that the program and information both remain current, unbiased, and accurate, and discourage phobias and misinformation."³¹³

The Ontario Regional HIV/AIDS Advisory Committee recommended that "[e]ducational efforts should be delivered towards both staff and offenders."³¹⁴ It further recommended that a handbook be developed for staff "which describes the general principles of AIDS and HIV infection" and should include information pertaining to modes of transmission, prevention, and treatment.³¹⁵ The Committee also recommended that a one-day workshop on HIV/AIDS for institutional physicians, chiefs of health-care services, and nurses be conducted.³¹⁶ This workshop, called "HIV in the Workplace: Knowledge is the Key to Prevention," was held on 13 October 1992. Following a plenary session, the participants broke into five groups to identify and discuss issues that were identified as potential risks or concerns. The following is a summary of some of the findings of the working groups.

(1) The first group discussed the nature of exposures in the correctional environment. The group concluded as follows:

1. Needlestick injuries are common. Tracking mechanisms are inadequate and reporting is poor. No specialized tracking mechanism exists for needlesticks such as a specific incident report which is collated and summarized to allow conclusions to be drawn. Needlesticks occur while providing immunizations or performing bloodwork on inmates. Sharps containers are often kept in locked cupboards and therefore not available which increases the risk of injuries. Special sharps containers are required which provide security for the contents as well as accessibility at the point of use of the needle.

2. Slashings are the second most common type of blood exposure both for health care providers and for security staff. Blood is occasionally collected by inmates and used as weapon against correctional staff. Security staff are not well versed in the

issue of universal precautions and the infectivity of various body fluids. There are no standardized procedures or supplies available to handle these situations.

3. Searches occur on a regular schedule in some institutions and on an "as needed" basis in others. While carefully examining a cell and its contents, injuries do occur from hidden needles, tattooing devices, razor blades, etc. The ways in which these objects are hidden is often extremely difficult to detect in advance. Using heavy gloves would provide for safety but would make carrying out the search effectively very difficult because palpation is an important way to detect contraband. A working group of experts in this area may be required to determine the best protocol for searches. It was also decided that searches should only be done when needed to balance the risks and benefits of this activity.

4. Emergency situations such as resuscitation occur and it is felt that existing equipment and protocols are inadequate to provide appropriate care and universal precautions. For example: one-way valve ambu bags, goggles, masks, gowns, etc. are required. Intravenouses are also started and new systems exist which limit exposures to needles during management of intravenouses.

5. TB exposure is a concern to health care staff. It is the impression of health care staff that the number of inmates with positive Mantoux skin tests are increasing. Twenty-five percent are felt to be positive at the Millhaven institution, for example, a good number of which are new immigrants.... This is of increasing concern because of the documented increased rate of multiple drug resistant TB occurring worldwide, especially in some parts of the U.S.A. with whom we exchange inmates regularly.

6. Other body fluids have been collected by inmates and thrown at correctional staff including feces and blood, semen, etc.

7. Suturing is also performed by contract physicians. When a slashing has occurred the nurse on duty can elect to use bandages and steristrip the slashing wounds. Depending on the circumstances this can result in significant blood exposure and protocols need to be developed to give uniformity as to how this situation is approached.

8. Cleaning of Blood Spills

Concern was raised that there is no standard protocol. Cleaners are decided upon by each institution and it may be better to have a uniform policy and procedure for cleaning up blood and body fluid spills. The point was made that different institutions have different types and different intensity of exposures to body fluids.

9. It was felt that standardized protocols, search carts and emergency carts with appropriate barrier supplies be established and stocked and checked on a regular basis.

10. There needs to be a process for evaluating new safety equipment and supplies before they are purchased and used in the correctional environment.³¹⁷

The second group discussed issues related to the disclosure of offender medical information. These concerns are addressed supra, chapter IV, section 3.

The third group discussed the management of health-care workers exposed to blood and bloodborne pathogens in the correctional environment and came to the following conclusions:

1. Documentation with a specific incident report form is required and does not presently exist.

2. A Health and Welfare Federal Nurse who covers the entire Ontario Federal Services cannot possibly track all such incidents.

3. It is recognized that no standard protocol for Occupational Health and Safety in the area of blood borne pathogens and exposure to blood and body fluids exists at CSC. This is felt to be urgently required. It was suggested that each institution would have a dedicated occupational health and safety nurse who would be involved in education as well as tracking needlestick injuries and other blood borne pathogen exposure which could be summarized and used to determine effective means of prevention. As well this person could provide standardization of the medical follow up of exposed health care workers with respect to Hepatitis vaccination, Hepatitis B immunoglobulin and where appropriate, AZT therapy when exposure to HIV has been shown to have occurred.

It was stressed that the current health care staff do not have the authority to provide medical assistance to other health care staff in their institutions.

4. Consultation should occur with experts in Infectious Diseases to give advice about developing a protocol for post-exposure management of health care workers, as well as prevention programs.

5. The confidentiality of the exposed health care worker must be maintained at all times. It was felt that the advantage of a Federal Health and Welfare nurse was that he/she kept separate records which were not part of the institutional records and therefore the level of confidentiality was high. Here again results could be summarized and provided to health care administration for the purposes of determining the causes of needlesticks in an unlinked fashion. If each institution was to have a separate Occupational Health and Safety nurse, which appears indicated, some mechanism for confidentiality would have to be worked out.

6. The psychological impact of the needlestick injury and the concern that these cause, must be acknowledged and efforts should be made to provide professional support of the health care staff in dealing with this level of stress.

7. It was felt that not enough emphasis has been placed on preventing needlestick injuring and other exposures to blood and body fluids in the correctional environment. This has to be the first priority and again, an institutional occupational health and safety nurse may be able to take the lead and manage these activities at each institution.³¹⁸

The fourth group discussed how universal precautions may be applied within CSC and came to the following conclusions:

1. Most institutions are different especially the Regional Treatment Center and therefore, protocols and procedures will differ from each institution although it was felt that some standardization of protocols was essential.
2. The barriers to implementation of universal precautions were:
 - a. Financial commitment is required and this seems to be decreasing.
 - b. Nursing staff and security staff need to be educated. This was felt to be an absolute high priority.
 - c. There has to be the allocation of appropriate resources and freeing up of time for the nurses involved to allow implementation to occur. An identified person has to be hired to carry out the process. i.e. Health and Safety nurse.
 - d. Application of universal precautions would have to take into account the unpredictable nature of the clients and the environment.
 - e. A resource occupational health and safety nurse who may also be involved with infection control, is required to implement universal precautions to maintain the educational process.
3. Suggestions for the implementation of universal precautions:
 - a. Standardization of protocols and procedures at institutions for the wearing of masks, gloves, gowns, and protective equipment.
 - b. Ongoing education, both when hiring staff and on an ongoing basis is necessary.
 - c. Follow up care for exposed health care providers needs to be standardized and supervised by appropriate nursing and medical staff.
 - d. Safety equipment should be used by all nurses and security staff and be provided in each work as required. Emergency carts and search carts, etc. were considered a good idea.
At the orientation of new hires for correctional staff universal precautions teaching should be standard.
 - e. Occupational health and infection control nurses at each institution should be involved with the standardization process throughout CSC and be involved in establishing the training program.³¹⁹

The fifth group discussed education regarding universal precautions at CSC and came to the following conclusions:

WHO:

Front line staff, health care providers, security staff, case managers, psychologists and instructors, etc. The management of health care need to be involved in establishing and maintaining the education process.

WHAT:

The fears, attitudes and misinformation that exists must be addressed. Very basic education is needed for the bulk of the staff with advanced education for the health care providers who will act as resource persons within each institution.

WHEN:

This was felt to be an urgent requirement. Education should have occurred a long time ago but at the very least, the process should begin immediately to upgrade the level of knowledge of all staff at Corrections Canada regarding universal precautions.

Education is not a one shot deal and a compulsory booster shot of education on a regular basis to upgrade persons is essential.

All correctional staff should receive basic universal precaution teaching during their correctional training.

HOW:

It was suggested that independent, professional educators would be necessary. A CSC occupational health and safety/infection control nurse may have the confidence of the staff in each institution to be credible and respected. The current Health and Welfare nurse has a huge area of supervision and cannot meet this need. The educator responsible must have knowledge of each institution and its unique needs. It is felt that at least one nurse occupational health and safety/infection control manager/educator was needed for each institution. In some larger institutions more than one such nurse will be required.

It was felt that this education requirement is urgent. It is necessary in order to decrease the fears and effect a change in attitudes starting with the correctional officer level and working towards other front line staff with an emphasis on long range planning. At regional and national levels there is a gap between policy and reality. This gap needs to be closed with some immediacy. It is necessary to translate planning for the future into action now using a fast-track approach.

An appropriately qualified medical consultant in infectious diseases and infection control should be sought by correctional services to act as a medical consultant to the implementation of the infection control/universal precautions and occupational health and safety issues. A working committee consisting of a designated occupational health and safety/infection control educator nurse at each institution plus the chiefs of health care and appropriate administrative staff along with this

medical consultant could go a long way to establishing uniform policy and procedures for implementation at CSC.³²⁰

The workshop issued the following recommendations:

1. THAT CSC begin **immediately** the education process for **universal precautions** for **all** staff [emphasis in the original].
2. THAT CSC provide the necessary equipment for the safe provision of health care and the handling of inmates' body fluids. This includes standardizing protocols for cleaning blood spills and providing equipment for safe search procedures as well as necessary emergency supplies.
3. THAT CSC provide for the immediate qualified medical follow up of all staff exposed to the blood or high risk body fluids of any inmate [emphasis in the original].
4. THAT CSC medical staff attempt to determine the infectiousness of the source inmate and provide for disclosure of this information when necessary for follow up of exposed staff. This must be done in a manner as to ensure the confidentiality of both the inmate and the staff member.
5. THAT CSC regional offices should seek the continued involvement of a qualified medical expert in infectious diseases to act as a consultant to CSC's occupational and infection control nurses.
6. THAT CSC hire an Occupational Health/Safety and Infection Control Nurse for each facility who would have the responsibility of educating staff and assisting in the development of protocols and procedures for the protection of the staff and inmates in each facility. This individual would be able to track each high risk exposure and ensure follow up was initiated.
7. THAT CSC establish regional infection and control committees. This complex and ever changing area of infection control requires a standing infection control committee mandated to develop, upgrade and implement protocols and staff educational programs for the prevention of transmission of infections in the correctional environment. The two top priority items for this committee would be the application of universal precautions and prevention of tuberculosis. Membership should include a regional medical expert in infectious diseases and occupational health/safety and infection control nurses in addition to CSC administrative staff, and representation from the inmate committees.

With regard to protective equipment and clothing, at the National Joint Occupational Safety and Health (JOSH) meeting in May 1992 a proposal was made to study and recommend the "best approach to ensuring that staff have access to appropriate clothing and equipment that

will provide protection against possible infection by an inmate who has an infectious disease."³²¹ As a result, a steering committee, acting as a subcommittee of the national JOSH, was established, and meetings were held "to identify the various clothing and equipment needs, depending on various scenarios in the institution and different work settings." As stated in the draft version of the report of the committee,

[t]he committee felt that it was important to ensure that the proper balance of theory and practicality was reached in making recommendations to ensure that staff would be adequately protected while still allowing them to be able to perform their duties unimpaired by cumbersome clothing or equipment.³²²

The draft report continued by saying that

[a] trade-off needed to be made between something that would virtually guarantee against spread of infection under any circumstance and what was practical, likely to be used and reasonably priced.

The committee's discussions focused on the following areas:

- (1) Identification of the occupational groups which would require the use of protective clothing;
- (2) Identification of the tasks/situations which would necessitate protective clothing against infectious diseases;
- (3) The clothing staff would require;
- (4) The location of the protective clothing and equipment;
- (5) The preparation of policy documents and guidelines supporting and enforcing the use of protective clothing.

The discussions "highlighted the importance of staff practising Universal Precautions" and it was emphasized that "[r]esearch of practices used in a multitude of settings in North America and Europe, indicated that these procedures in combination with appropriate clothing and equipment were commonly accepted as being adequate protection against the spread of infectious diseases."³²³

Clothing and equipment needs were identified with regard to specific work settings and job categories in CSC. The following are some of the recommendations:

4.1 Institutional Operations

4.1.1 Daily Activities

As a basic requirement, all correctional staff should be issued a small kit that could be attached to their belt containing disposable latex gloves and a disposable airway for applying mouth-to-mouth resuscitation. ...

4.1.2 Controlling an Aggressive Inmate

In a situation where it is known in advance that the inmate will be uncooperative, the first approach would be to use something to try to subdue the aggressiveness of the inmate, thereby reducing the risk of physical confrontation with the officer.

Failing that, it is recommended that a water repellant jumpsuit, helmet, gloves (waterproof and cut resistant) and mask be used. These clothes should be available in a central location in the institution and in sufficient numbers and sizes to ensure adequate coverage. ...

4.1.3 Cleaning up Body Fluids

Disposable latex "floor" gloves should provide sufficient protection. ...

4.1.4 Cell Searches

Officers need to search in dark and inconvenient places for contraband and this sometimes involves using their fingers to feel for things. Research is being done to find a way to use a machine (eg. laser, scanner) that would be able to identify foreign objects. In the interim, the use of mirrors for viewing underneath objects is strongly encouraged so that an officer will not prick himself/herself with a sharp object. A puncture proof glove is also being investigated for usefulness. However, in some cases the coating makes the glove so thick that it isn't possible to feel very much.³²⁴

The draft report concludes by saying that "[t]he Service has an obligation to protect its employees from being infected with any communicable disease" and that "[t]hrough input from local JOSH committees and collaboration with regional and national staff, an approach will be developed that will ensure that CSC staff will be properly protected."³²⁵

In Australia, it has been stated that "[t]he precautionary procedures to be followed by prison staff are essentially the same as for health workers."³²⁶ The Australian Council of Trade Unions (ACTU) has listed the following three elements essential to a union response to HIV infection:

- Implementation of occupational health and safety guidelines on infectious diseases in the workplace.
- Provision of clear and accurate information on infectious diseases to all union members.
- Protection of union members, particularly those perceived to be members of high risk groups, from discrimination in the workplace.³²⁷

Heilpern and Egger have identified the following key elements of an effective occupational health and safety program:

- Occupational Education
The authors state that staff education should stress the use of universal infection-control precautions and should include instructions on procedures to be adopted in a variety of specified situations involving contact with an inmate's blood or bodily fluids.
- Infection-Control Guidelines
The authors recommend the development of infection-control guidelines to be disseminated widely throughout prisons, and regular assessment respecting compliance with such guidelines.

- Exemptions from Correctional Duties

While acknowledging that there is generally no reason to excuse staff at their own request from working with prisoners with HIV infection or AIDS,^[27] the authors state that special exemptions, for example for pregnant employees, may be desirable.

- Employees with HIV Infection

Importantly, the authors state that no work restrictions need be imposed on correctional staff who are diagnosed as seropositive, whether transmission was work-related or not.

C. ECAP's Assessment

ECAP strongly feels that staff concerns for their safety have to be taken very seriously. In order to learn more about these concerns, the Committee met with staff during its prison visits, sent a questionnaire to staff, and consulted with the Union of Solicitor General Employees. ECAP recognizes that the protection of staff against the risks of HIV transmission is clearly an important obligation borne by CSC. ECAP further acknowledges that there are many situations in which staff may potentially be exposed to infectious diseases, including HIV infection. Such situations include conducting body and cell searches, performing emergency first aid where blood or other body fluids are present, controlling aggressive inmates, and supervising the cleaning of blood and body fluids.

ECAP commends CSC for its efforts to protect staff against exposure to and transmission of infectious diseases. These efforts have included education about infectious diseases and the risk, or absence of risk, of transmission of infections in the workplace, the issuing of infection-control guidelines, and the provision of protective clothing and equipment to staff. However, staff's concerns about and fear of being infected with infectious diseases, in particular with HIV, during the course of their work persist, as do misperceptions about the risk of HIV infection attributable to work in federal penitentiaries. ECAP identified a variety of measures that could be undertaken by CSC to provide staff with increased protection and alleviate their concerns and fears.

(1) Education

ECAP considers that education is the best prevention. The Committee acknowledges that CSC has made a major effort to educate its staff. As a result, staff are generally well-informed about HIV/AIDS. However, some staff reported to ECAP that they had not received education about HIV/AIDS or that it had been provided to them a long time ago and had not been updated. Other staff, although they had received education, had unnecessary fears and misperceptions about HIV transmission. Preliminary analysis of the results of the questionnaire that ECAP sent to staff reveals that staff consider that they need and should receive more and updated education and information. ECAP believes that education and information should be provided on a regular basis, and that its credibility would be improved by asking experts or external, community-based AIDS and health organizations to provide input into it.

[27] In Canada, this issue was addressed in the case of *Walton*. See *supra*, chapter III, section B(3).

(2) *Infection-control guidelines*

ECAP commends CSC for having developed infection-control guidelines for staff. However, the Committee believes that these could be improved by updating them on a regular basis. Further, an increased effort could be made to train staff to apply infection-control procedures and practices universally whenever they may be exposed to an inmate's blood or body fluids. This would include educating staff about the need to always comply with universal precautions when confronted with such situations, and not only when this is convenient or when an inmate is known to be infected. In particular, ECAP does not believe that revealing the HIV status of known infected inmates to staff would increase staff safety. On the contrary, ECAP is convinced that this would be counterproductive in terms of their safety, in particular with regard to efforts to educate staff to always use universal precautions. A brief, authoritative document on HIV/AIDS, tailored for correctional service staff, could be developed to address the fact that there is a low risk of contracting infections when working in the correctional environment and that there are ways in which this risk may be reduced or avoided.

(3) *Provision of protective equipment*

ECAP strongly supports the findings of the report of the committee studying protective clothing and equipment and encourages CSC to act upon its recommendations.

(4) *Preventing exposure*

ECAP agrees with the finding of one of the working groups at the workshop on HIV/AIDS recently held in the Ontario Region that "not enough emphasis has been placed on preventing needlestick injuries and other exposures to blood and body fluids in the correctional environment."³²⁸ The working group concluded that "[t]his has to be the first priority."³²⁹ ECAP acknowledges that staff cannot always avoid exposure and that they will sometimes be unable to use precautions, such as when they are assaulted by inmates. Nevertheless, as was stated in the report of the committee studying protective clothing and equipment, there are many situations "where it is known in advance that the inmate will be uncooperative."³³⁰ ECAP agrees with its assessment that in such situations "the first approach would be to use something to try to subdue the aggressiveness of the inmate, thereby reducing the risk of physical confrontation with the officer."³³¹ ECAP considers it essential that there be continuing education of staff about how to react to "risky situations," such as when inmates are violent.

(5) *Follow-up of exposure*

ECAP considers that any incident involving exposure to blood or body fluids should be immediately followed up and that procedures should be developed for doing so. Such situations are relatively common in health-care settings, and there is extensive experience concerning the management of them. Follow-up would include a written report about the incident and a medical assessment of whether there has been a potential risk of HIV transmission. In most cases, such as when staff have been bitten or spat upon, there will be no risk or minimal risk of HIV

transmission.^[28] It should be noted that there has been only one documented case of occupational transmission in any prison in the world.^[29]

Following exposure, staff should be offered counselling and psychological support. Where it is established that there has been a risk of HIV transmission, early medical intervention should be available, including prophylaxis with AZT and referral to specialists familiar with the problem. At the same time, the person who is the source of the exposure should be encouraged to volunteer information about his or her HIV status. Those who do not know their HIV status should be encouraged to undergo voluntary HIV testing (see Appendix 1).

(6) *Family and partner support*

ECAP considers that the families and/or partners of staff should be encouraged to participate in educational sessions on HIV/AIDS. Further, they should have access to counselling and psychological support at their request whenever the partner has been exposed to HIV.

ECAP is convinced that what are often perceived as conflicting interests between staff on one side and prisoners on the other are really compatible interests. For example, measures that will protect inmates, such as providing them with education and the means to protect themselves against HIV infection (including bleach), will ultimately also benefit staff and the public because they will result in fewer infected inmates being housed in the institutions and in fewer infected inmates being released into the community after serving their sentences. Equally, the measures that will protect staff from contracting HIV infection, namely education and the application of universal precautions, are compatible with the inmates' interest in seeking out counselling and HIV testing and in maintaining their medical information confidential until they decide themselves to share it with others.

D. Conclusions

ECAP considers that education about HIV infection and AIDS is the most important effort to promote and protect the health of staff and prevent

[28] This was recently acknowledged in the case of *Lesieur*, in which an inmate who knew that he was HIV-positive tried to bite CSC staff. He then sprayed them with his blood, saying he would thus contaminate and kill them. The inmate was charged with a number of offences, including attempted murder. On 17 February 1993 a jury returned a guilty verdict on charges of assaulting a peace officer, uttering threats to cause death or serious bodily harm, and assault causing bodily harm. However, the inmate was found not guilty on the charge of attempted murder (see chapter III, section 3(B)(2)). In another case, decided in November 1992, another federal HIV-positive inmate was convicted of assault and sentenced to six months' imprisonment after he bit a correctional officer at Port-Cartier Institution. These cases clearly show that courts acknowledge the absence of risk of HIV transmission in such incidents.

[29] This case occurred in Australia. It was alleged that a young officer, newly recruited to the service, was attacked and stabbed with a blood-filled syringe. The officer later tested positive for HIV. The incident was widely reported in the press. See Doyle J. Management Issues—A Prison Officers Union Perspective. In: HIV/AIDS and Prisons, *infra*, endnote 111. Until July 1990 there were no known cases of occupational transmission among correctional staff anywhere in the world. See Hammett, *infra*, endnote 70.

transmission of HIV and other infectious agents in federal correctional institutions. ECAP recognizes that educational efforts are already in place in correctional institutions but it considers that these efforts may be improved by the following:

- (1) All staff should receive written information about HIV infection and AIDS. This could be in the form of a brief, authoritative document tailored for correctional service staff from an outside organization or expert. This would point out the low risk of contracting infections through working in the correctional environment and indicate ways in which this risk may be reduced or avoided.
- (2) All staff should receive educational sessions about HIV infection and AIDS, including the subject of universal precautions, when they begin their employment and on a regular basis thereafter.
- (3) External, community-based AIDS and health organizations or experts should be invited to participate in these sessions.
- (4) Family members or partners of staff should be encouraged to attend the educational sessions.

Further, ECAP considers that, for staff to protect themselves, access to and the correct use of materials and equipment with which the risk of transmission of infectious diseases, including HIV, may be reduced, are essential. ECAP recognizes that materials and equipment are already available in federal correctional institutions. However, in order to reassure staff and to ensure continued proficiency in the use of such materials, equipment, and protective procedures and practices, CSC should:

- (1) regularly review access to and use of protective materials and equipment;
- (2) regularly review protective protocols and staff compliance with them;
- (3) provide the necessary equipment for the safe provision of health care and the handling of body fluids. This includes standardizing protocols for cleaning blood spills and providing equipment for safe search procedures as well as necessary emergency supplies. In particular, CSC should consider provision of so-called puncture-resistant or cut-resistant gloves to replace latex gloves for use when handling emergency situations, dealing with aggressive or violent inmates, and carrying out searches.
- (4) provide for the follow-up, including medical follow-up, of all staff exposed to the blood or blood-contaminated body fluids of any inmate or fellow staff.

8. HEALTH CARE

A. Current Situation

In 1988 the Correctional Services' Health Care Branch adopted national standards for health care "to ensure that offenders receive up-to-date care throughout their sentences, care which is comparable to that available in the community."³³² According to the document, *Standards for Health Care*,³³³ the objectives of CSC health services are as follows:

Although the offender has the primary responsibility for his/her own health status, CSC is responsible for ensuring appropriate, equitable and adequate access to professional physical and mental health services. These services contribute to the offenders' adjustment within the institution and assist them to become law-abiding citizens by:

- 1) identifying through assessment/diagnostic services the needs of individual offenders and special categories of offenders amenable to assistance from health services;
- 2) providing services and continuity of care for offenders suffering from physical, psychiatric, emotional, social or behavioral difficulties, at standards of professional quality consistent with those governing the provision of services to the Canadian public in general; and
- 3) providing advice or guidance as subject matter experts for the purpose of strengthening an overall, integrated CSC physical and mental health service.³³⁴

In order to ensure an integrated, comprehensive service from the admission of an offender until his or her release, the following principles were established:

1. A multi-disciplinary approach to the provision of care to the offender throughout his sentence shall be implemented;
2. The offender retains the primary responsibility for maintaining and improving his/her health status, notwithstanding the constraints inherent to the correctional environment;
3. The offender is entitled to reasonable access to the full range of health services, including prevention, treatment and rehabilitation, in accordance with generally accepted community standards;
4. Health service delivery shall be appropriate to the offender's age, sex and condition and shall respect the individual's religious or cultural values;
5. The offender, who is of sound mind, has the right to refuse health treatment or advice except where otherwise provided by law. The health professional is obligated to provide the necessary information to enable the offender to make an informed decision;
6. The offender has the right to have medical information dealt with in a confidential manner. Standards of confidentiality shall be consistent with professional standards, Commissioner's Directives, the Privacy Act and other federal legislation;

7. Current professional standards promote the obtaining of a second opinion where there is a margin of doubt. CSC shall provide this service upon the request of the physician. However, second opinions initiated by the offender may be permitted at the offender's own expense;
8. The health delivery system within CSC must meet the requirements of existing federal laws and applicable provincial legislation;
9. The health delivery system shall be based on the community health model, with a focus on the health of the prison community as a whole, by intervention at the individual and group level. The curative and preventive services offered shall be coordinated to encourage continuity of care for the duration of the sentence;
10. The health services shall be provided by health professionals/practitioners currently registered/licensed (or eligible for registration/licensing) in Canada and preferably in the province of practice;
11. The range and level of health services available to offenders shall be established in policy and audited on a regular basis; and
12. All research undertaken shall be approved by a research review committee charged with the responsibility to ensure that ethical standards, proper design and supervision are met, and that the full voluntary and informed written consent of the participant is obtained.³³⁵

A list of standards for the delivery of Health Care Services to offenders within CSC was drawn up. These standards "must be considered when programs are being developed and delivered,"³³⁶ and include, among others:

- **Informed Consent and the Right of Refusal**
Informed consent of a mentally competent offender shall be obtained before commencing a treatment program and such an offender shall have the right to refuse treatment.
- **Research**
Any research which involves offenders as subjects, shall be approved by a research review committee. This committee shall ensure that all research meets the highest ethical standards and has proper design and supervision. Offender participation shall be contingent upon voluntary and informed written consent.

- Levels of Service

The Correctional Service of Canada shall ensure the provision of a range of health services for offenders including mental health and general health care. Services shall be available at a primary, intermediate and intensive or tertiary service level.

Criteria

- 1) Primary level of service shall be provided on an ambulatory basis to offenders who remain in general population.
- 2) Intermediate level of service shall be a specialized program delivered in a dedicated living space within a regular institutional setting.
- 3) Intensive/tertiary level of service refers to in-patient beds in a facility designated under mental health legislation or to in-patient beds in a general hospital.

- Access to Services

Offenders shall have access to health services on a 24-hour basis.

Criteria

- 1) Clustering of all services, where proximity of institutions allows for cost effective use of it, shall be implemented.
- 2) Where 24-hour nursing coverage is not provided on-site, staff with basic first aid and cardio-pulmonary resuscitation (CPR) training will be on duty.
- 3) Nursing services shall be provided 24 hours per day in institutions where in-patients are cared for (Intermediate level).

- Referrals

Referrals to outside agencies for consultation, treatment and surgery shall be for essential services. Essential services can be categorized as emergency, urgent or non-urgent.

Criteria

- 1) Emergency: a case where delay will endanger the life of the offender.
- 2) Urgent: the condition is likely to deteriorate to an emergency or it is interfering with the offender's ability to carry out his or her activities of daily living.
- 3) Non-urgent: the condition is not affecting the offender's activities of daily living now, but may in the future.

- Admission Assessment

Assessment of all offenders' health status shall be completed on admission.

The *Correctional and Conditional Release Act* also emphasizes health, safety and personal dignity. Further, it prohibits any treatment that is cruel or degrading and seeks to ensure that

standards comply with United Nations treaties and the *Canadian Charter of Rights and Freedoms*. The relevant provisions of the *Act* read as follows:

- 86.(1) The Service shall provide every inmate with
- (a) essential health care; and
 - (b) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.
- (2) The provision of health care under subsection (1) shall conform to professionally accepted standards.

87. The Service shall take into consideration an offender's state of health and health care needs

- (a) in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and
- (b) in the preparation of the offender for release and the supervision of the offender.

With regard to treatment, s. 88 of the *Act* provides that offenders must give their informed consent to any treatment, have the right to refuse treatment, and may participate in research projects, but only if they give informed consent and if an independent committee has reviewed the case and approved the project.

In accordance with these provisions and the above standards, every inmate entering the federal penitentiary system goes through a thorough health assessment. This includes screening for tuberculosis. Inmates are also offered hepatitis-B vaccination.

B. The Debate

CSC makes major efforts to ensure that the quality of care available to inmates in the federal corrections system is on a par with that available to Canadians generally.³³⁷ It has mandated the Health Care Advisory Committee to monitor these efforts.

Nevertheless, prisoners with HIV infection have sometimes complained that they have not received adequate medical care:

They [inmates with HIV/AIDS] know that, without the specialized medical attention which they will not receive in a Canadian prison, they are facing terrible suffering.³³⁸

The Federal/Provincial/Territorial Advisory Committee on AIDS has recommended that all inmates have access to "medical, nursing, in-patient and out-patient services equivalent to those available in the community at large."³³⁹

PASAN has recommended that "[p]risoners with HIV/AIDS must be guaranteed access to medical and dental workers of their choice" and that "they must have access to experienced and expert HIV primary care physicians."³⁴⁰ Further, it has been suggested that a comprehensive plan for the medical and psychosocial care of prisoners with HIV infection should be

developed,³⁴¹ and that prison populations be included in research on new treatments of HIV infection and AIDS.

The Ontario Regional HIV/AIDS Advisory Committee recommended a variety of measures to establish "strong and effective links with community treatment programs in order to facilitate their work with offenders, both outside and within CSC facilities." In particular, the Committee recommended that:

The Chief Health Care Services and the Deputy Warden Correctional Operations of each institution, in consultation with the visiting physician, shall ensure that appropriate facilities are available for the provision of confidential assessment and treatment services to offender patients which will also provide the highest level of security.³⁴²

This Committee also addressed concerns about the privacy and security of inmates escorted to outside HIV/AIDS clinics, and examined the issue of the sharing of information with community agencies assisting CSC in the management of offenders with HIV/AIDS, and the provision of services to an institution located at a great distance from available community services.

Internationally, there is emerging agreement that, with regard to access to health care, the same standards that apply outside prison should apply to prisoners.³⁴³ This was stated in the United Nations "Basic Principles for the Treatment of Prisoners"³⁴⁴ and the World Health Organization stated that this principle of equivalence should apply to HIV/AIDS.³⁴⁵

In the United States, the principle was reaffirmed by the Presidential Commission on the HIV Epidemic, which recommended that "[c]are and treatment available to HIV-infected inmates in correctional facilities should be equal to that available to HIV-infected individuals in the general community,"³⁴⁶ and by the National Commission on AIDS:

Individuals who test HIV positive need to be properly examined and regularly monitored by a physician who is knowledgeable about infectious disease and keeps abreast of medical developments in HIV treatment. The full range of approved medications to prevent or treat symptoms of HIV disease must be available in order for the promise of early intervention to be fulfilled.³⁴⁷

The Commission acknowledged that, "[b]ecause treatments for HIV disease tend to be novel, experimental, and expensive, HIV disease tests the limits of prison health care."³⁴⁸

With regard to participation in clinical trials, the Commission stated that "[a]s new drugs become approved and available through clinical trials, prisoners should and can be permitted to choose to participate in clinical trials, while remaining protected from coercion and abuse."³⁴⁹ The Commission concluded that adequate care in correctional facilities includes, but is not limited to:

- meaningful access to HIV testing ...;
- regular examinations by physicians with sufficient training to diagnose and treat HIV infection and HIV related illnesses;
- a full physical examination at the time infection is diagnosed, and subsequently as medically indicated;

- access to necessary specialist care where appropriate;
- T-cell monitoring at the intervals prescribed by the U.S. Public Health Service;
- timely, consistent and appropriate access to necessary medications, including prophylactic drug therapies approved by the Food and Drug Administration or recommended by federal health authorities;
- access to dental care;
- access to mental health care;
- access to meaningful drug treatment on demand;
- clean, hygienic housing facilities; and
- appropriate diets.³⁵⁰

Similar recommendations were made by the United States National Prison Project.³⁵¹

In Australia, Heilpern and Egger acknowledged that "[t]o provide an equivalent medical service to that available in the community, in a prison setting, is a formidable task for both prison administrators and health authorities."³⁵² They recommended that policies and plans be prepared to meet a potential increase in the number of seropositive prisoners likely to develop symptoms while serving prison sentences, and that these policies should address:

- the development of criteria to ensure that prisoners receive equivalent medical care to that provided in the general community;
- the evaluation of existing medical services against these criteria;
- planning to develop co-operative programs with [the] Department of Health;
- the long term resource needs of the prison medical services;
- accessibility of community-based multidisciplinary services.³⁵³

Summarizing the situation with regard to medical care at the international level, Harding and Schaller have stated:

Some prisoners receive up-to-date, state-of-the-art specialized care for their HIV disease. Many do not. Expensive treatments may not be financed by prison services; many therapies, such as aerosolized pentamidine, are not available to inmates unless they are hospitalized. In many instances, overstretched prison medical facilities are unable to organize and maintain the necessary care.³⁵⁴

C. ECAP's Assessment

ECAP commends CSC, and in particular CSC's health-care services, for the efforts made to provide HIV-infected inmates with quality medical care. In particular, ECAP recognizes that there is genuine concern and effort to provide inmates with health care that is comparable to community standards outside prisons. This includes efforts to assess the quality of services in place and to respond to emerging trends, innovations and problems in health care, in particular through CSC's Health Care Advisory Committee.

Attesting to this, ECAP heard from some inmates with HIV infection and from those who care for inmates with HIV infection or AIDS, that the care that inmates with HIV infection or AIDS receive may be better than the care that would be available to them outside prison.

Nevertheless, ECAP was informed of instances in which inmates with HIV infection have not had access to medical care that would have been available to them outside.

ECAP has identified at least three reasons for this problem, namely: the restricted mobility of inmates; medical coverage when illnesses occur; and the capacity of medical services to expeditiously provide care and treatment.

(1) *Restricted mobility of inmates*

Access to health care for persons with HIV infection or AIDS who live outside prisons is relatively uncomplicated and efficient. Usually they need only arrange an appointment with their physician or go to a clinic or hospital to obtain the care they may require. For inmates, access to health care necessitates arranging for a visit to a physician, clinic or hospital outside the correctional facility, or waiting until this service is available in the institution. Interim services are provided by the prison health services. HIV infection and AIDS are complex diseases that often require expertise not widely available in Canada, including inside correctional facilities. Logistical problems in safely transporting inmates to where this expertise is available or in having experts visit an institution may require justification that the care is necessary at a particular time, and may lead to delays or to perceptions of institutional inefficiency or of care not being accessible. These problems may be aggravated by the security arrangements required for transporting inmates. Some of these problems are analogous to those of persons living in remote areas, and the solutions to them involve balancing needs, benefits, costs and logistics. Sometimes the only effective solution may be for the person to relocate nearer to the required services. In the context of federal penitentiaries, relocation of inmates who require very complex or urgent care may be one solution to this problem. Another may be for prison health services to ensure that their medical staff are proficient in providing this care. However, this solution is not possible without the trust and confidence of the inmate in the services available.

(2) *Medical coverage when illnesses occur*

Although the onset of such diseases as immunodeficiency, wasting, or neurological disease attributable to HIV infection is a slow process, secondary infections or complications from these diseases or their treatment may develop rapidly and require urgent care. Examples include herpes simplex or herpes zoster infections, *Pneumocystis carinii* pneumonia and *Toxoplasma* meningoencephalitis. Development of such diseases at "off hours" or in institutions without physician coverage is a problem aggravated by the restricted mobility of inmates and their vulnerability to judgment by non-medical staff. Again, there would not appear to be any simple solutions to this problem. Among the possibilities are relocation of inmates, increased staffing and services, and communication with health-care personnel that bypasses staff decision-making concerning the need for such communication.

(3) *Capacity of medical services to provide care and treatment*

The growing complexity of care for HIV-infected inmates or inmates with AIDS poses difficult operational and logistical problems for prison health services (for example, access to new and often experimental treatments, access to special diets, availability of diagnostic tests that are often available only at tertiary-care centres, access to psychosocial support, in particular that provided by peers or community organizations, and access to research studies). These problems are not

unique to inmates with HIV infection or AIDS, but the growing diagnostic and treatment burden relating to this disease requires that they be solved as soon as possible. Among the possible solutions are prisoner relocation at their demand, increased staffing and services, recognition by staff that such care is not only necessary but that inmates are entitled to it, and closer liaison with outside health-care and community services.

ECAP recognizes the economic, security, administrative and geographic constraints imposed on health-care services in federal penitentiaries. Balancing the health needs of inmates with the availability and accessibility of services is not a simple problem, and ECAP considers that greater study is required to solve it than the Committee could provide. At the same time, the Committee considers that changes that would provide interim improvements in this system could be implemented. These changes are designed to improve trust and confidence of inmates in this system, in particular by providing them with the opportunity to communicate with prison health staff confidentially, and by enhancing opportunities to access new treatments and peer or community counselling and support services. ECAP further suggests that the approach provided by the Ontario Regional HIV/AIDS Advisory Committee be followed, namely that health services in each institution be assessed to ensure that the expertise necessary for the medical care of inmates with HIV infection or AIDS is available.

D. Conclusions

ECAP agrees that the care of inmates in federal correctional institutions should be comparable to that available in the community. In the context of HIV/AIDS, this includes access to new, experimental or special treatments, special diets, and peer and community-based organization counselling and support. ECAP acknowledges the efforts that CSC's health-care services have made to provide inmates with HIV infection or AIDS with care and treatment. However, in order to meet the community standard, ECAP considers that:

- (1) strong and effective links with external health-care services are necessary to ensure that the care of inmates with HIV infection or AIDS is efficient and accessible, and that continuity of care is provided for whenever they are transferred, given temporary absences, or are released;
- (2) incarceration should not be an impediment to accessing new or experimental or special treatments for HIV infection, AIDS or their associated diseases, or for enrolling in research studies to which those with HIV infection or AIDS would otherwise be eligible to enroll; when such services or treatments are unavailable or inaccessible, the inmate should have the opportunity to relocate to an institution in which they would be accessible, subject to security considerations;
- (3) health-care services in each institution should be assessed to ensure that the expertise necessary for the medical care of inmates with HIV infection or AIDS is available, and that the services for dealing with the care of inmates with HIV infection or AIDS will be efficient and accessible;

(4) external community-based AIDS or health organizations should be readily accessible to inmates with HIV infection or AIDS;

(5) in each institution, CSC should create or designate one or more inmate jobs as peer health counsellors, and provide for appropriate training, support and evaluation.

9. TUBERCULOSIS

A. Current Situation

In order to prevent the spread of tuberculosis (TB)^[30] in federal penitentiaries, in 1990 CSC adopted a policy that provides for voluntary TB testing of inmates entering the correctional system. Unless there is documented evidence available that a TB skin test was done prior to admission, inmates are Mantoux or tuberculin tested upon entry into the federal institution. Inmates are exempt from the test only when they have been vaccinated with Calmette-Guérin bacillus (BCG) or when they have tested positive on a past occasion. When, on admission, an inmate has a positive reaction to the TB skin test, has had a positive skin test in the past, has received BCG, or refuses TB skin testing, he or she will be screened for TB by chest x-ray. If the x-ray suggests infection, a sputum specimen is tested for the presence of TB. When it is confirmed that an offender has tuberculosis and is infectious (has active TB), he or she will be isolated until no longer infectious to prevent the further spread of the disease. When an inmate refuses an x-ray, the physician will decide whether there is sufficient concern to transfer the person to the health-care centre for observation.

In response to the recent development of drug-resistant strains of tuberculosis, CSC decided to annually retest inmates who have previously tested negative on Mantoux testing.^[31] This will allow "identification of persons who may have had contact with the disease and are at significant risk of developing it and infecting others."³⁵⁵ This policy was approved by the Laboratory Centre for Disease Control of Health and Welfare Canada.^{356[32]}

In 1992 there were five new cases of TB in federal penitentiaries—three in the Ontario Region and one each in the Quebec and Atlantic Regions. In January 1993 there were two new cases of TB in the Quebec Region and in February 1993 there were three new cases in the Ontario Region.³⁵⁷

In December 1992 active TB was diagnosed in an HIV-infected inmate housed in Drummond Institution. At the time of entry into prison, the inmate had refused both TB and HIV testing. The inmate later tested positive for antibodies to HIV. In December 1992 he was admitted to a community hospital where he was diagnosed as having active TB, HIV infection, and opportunistic infections. At Drummond Institution a plan of action was formulated: the institutional physician arranged for a local infectious-diseases specialist to speak to staff and inmates about TB; information meetings were held with union members and the institution's Health and Safety Committee as well as the Inmate Committee; a video was prepared by the Chief

[30] In this section the term TB is used to indicate infections with *Mycobacterium tuberculosis* and excludes other strains of mycobacteria.

[31] Some newspapers incorrectly reported that CSC was planning to immunize all inmates against tuberculosis.

[32] Policies concerning TB have also been adopted by some of the provincial prison systems. See, e.g., the directive of the Alberta Solicitor General, Correctional Services Division, Section: Health Services, Number: 20.15.05 of 5 June 1990. According to this directive, TB testing "shall normally be administered only to offenders that fall into identified high risk groups, however centres retain discretion to conduct TB tests in a more generalized manner."

of Health Care and by the Inmate Committee and broadcast periodically over the internal closed-circuit television system; an information bulletin was prepared and distributed to each employee of the institution; and staff and inmates were screened to determine if any were infected with TB.

B. The Debate

Tuberculosis has featured in news headlines in Canada for the first time in decades. A curable disease has once again emerged as a public health threat in the developed world. The resurgence of TB in the United States, attributable in great part to the HIV epidemic and the social conditions that give rise to the spread of TB, and the emergence of multiple drug-resistant strains of tuberculosis (MDR-TB), has created increasing concern in Canada. Recently, outbreaks of MDR-TB have occurred in the United States in occupational settings such as hospitals and prisons, with serious consequences for HIV-infected persons and for health-care workers. It has been said:

In many areas of the United States the battle against tuberculosis is being lost. Two major markers of this failure are the increasing incidence of tuberculosis and the rising prevalence of drug-resistant tuberculous infection. The recent epidemic of multidrug-resistant tuberculosis in several East Coast hospitals and an explosive outbreak in the New York state prison system have taken well in excess of 100 lives. Since 1985, after 35 years of steadily declining incidence (with declines averaging 6 percent per year), tuberculosis case rates have increased each year. Direct and indirect epidemiological data indicate that the human immunodeficiency virus (HIV) has had a dominant role in this resurgence. In 1990, there were 25,701 new cases of tuberculosis reported in the United States—9883 more cases than anticipated on the basis of earlier trends.³⁵⁸

As stated by Bayer et al., the emergence of MDR-TB in the United States is fundamentally a reflection of failed social policy:

If the resurgence of reactivation tuberculosis can largely be traced to the concurrent epidemic of HIV infection and the social conditions that give rise to the spread of tuberculosis infection, the emergence of resistant strains fundamentally reflects a failure of social policy. ...

The congregate sheltering of large numbers of homeless individuals, hyperincarceration in jails and prisons have exacerbated the problem: the microbacterium spreads most efficiently in confined environments where there are large numbers of highly susceptible persons with compromised immune systems, including those with HIV infection. [with many references]³⁵⁹

Dr. Hiroshi Nakajima, WHO's director-general, stated that "[m]ore and more, tuberculosis is becoming a socioeconomic disease that hits the underprivileged hardest in both developed and developing countries."³⁶⁰

Neither TB nor MDR-TB appear as yet to be a major problem in Canada. Of the 1996 TB cases reported in Canada in 1990, only 63 involved resistant organisms. Of these, only one

was found to be resistant to four or more drugs.^{361[33]} Nevertheless, it has been said that "[a]lthough there is currently no information to suggest that the interaction between tuberculosis and HIV is a major problem in Canada, many of the conditions that favoured this interaction in the United States exist here."³⁶² Further, in both countries "[t]here are population groups that are at risk for both HIV and TB; both diseases converge in hospital settings, prisons, and other public institutions, in ways that may favour transmission of TB among HIV infected persons."³⁶³

With regard to TB in prisons, Tomaševski stated that "[t]he publicity for AIDS has diverted attention from 'traditional' communicable diseases, such as tuberculosis, which is far from eradicated."³⁶⁴ Recent reports from the United States have drawn attention to the dramatic increase in the incidence of TB in New York's state prison system—from 15.4 per 100,000 between 1976 and 1978 to 105.5 per 100,000 in 1986.³⁶⁵ In New Jersey during 1987 the incidence of TB among state inmates was 109.9 per 100,000—a rate 11 times that of the general population of New Jersey that year.³⁶⁶ So severe is New York's TB caseload increase, especially among HIV-positive persons, that a federal judge ordered that a special unit for city jail inmates with TB be constructed. According to a report in the 10 February 1992 issue of *American Medical News*, New York corrections officials reported that 12 inmates, all with AIDS, died of TB in 1991. It was estimated that 26 percent of the female inmates and 16 percent of the men at New York's Rikers Island jail are HIV-positive, while 15 to 25 percent of all inmates test positive for past TB infection.³⁶⁷

Harding and Schaller drew attention to the fact that an increasing incidence of active pulmonary tuberculosis among HIV-infected prisoners has also been confirmed in prisons in France, Spain and Switzerland.³⁶⁸ They concluded that, "[i]n view of prison conditions—a closed environment with frequent overcrowding and lack of ventilation—the problem of infectious tuberculosis requires special attention."

In his submission to ECAP, Ron Shore, a prison outreach worker with the Kingston AIDS Project, stated:

We have already seen cases of TB in the detention centres of Toronto and in the federal prisons. It is only a matter of time before it grows into a plague. And unlike HIV, which requires intimate contact, TB can be transmitted through the air, via coughs and sneezes. In a setting such as today's prisons, it could become ... "wildfire death."³⁶⁹

In the United States, both the National Commission for Correctional Health Care and the Centers for Disease Control (CDC) have called for increased prevention and control efforts in prisons.³⁷⁰ The United States Advisory Committee for the Elimination of Tuberculosis concluded that "[t]ransmission of TB in correctional facilities presents a health problem for the institutions and may also be a problem for the community into which inmates are released."³⁷¹ The Committee made a series of recommendations regarding control of TB in prisons:

Each correctional institution should designate an appropriately trained official responsible for operating a TB prevention and control program in the institution.

[33] However, data on drug resistance were unknown for 648 of the reported cases.

A multi-institutional system should have a qualified official and unit to oversee TB-control activities throughout the system. These responsibilities should be specified in the official's job performance plan. The basic activities to be followed are surveillance, containment, and assessment.

The Committee further recommended, among other things, that skin testing of inmates and staff should be carried out at entry or on employment, respectively, and that tests should be repeated at least annually; that inmates with TB should be routinely offered testing with appropriate counselling for HIV infection; that all inmates and staff with positive tuberculin reactions who have not previously completed an adequate course of preventive therapy be considered for preventive therapy unless there are medical contraindications; and that persons for whom TB preventive therapy is recommended but who refuse or are unable to complete a recommended course should be counselled to seek prompt medical attention if they develop signs or symptoms suggestive of TB. These recommendations will be periodically revised.

C. ECAP's Assessment

ECAP is concerned about the recent resurgence of TB in prisons in the United States, particularly in view of its disproportional incidence among and impact on HIV-infected prisoners. The Committee commends CSC for its policy to control the spread of TB in federal correctional facilities and, in general, for taking the emerging issue of TB in prisons seriously.

Members of ECAP and CSC's Health Care Services Branch participated in the National Workshop on Tuberculosis: HIV and other Emerging Issues, held in Toronto in May 1993. ECAP will review the issues raised by TB in prisons and provide additional comment in its final report.

D. Conclusions

ECAP commends CSC for its efforts to prevent the transmission of tuberculosis in federal correctional institutions.

The Committee considers that the issue of tuberculosis in federal correctional institutions should be monitored closely by CSC, in particular by its Health Care Services Branch and the Health Care Advisory Committee, and that CSC's policy with regard to tuberculosis should be reviewed regularly.

10. PRISON HEALTH SERVICES

While the suggestions and recommendations made in section IV.8 address some of the immediate needs of infected inmates, this section addresses an underlying problem, namely inmates' distrust with regard to prison health-care services.

A. Current Situation

In the federal prison system, as in most other prison systems, health services are an integral part of, and those who provide them are responsible to, the prison system. Support staff and nurses are employees of CSC, physicians contract their services to CSC, and services are generally located in the institutions. In addition, federal inmates are excluded by the *Canada Health Act*³⁷² from free medical coverage under provincial health-care plans.

B. The Debate

Harding has emphasized how important prisoners' confidence in the independence, integrity and competence of the medical service is, especially in dealing with highly charged issues such as the HIV epidemic.³⁷³ He concluded:

It is therefore in the prison administration's interest to accept, and even encourage, the independence of medical services and their strict observance of ethical rules. The underlying principle is that of equivalence. The prison doctor faced with an ethical dilemma should ask himself/herself: what would I do in the equivalent situation outside the prison? The same rules and principles should apply, whether in the face of a prolonged fast, the administration of tranquillizers to an agitated person, body searching, examinations requested by the authorities, the communication of medical information or free and confidential access of prisoners to health staff.³⁷⁴

In practice, prison health services are often perceived by prisoners to lack independence and confidentiality. Michael Linhart, a federal inmate with HIV infection, said:

Any prisoner who has served a few years in a prison will tell you that health care is a primary concern among prisoners. We need to feel that we are being provided with competent and knowledgeable medical services. Often in prescribing medications to prisoners, doctors seem to follow a set of administrative procedures and policies outlining the types of medications given to prisoners. I know of many cases where doctors were about to prescribe a medication for a prisoner only to be told by the nurse in attendance that inmates are not allowed to have that drug in this institution. To myself, and many other prisoners, this seems to indicate that institutional policy is dictating to the doctor the type of medical attention they may render.³⁷⁵

The separation of prison health services from community health services, which underlies inmates' lack of confidence, is increasingly being challenged.³⁷⁶

Under the current system, the duties and responsibilities of prison health professionals go beyond providing medical services to inmates. The multiplicity of tasks that the prison health service has to perform, and the consequent difficulties in reconciling these tasks, has been well described by Arpo:

We may be accused of having become an integral part of the correctional machinery, who expend more energy on discovering malingerers than on treating sick patients, and who prescribe tranquillizing and hypnotic drugs in order to keep disruptive prisoners content and the prison nice and quiet. On the other hand, when the mass media report with sensational headlines of serious crimes committed by ex-convicts, we may be blamed for endlessly understanding and explaining the behaviour of the criminals, for doing nothing but letting them out to continue disturbing decent, respectable people. And inside the prisons, we may be accused by our fellow workers of putting too many prisoners on the sick list and thus endangering the productivity of prison industry.³⁷⁷

As stated by Tomaševski, existing international standards combine the provision of medical services with custodial duties, and continue burdening the prison health personnel with too many tasks, which often conflict with each other.

Protecting the health of prisoners and participating in decision-making on their disciplinary punishment are proverbially difficult to reconcile, and illustrate the difficulties inherent in giving the same institution and the same personnel three distinct responsibilities: custody, punishment, and care.³⁷⁸

That problems are created by organizing prison health services outside the ordinary health system has been acknowledged by the Select Committee of Experts on the Impact of the AIDS Epidemic on Health Care Services and Planning in Europe.³⁷⁹ A variety of solutions to these problems were proposed, including recourse to ordinary health services such as intervention by outside staff in prisons and early treatment outside prison.³⁸⁰

In at least one provincial institution in Quebec, health care is already provided by an outside community clinic,^[34] and in Norway health services for the prison population have been fully integrated into the national health system. In these settings the principle of equivalence has been fully implemented, and all health services are provided by community health services. In most other prison systems, access to community health services for inmates is restricted:

[Inmates'] access to the community medical facilities is limited by the degree to which such facilities can provide secure accommodation and are willing to take on the responsibility for the security of inmate patients. Effectively, prisoners' access to outside services and facilities is determined by the decision of the prison health

[34] This is Tanguay Institution in Montreal.

service, or the prison administration, and is often discretionary. The most frequent practice is the referral by the prison physician to the community health care service where and when s/he deems it necessary.³⁸¹

In an article that recently appeared in *Le Monde diplomatique*, it was stated that HIV/AIDS would force prison administrations to transfer the costly and over-burdened prison health-care services to the community:

[Translation]

How, for example, are prison administrations going to deal with the forecast increase in the number of inmates who require intensive medical care when their health budget is already inadequate to meet the needs of a highly disadvantaged population? The impossibility of successfully managing the AIDS budget of prisons is without doubt the deciding factor in the need to transfer an archaic system of prison health management by prison administrations alone to a system of management by the public health-care system....³⁸²

In Canada, the Parliamentary Ad Hoc Committee on AIDS recommended that the advantages of prison health-care services being provided by outside agencies should be further studied.³⁸³

C. ECAP's Assessment

ECAP acknowledges CSC's efforts to provide health care that is equivalent to that outside prison. However, ECAP is concerned that some inmates, in particular HIV-infected inmates, do not utilize these services because they perceive them to lack independence and are afraid that their medical information will not be held confidential. ECAP is aware that separating CSC's health-care services from CSC and integrating them into the provincial health-care system raises many problems that the Committee could not address. Because this is an important issue that needs to be studied in detail, the Committee concluded that the issue should be brought to the attention of CSC, and in particular its Health Care Advisory Committee, for further study.

D. Conclusions

ECAP considers that CSC, and in particular its Health Care Advisory Committee, should study the feasibility of prison health services being provided by outside agencies.

11. COMPASSIONATE RELEASE

A. Current Situation

In 1989 the National Parole Board (NPB) initiated an examination of its conditional-release policies with regard to HIV-infected offenders, in response to requests for guidance from Board members who were having to confront the issue of conditional release of inmates with HIV infection or AIDS. In general, the primary objective of NPB decision-making is to contribute to the protection of society through the assessment and management of the risk that offenders represent when released into the community. Risk has traditionally been interpreted as the risk that a released offender may reoffend. As stated by Mr. Gibson, then Chairman of the NPB,

[i]n examining the issue of AIDS and conditional release, the Board sought to determine if, during its deliberations on a case, it should take into consideration the offender's medical condition, which is known to the Board, together with his/her social attitude, when it might constitute a risk to society.³⁸⁴

The Board hosted a one-day seminar on 23 March 1989 at which a variety of experts from different backgrounds provided an overview of the legal, medical and ethical issues "and assisted the Board in focusing its review on those issues that affect re-integration decisions."³⁸⁵ Following the meeting, a policy on Acquired Immunodeficiency Syndrome (AIDS) and Conditional Release Decisions was issued and became effective on 1 May 1991. In developing the policy, NPB was guided by the *Parole Act*, the Board's mission statement, decision policies and evolving government policy. In particular, "[t]he Board sought to reflect the concerns which were expressed by the participants at the seminar and others who were consulted."³⁸⁶

The purpose of this policy is "[t]o provide guidance to Board Members in making conditional release decisions in cases where an offender has tested positive to the HIV virus, and therefore may or may not have developed AIDS." The policy focuses on risk assessment and the reintegration potential of the offender while attempting to be responsive to the special needs of offenders infected with HIV. In turn, risk assessment focuses on the previous behaviour or documented expressions of intent by the offender, and not on HIV status alone. HIV status will be a factor for consideration in decision-making only when parole by exception for humanitarian reasons is proposed. The policy reads as follows:

HIV status in and of itself is not a factor in risk assessment or decision making. In its risk assessment and decision making, NPB will not require information on whether or not an inmate tests HIV antibody positive.

The Board is committed to giving full consideration to applications for release, including parole by exception, where necessary in order to ensure medical treatment or palliative care not otherwise available within the institution. The Board is sensitive to humanitarian considerations with respect to all terminally ill offenders. Considerations for release must always take place within the context of the risk to society.

The Board will consider in its risk assessment evidence of behaviour or expressed intent which demonstrates wanton disregard for public safety and which may cause loss of life or serious harm, such as through HIV transmission, and may use such evidence in reaching its decision.

The Board is committed to ensuring that training and education in the understanding of the medical and social dimensions of HIV infection is available to Board members and staff.

On 1 November 1992 the *Corrections and Conditional Release Act* was passed into law and replaced the *Penitentiary Act* of 1961 and the *Parole Act* of 1959. With regard to eligibility for parole in so-called exceptional cases, s. 121 of the *Corrections and Conditional Release Act* provides as follows:

- (1) Subject to section 102 and notwithstanding section 119 or 120 or any order made under section 741.2 of the *Criminal Code*, parole may be granted at any time to an offender
 - (a) who is terminally ill;
 - (b) whose physical or mental health is likely to suffer serious damage if the offender continues to be held in confinement;
 - (c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced; or
 - (d) who is the subject of an order to be surrendered under the *Extradition Act* or the *Fugitive Offenders Act* and to be detained until surrendered.
- (2) Subsection (1) does not apply to an offender who is
 - (a) serving a sentence of life imprisonment imposed as a minimum punishment or commuted from a sentence of death; or
 - (b) serving, in a penitentiary, a sentence of detention for an indeterminate period.

Section 121(1)(a)-(c) is nearly identical to section 11.1(1)(a)-(c) of the *Parole Regulations* that it replaces. Under section 11.1 of these Regulations, "Parole by Exception" could be granted to inmates who were not otherwise eligible for parole under the same circumstances that are now specified in the *Corrections and Conditional Release Act*. Other than temporary absences, parole by exception and executive clemency are the only forms of release that formally permit the consideration of humanitarian concerns such as those that could arise in cases of inmates with HIV infection or AIDS. The procedure is only used in rare cases,³⁸⁷ and all the other criteria for the granting of parole—particularly that the inmate not be an undue risk to society—must also be fulfilled for a grant of parole by exception.³⁸⁸

B. The Debate

The current system and practice of granting parole by exception has been criticized by PASAN as follows:

Currently, compassionate release is only considered for terminally ill prisoners whose sickness is so advanced that they are near death. Release, at this point, means little other than a transfer from prison institutions to another form of institutionalization—the hospital.³⁸⁹

PASAN therefore suggested that new guidelines be developed to allow for early parole and probation for medical reasons. PASAN concluded:

If possible prisoners living with HIV/AIDS should be released from the penal system as early into their sentences as is thought possible (remembering security concerns). Living with HIV requires a positive and healing environment, not the punishment, violence, and powerlessness that is the norm in prisons.³⁹⁰

Similarly, the Federal/Provincial/Territorial Advisory Committee on AIDS recommended that consideration be given to "compassionate early release" for inmates with AIDS.³⁹¹

In the United States, the National Prison Project stressed the need to develop compassionate early-release programs for prisoners with AIDS:

Prison medical centers and hospitals are not equipped to deal with the complexities of the AIDS virus. When prisoners are ill with AIDS, assuming they have a place to go on the outside—hospices, family, etc.—there should be a procedure for their release. Right now most medical clemency programs both in the federal and state systems are too slow moving to be effective. By the time the prisoner gets processed through the prison bureaucracy, he or she is dead or near death.³⁹²

The National Commission on AIDS stated "that there also needs to be in place in every corrections system a responsive mechanism for the early release of all terminally ill prisoners, including those with HIV disease, who no longer pose a danger to society and whose further incarceration would serve no purpose."³⁹³ In particular, the Commission encouraged the Federal Bureau of Prisons as well as states and localities to review the early-release options available so that incarceration for persons with HIV disease is not a death sentence. The Commission recommended that "[m]echanisms for early release should be streamlined and made readily available for prisoners who are seriously ill and whose release would be unlikely to pose a danger to society."³⁹⁴

C. ECAP's Assessment

Mechanisms for release similar to those that have been proposed in the United States already exist in Canadian law. However, concern was voiced to ECAP that, in practice, inmates with AIDS are sometimes released from institutions only shortly before their death. There is concern that under

the current legislation, inmates will be released only when they are terminally ill. In practice, this would mean a release from prison to a hospital or hospice. For many reasons, ECAP concluded that, whenever possible, inmates should be released earlier in the course of their disease. ECAP recognizes that imprisonment can be more detrimental to the health of a person with HIV or AIDS than to the health of prisoners whose immune systems are not compromised. Generally, life in prison for inmates with a chronic or progressive fatal disease is more psychologically stressful and more physically detrimental than for inmates who are healthy. This is particularly true for inmates with HIV infection or AIDS. Among the reasons for this are: exposure to infections that might otherwise be avoidable; access to support and counselling from community-based organizations, friends, partners and family; potential delays in access to specialists, special diets and new or experimental treatments; and discrimination. A 1986 study by the New York State Commission on Correction showed that prisoners with AIDS lived only half as long as people with AIDS outside prisons.³⁹⁵ Although the results of this study are not necessarily applicable to Canadian penitentiaries, they nevertheless indicate the potentially serious consequences of imprisonment for people with HIV infection or AIDS.

ECAP acknowledges that protection of the public has to remain the paramount consideration in all decisions relating to the release of inmates, including inmates with HIV infection or AIDS. Within this limit, however, ECAP considers that protection of inmates' physical and mental health should be given greater consideration in such decisions. Inmates with HIV infection or AIDS should be granted parole by exception before they are terminally ill, whenever they do not constitute a threat to the public. This approach should equally apply to any inmate with a chronic or progressive life-threatening disease whose health is likely to suffer if the inmate continues to be held in confinement. This approach would not necessitate changes in the provisions of the *Corrections and Conditional Release Act* or in NPB's policy. However, in practice it should lead to more frequent granting of parole by exception to inmates with progressive life-threatening diseases.

D. Conclusions

ECAP considers that inmates with progressive life-threatening diseases, including AIDS, should regularly be released earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety.

12. AFTERCARE

A. Current Situation

At present, the only specific provision relating to the continuation of care and support of inmates with HIV infection or AIDS after their release into the community is s. 20 of Commissioner's Directive 821, which reads as follows:

20. Upon transfer to parole jurisdiction, health care staff shall, with the inmate's consent, ensure that arrangements have been made for follow-up with an appropriately qualified community physician.

In the revised version of this Directive (approval pending), this section remains unchanged.

B. The Debate

PASAN stated that, to ensure the success of CSC's efforts to provide services and care for inmates with HIV infection or AIDS, "mechanisms must be implemented to ensure that these programs can be continued upon a prisoner's release."³⁹⁶ In particular, PASAN made the following recommendations:

31. Parole Officers, Probation Officers, workers in halfway houses, and other aftercare workers must be educated about HIV/AIDS.

32. Exit kits with HIV/AIDS information, contacts with community-based organizations, condoms, bleach kits, etc. must be made available to prisoners when they are released from correctional facilities.

33. Programs providing continuity of care after release must be established for prisoners with HIV/AIDS.

34. Any special programs used by a prisoner with HIV/AIDS must remain available to her or him outside of prison.

35. Community-based groups must be involved with the development and implementation of aftercare strategies.

36. The Ministry of Correctional Services and CSC should work with community-based HIV/AIDS housing programs and service organizations to ensure that they meet the needs of ex-prisoners.³⁹⁷

In the United States, the National Commission on AIDS emphasized that "[c]areful planning for the discharge of prisoners living with HIV disease is a critical aspect of their care"³⁹⁸ and recommended that "[t]o maintain continuity of care during the transition from prison to the community, every inmate with HIV disease should be assisted in finding medical care

and support services in the community."³⁹⁹ The Commission continued by saying that "[t]his should include assisting prisoners to register with community based case management services prior to release where such services are available and if the prisoner so desires."

Discharge planning is an important component of the HIV policy proposed to the District of Columbia Department of Corrections by the D.C. Prisoners Legal Services Project.⁴⁰⁰ According to this policy, discharge planning includes, among other things:

- (1) providing all prisoners, regardless of HIV status, with counselling as well as written HIV educational materials about community resources, including referrals for medical care, substance abuse treatment, and social and legal support services;
- (2) providing prisoners with condoms and dental dams upon release into the community or to a halfway house;
- (3) preparation by medical staff, for each prisoner with HIV or AIDS, of a so-called "Discharge Packet", containing information about current diagnoses and medical/mental health problems; current treatments and treatment history, including laboratory test results and complete medical, dental, and mental health records; HIV-related medical complications, including full documentation for any HIV-related opportunistic infections; allergies; description of conditions on discharge; and follow-up instructions; if the prisoner provides appropriate authorization, the medical staff will send a copy of the prisoner's complete discharge packet to the prisoner's outside care provider;
- (4) an exit interview for HIV positive prisoners. At this interview, the medical staff shall provide referrals for health care, drug treatment, and psycho-social support service providers in the community where the prisoner is to be released. If the prisoner does not already have an outside primary medical care provider, the medical staff will help the prisoner select one.
- (5) arrangement of an initial medical consultation in the community and notification of prisoners of the time and place of the consultation when prisoners' medical condition renders them unable to participate in medical discharge planning;
- (6) efforts to contact the prisoner's family or other designated persons to assist in the discharge planning process, if the prisoner authorizes the release of HIV-related information. Families will be offered education and counselling on HIV/AIDS "to help understand the needs of the prisoner and allay any fears they may have about HIV transmission and casual contacts."⁴⁰¹

C. ECAP's Assessment

ECAP commends CSC for its efforts to assist inmates with HIV infection or AIDS to build links with outside support and service organizations. Sometimes, however, inmates have had difficulty with the continuity of their care after their release from federal correctional facilities.

ECAP considers that, in order to ensure the success of CSC programs for inmates with HIV infection or AIDS, it will be important to increase efforts to provide inmates with continuity of care and support.

D. Conclusions

ECAP considers that inmates with HIV infection or AIDS should have the opportunity and be encouraged to maintain or build links with the outside world, in particular with HIV/AIDS service, support and health organizations. In order to ensure this, the following should be undertaken:

(1) Parole and probation officers, workers in halfway houses, and other aftercare workers should receive educational sessions about HIV/AIDS, in particular concerning the needs of and the community resources for people with HIV infection or AIDS.

(2) A "health kit" should be offered to every inmate on exit from a correctional institution along with information about available community resources.

(3) CSC should continue to assist inmates who require ongoing medical care to organize this care before they are released.

(4) Inmates should be encouraged to arrange for the transfer of their medical records to their future care providers.

(5) External, community-based AIDS, health or prisoner organizations that provide services and education to people with HIV infection or AIDS should be encouraged to provide such services in federal correctional institutions so that, prior to their release into the community, inmates can establish links with these organizations.

13. WOMEN INMATES

A. Current Situation

In 1991 women constituted only 2.3 percent of the federal on-register offender population.^[35] Many of them serve their sentence in the Prison for Women in Kingston, the only federal correctional facility for women. Others serve their sentence in provincial facilities under federal-provincial exchange-of-services agreements. The number of federally sentenced women with HIV infection or AIDS is unknown. However, a seroprevalence study undertaken in a provincial medium-security prison for women in Montreal⁴⁰² as well as a series of studies undertaken in prison systems in other countries have shown that HIV infection is prevalent among women prisoners, in particular among those who have a history of injection drug use. As the following data illustrate, HIV seroprevalence among women prisoners generally exceeds that of male prisoners and is very high in some prisons:⁴⁰³

Montreal	women 7.2%	men 3.6%
Brazil (Sao Paolo)	women 28.7%	men 20%
England	women 15%	men 7.7%
Ivory Coast	women 23%	men 18%

Among prison entrants in the United States, HIV seroprevalence rates are also generally higher for women than for men.⁴⁰⁴ The US National Commission on AIDS reported that in New York State the seroprevalence rate for female entrants was 18.8 percent compared to a rate of 17.4 percent among male entrants.⁴⁰⁵ The Commission further reported that preliminary results from a study of 1,000 consecutive entrants in each of ten different correctional systems throughout the United States indicated that in general HIV prevalence rates were higher among female than among male entrants. Data were available for offenders entering prisons as well as for offenders entering jails. The seroprevalence rates among male offenders entering the prison systems ranged from 2.1 to 5.9 percent, while among female offenders they ranged from 3.2 to 7.8 percent. Among male offenders entering the jail systems the rates ranged from 2.3 to 7.6 percent, and among female offenders they ranged from 2.5 to 14.7 percent.⁴⁰⁶

With regard to female offenders, s. 77 of the *Corrections and Conditional Release Act* states that CSC shall

- (a) provide programs designed particularly to address the needs of female offenders; and
- (b) consult regularly about programs for female offenders with
 - (i) appropriate women's groups, and
 - (ii) other appropriate persons and groupswith expertise on, and experience in working with, female offenders.

[35] The on-register population includes federal offenders incarcerated in provincial institutions and provincial offenders incarcerated in federal institutions under federal/provincial exchange-of-services agreements. It includes offenders on federal day parole. *Offender Population Profile System*. Management Information Services, CSC, 31 March 1991.

B. The Debate

Like every other epidemic, AIDS develops in the cracks and crevasses [sic] of society's inequalities. We cannot face the epidemic if we try to hide the contradictions and conflicts which it exposes.⁴⁰⁷

Underlying many of the problems that women in prison encounter is that "[t]he majority of women in prisons are members of social groups marginalized not only on the basis of gender, but also on the basis of race, class, sexual orientation, disability, substance use, and/or occupations as sex workers."⁴⁰⁸ Female inmates often have more health problems than male inmates. Many suffer from chronic health conditions resulting from lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition, and poor preventive health care. Within our society, women have traditionally been the caregivers, often subordinating their own health and well-being to that of others.⁴⁰⁹ Women are often deprived of the power to determine the conditions upon which their sexual relationships with men take place: "For many women, sexual intercourse is not a question of choice but rather a question of survival."⁴¹⁰

Many HIV-infected women do not receive the diagnostic and treatment services that could benefit them as early as do HIV-infected men. Among the reasons for this is that women are often unaware of having been exposed to HIV by their sexual or drug-using partners and as a result do not seek counselling, HIV testing, and care and treatment. Second, the needs of HIV-infected women differ from those of men, and social and community support are often less frequently available and less accessible. As a consequence, women are often less educated than men about HIV infection and AIDS and do not have the support structures they need. Third, disease manifestations attributable to HIV infection or AIDS are often different in women than in men, leading to underrecognition or delays in diagnosis. Thus, women who are infected are often diagnosed as infected or having AIDS later than men, are deprived of the potential benefits of early detection of HIV infection and its treatment, and often have advanced disease when their infection is diagnosed.^[36]

For all these reasons, "[t]he educational needs of women prisoners regarding AIDS are different from the needs of male prisoners" and "the need for HIV prevention programs in women's prisons may be even more pressing than in male prisons."⁴¹¹

PASAN recommended a variety of measures to address women prisoners' needs with regard to HIV/AIDS:

37. Education and prevention information must be culturally sensitive and gender specific.

Such information should include pamphlets, posters, videos, speakers, and counsellors which target readers and audiences with diverse cultural backgrounds and literacy skills. As well, there should be information about pregnant HIV-

[36] In an effort to improve this situation, the medical community is reviewing criteria for diagnosis of AIDS, in particular as it relates to women, and international and national organizations have called for increased educational, support, diagnostic and treatment services for women who are infected with HIV or who have AIDS.

positive women and HIV-positive mothers with both HIV-positive and HIV-negative children.

38. A broad range of prevention material, addressed specifically to women, must be made available in such ways as to protect prisoners' confidentiality.

The following prevention materials must be made available: dental dams, condoms, thin latex gloves, water-soluble lubricants, bleach kits, and clean needles ...

39. Women with HIV/AIDS must have access to appropriate treatments and hospital care.

Often current levels of medical care and expertise within the prison system are insufficient to meet the needs of women living with HIV/AIDS. Women must have HIV primary-care physicians who are knowledgeable about women's symptoms; prisoners should be free to choose the physician they believe is appropriate for their needs.

40. Women with HIV/AIDS must have access to 'outside' resources such as female counsellors and facilitators who are culturally and ethnically appropriate.

Not only can community-based AIDS workers support women prisoners to live with HIV/AIDS, they can assist in the development of peer support groups within and outside the prison.⁴¹²

A proposal for a Women's Health Education and Support Program was submitted to ECAP by Tracy Brownlee, formerly with the Prison Health Program of the Kingston AIDS Project. The proposed program is intended to encourage the promotion of self-care and wellness among women prisoners, and to increase the level of choice, self-esteem and control that women possess, in order to maximize their own welfare. This would be done by addressing the larger issues women face and by including a broad definition of health and well-being. Issues of physical (e.g., HIV and AIDS), mental (e.g., drug use), emotional (e.g., depression and abuse) and spiritual (e.g., wellness and self-esteem) health would be addressed. Prevention of illness, stress reduction, mental, spiritual and emotional health, and physical self-care would be given equal attention. The women would also be provided an opportunity to share and learn effective coping skills for dealing with stress, trauma and the various risks to their health.⁴¹³

In the United States, the National Commission on AIDS stated that "[i]ncarcerated women have been, and continue to be, a forgotten population."⁴¹⁴ The Commission concluded that urgent attention needed to be given to the special needs of female inmates, and made the following statement:

In addition to the services available to their male counterparts, women in prison are in desperate need of HIV education regarding perinatal transmission and pediatric AIDS, frequent pap smears and other services sensitive to gender and the distinct history of female inmates regarding the conditions of their confinement. In

addition, pregnant inmates are in need of prenatal services where HIV testing is offered upon request. Special care to provide education and counselling in a context of freely available reproductive choice is essential.⁴¹⁵

In some prison systems, programs to address the particular needs of women inmates with regard to HIV/AIDS have already been developed. For example, at a provincial medium-security prison for women in Montreal, community input into information and prevention efforts started as early as 1987, after the first case of an HIV-infected woman in that prison became known in March of that year. These efforts have included education about HIV/AIDS for both staff and prisoners, access to anonymous HIV testing carried out by outside community-health clinics, and cooperation with external resources for medical and psychosocial support. Research on seroprevalence and on risk factors among prisoners started in 1989. As a result of these efforts, a climate of tolerance replaced the initial reactions of fear and discrimination against HIV-infected prisoners.⁴¹⁶

In New South Wales, prisoners' AIDS committees operate within prisons. Their function is to impart knowledge of HIV/AIDS prevention to prisoners. Methods used include group sessions, preparation and distribution of pamphlets and posters, plays, video script writing, and musical compositions. An AIDS education officer from outside prison facilitates the committees' work with up-to-date information. Liaising with prison staff and superintendents about committee activities keeps communication channels open.⁴¹⁷

At several prisons for women in the United States, peer education programs have been developed. Among these is PLACE (Pleasanton AIDS Counseling and Education), which developed a project of self-education of women prisoners about HIV/AIDS. The emphasis of this project is on self-empowerment:

From the beginning, we tried to make this OUR program—defined by women prisoners and our needs, and run by us, within the extremely restricted context of being in prison. In our self-education phase, this meant each of us taking responsibility for a very basic presentation on different aspects of AIDS/HIV. This wasn't easy for many of the women in the group; most of us have never formally spoken in front of even small groups of people. But in the process, we were also confronting deeper issues: empowerment and self-direction. ... So the small steps of learning new information and presenting it to a group, or of figuring out goals and a program of AIDS education for our sister prisoners, are really giant steps in the process of empowerment, commitment, and enhancing our self-esteem.⁴¹⁸

C. ECAP's Assessment

ECAP met with inmates and staff at the Prison for Women in Kingston on 19 November 1992 in order to hear their views and suggestions on how to address issues relating to HIV/AIDS of particular relevance to women inmates.

ECAP acknowledges that the problems encountered by female inmates in the correctional environment often reflect, and are augmented by, their vulnerability and the abuse many of them have suffered outside prison. The task of protecting women prisoners from HIV transmission therefore presents different—and sometimes greater—challenges than that of preventing HIV

infection in male prisoners. At the same time, ECAP witnessed that women in prisons often offer each other more support and are more compassionate than many male prisoners. ECAP feels that the challenge is to address women's needs and concerns while building on their ability to be compassionate and to offer each other support. The Committee examined a variety of possible ways to achieve this, including:

- Education and prevention information specifically targeted at women inmates.

ECAP found that HIV education and prevention efforts in prison, as outside, seldom address the specific needs of women. Consequently, there is a need for educational and prevention programs for women. Among the issues that should be addressed in such programs are: pregnancy, contraception, HIV transmission from mother to child, safer sex activities, and women's health problems.

- Efforts directed at decreasing the vulnerability of women to abuse in general, and to HIV infection and drug use in particular.

ECAP concluded that prevention efforts must be designed that will enable women to protect themselves from exposure to HIV. With regard to HIV infection, persuading sexual partners to use condoms is often a difficulty for women. It is therefore essential to empower them to negotiate safer sex practices and to practice safe activities while in prison and to continue to carry them out upon release.⁴¹⁹ In a broader perspective, efforts are needed to increase women's self-esteem and to decrease their vulnerability to abuse in general.

- Promotion of community and peer input into information and prevention efforts.

ECAP considers that supporting and implementing peer education programs and programs provided by outside community groups will be essential. There are several models of this approach that are operational in prisons in Quebec, the United States and Australia. The proposal for a Women's Health Education and Support Program submitted to ECAP is another example of what might be implemented by CSC. Developing such programs would be consistent with the goals of s. 77 of the *Corrections and Conditional Release Act*.

D. Conclusions

ECAP recognizes the special needs and concerns of women inmates with regard to HIV infection and AIDS, and considers that the following should be provided to them:

(1) educational and prevention programs specifically targeted to women inmates, including information about pregnancy and HIV transmission from mother to child, women's health problems, and the risk of transmission of HIV and other infections from sexual activities, including lesbian sexual activities;

(2) programs that will empower women inmates and decrease their vulnerability to abuse in general and to HIV infection and drug use in particular;

(3) community and peer input into these programs, for example, as provided in some prisons in Quebec, the United States and Australia, or as proposed in the Women's Health and Education and Support Program submitted to ECAP.

(4) counselling and support for HIV-infected pregnant inmates.

14. ABORIGINAL INMATES

A. Current Situation

In prisons in Canada, Aboriginals are overrepresented compared with the general inmate population. In 1990-91 they accounted for 11.2 percent of the male, and 15.4 percent of the female federal inmate population. In some areas the percentage is much higher. For example, in the Prairie Region Aboriginal offenders accounted for 36.4 percent of the male and 47.2 percent of the female population.⁴²⁰ They accounted for approximately 19 percent of all sentenced admissions to provincial institutions.⁴²¹ This proportion varies across Canada, but everywhere Aboriginal offenders are vastly overrepresented. For example, 6.6 percent of offenders admitted to institutions in Ontario are Aboriginals, whereas Aboriginals represent only two to three percent of the entire population of Ontario.⁴²²

There are no data on levels of HIV infection among Aboriginal inmate populations. For example, the two seroprevalence studies undertaken by Hankins in provincial institutions in Quebec⁴²³ do not allow for identification of how many, if any, of the participants testing positive for antibodies to HIV were Aboriginals.

The needs of Aboriginal offenders have been recognized in sections 79 through 84 of the *Corrections and Conditional Release Act*. In particular, sections 82 and 83 read as follows:

82. (1) The Service [CSC] shall establish a National Aboriginal Advisory Committee, and may establish regional and local aboriginal advisory committees, which shall provide advice to the Service on the provision of correctional services to aboriginal offenders.

(2) For the purpose of carrying out their function under subsection (1), all committees shall consult regularly with aboriginal communities and other appropriate persons with knowledge of aboriginal matters.

83. (1) For greater certainty, aboriginal spirituality and aboriginal spiritual leaders and elders have the same status as other religions and other religious leaders.

(2) The Service shall take all reasonable steps to make available to aboriginal inmates the services of an aboriginal spiritual leader or elder after consultation with

(a) the National Aboriginal Advisory Committee mentioned in section 82; and

(b) the appropriate regional and local aboriginal advisory committees, if such committees have been established pursuant to that section.

B. The Debate

Issues relating to HIV/AIDS and Aboriginal inmate populations in Canada were studied by Trasher Consultants for the Joint National Committee on Aboriginal AIDS Education and

Prevention in the fall of 1992. A Final Report on AIDS and Aboriginal Prison Populations was released in March 1993.⁴²⁴ The purpose of the research was to

determine the nature and extent of the problem; examine what is currently being done to address the issues both for prevention and treatment of HIV positive inmates; assess the appropriateness of these efforts; set out the nature of unmet educational needs of Aboriginal offenders; outline ways to more adequately meet those needs within the prison and community supervision; and ensure that the proposed initiatives are consistent with Aboriginal cultural values, beliefs and practices.

With regard to rates of infection among Aboriginal offenders, the Report cites one prison official who predicted that "if all Aboriginal inmates in prisons were tested the HIV rate would be high."⁴²⁵ Some correctional staff, however, suggested low rates of HIV infection among Aboriginal inmate populations because "Aboriginal inmates tend to engage in sex in institutions less frequently than non-Aboriginal inmates and that the drug usage of Aboriginal offenders is typically related more to alcohol, pills and sniffing rather than intravenous drug use." The Report continues by saying that until a national unlinked seroprevalence survey is carried out in the prison population in Canada, it will be impossible to understand the extent of the problem of HIV/AIDS among Aboriginal and non-Aboriginal offenders. The Report therefore recommends that CSC "contract an independent medical organization to undertake anonymous unlinked seroprevalence testing in a sample of federal correctional institutions in the Prairie Region aimed at ascertaining the prevalence of HIV/AIDS in the entire prison population."^{426[37]}

The Report points out that there are no specific prison policies or procedures pertaining to Aboriginal offenders. It then briefly reviews many of the issues raised by HIV/AIDS in correctional facilities. The following is an overview of some of its findings.⁴²⁷

With regard to injection drug use, the Report states:

Perhaps the most serious problem facing Aboriginal inmates in terms of HIV is the widespread use of potentially contaminated needles during intravenous-drug use. In one federal institution Aboriginal inmates and senior correctional staff estimated that there were about 18 needles used by about 30 inmates (out of a prison population of 249). Inmates, on the other hand, suggested that there are at least 40 needles in the institution. Some Aboriginal inmates reported using drugs as a means of coping with the pressures of prison life while others said that they had been using injection drugs on the street before coming to prison.

The most serious issue regarding intravenous drug use is the sharing of needles which are potentially contaminated with the HIV/AIDS virus. Aboriginal inmates

[37] Penitentiaries in the Prairie Region were suggested because the percentage of Aboriginal inmates is highest in that region. Test results would therefore ensure a significant representation of Aboriginal inmates. The Report opposes carrying out "the testing with just Aboriginal inmates because if test results indicated a significant number of positive results Aboriginal offenders could be singled out for discrimination by non-Aboriginal inmates." See *ibid*.

in federal prisons reported several cases where one needle several years old is being shared among ten inmates on a regular basis. In another instance Aboriginal offenders stated that one needle will circulate among twenty users in the penitentiary. Furthermore, they are aware that the needle cannot be properly cleaned between uses. The most frequently used method of cleaning the needles is by using hot water. In many cases needles are shared with other Aboriginal inmates.

With regard to the availability of bleach, the Report states:

In some institutions, both federal and provincial, bleach, in the form of cleaning substances, (e.g. Javex) is informally available to inmates in various locations (e.g. the laundry and cleaning storage areas). Whenever possible the bleach is used for cleaning the needles. However while the prison administration is aware of the practice of intravenous drug use and may "turn a blind eye", the practice is illegal. Therefore, the cleaning of needles with bleach is a hit and miss proposition at best as inmates have to be constantly aware of the risk of getting caught and having the needle confiscated. Further, the supply of bleach is not reliable.

With regard to tattooing, the Report states:

Virtually all of the individuals interviewed mentioned that another serious problem in terms of HIV/AIDS was the extensive tattooing that occurs in prisons among Aboriginal inmates. Tattooing is an integral part of Aboriginal inmate culture. It is done by inmates who are skilled in the practice using a variety of instruments that are available. Rarely are these instruments professional tattooing tools. Inmates reported that everything from [sic] broken glass to sharpened guitar strings are [sic] used for tattooing. The fact that tattooing is "illegal" in prisons accounts for the use of such diverse, and potentially unclean, tools.

The Report discusses whether and to what extent Aboriginal offenders constitute a "special needs group" with regard to HIV/AIDS and the issues raised by it.⁴²⁸ It reports that most observers have suggested that, with the exception of educational programs, the issues were not different for Aboriginal offenders. However, two potential concerns were raised:

The first related to the impact HIV/AIDS offenders would have if they were released to Aboriginal communities. There was a sense that irresponsible behaviour by the offender (e.g. unprotected sex) could be devastating to a small relatively closed community. Some suggested that Aboriginal inmates should feel obliged to be tested for HIV/AIDS to ensure that [they] were not a risk to their community. A second concern relates to the possible future contracting and spread of tuberculosis (TB). It is estimated that there are high rates of "inactive" TB in Aboriginal communities because of the history of the disease among Aboriginal people. If individuals became infected with HIV/AIDS their lowered immune

system could make them susceptible to TB ... leading to a serious problem of infection.⁴²⁹

The Report concluded that "[i]t is clear that there is no epidemic of HIV/AIDS among Aboriginal inmates," but that at the same time there may be reason for concern for three reasons:

First, there are now a limited number of cases confirmed among Aboriginal offenders. Second, the nature of the disease (i.e the long period (2 to 10 years) in which no symptoms are evident) makes it impossible to know if inmates are infectious. Third, inmates engage in high risk activities (sexual activity, injection drug use and tattooing).⁴³⁰

The Report contains a variety of recommendations, many of which concern issues addressed in previous sections of this Working Paper. With regard to issues of particular relevance to Aboriginal inmates, the following recommendations were issued:⁴³¹

That a senior official of Correctional Service of Canada be invited to become a member of the Joint National Committee on Aboriginal AIDS Education and Prevention with a view to establishing a comprehensive strategy to address the issues involved with HIV/AIDS among Aboriginal offenders in prisons.

That the Joint National Committee on Aboriginal AIDS Education and Prevention or some other appropriate body approach Correctional Service of Canada (CSC) and provincial corrections ministries to enter into discussions to develop appropriate policies and procedures for the prevention, education, and care and treatment of Aboriginal offenders with respect to HIV/AIDS.

That the Joint Committee on Aboriginal AIDS Education and Prevention enter into discussions with Aboriginal justice and corrections organizations (e.g. Aboriginal Legal Services of Toronto, Native Clan in Winnipeg, Native Counselling Services of Alberta, Feather Hope in Edmonton etc.) with a view to initiate contact with the Native Brotherhoods and Sisterhoods and other Aboriginal inmates to encourage them to be tested for HIV. Aboriginal Elders could be used in the initiative.

That HIV/AIDS education should be compulsory for all Aboriginal inmates and all staff in correctional institutions.

That the Joint Committee on Aboriginal AIDS Education and Prevention enter into discussions with CSC to coordinate the design and delivery of a comprehensive HIV/AIDS education program to be offered to Aboriginal offenders in prisons in Canada. CSC should contract with an appropriate Aboriginal organization to develop and deliver to [sic] program. The program should be tailored to the special needs of Aboriginal offenders.

That the Joint Committee on Aboriginal AIDS Education and Prevention coordinate the delivery of the HIV/AIDS education program to Aboriginal and non-Aboriginal agencies outside the prison system which deal with Aboriginal offenders (e.g. Friendship Centres, halfway houses, Parole and Probation Offices, Aboriginal Legal Services etc.).

That the Joint Committee on AIDS Education and Prevention, in cooperation with an Aboriginal agency, examine the need for the establishment of special Aboriginal treatment programs and facilities, such as an Aboriginal hospice, in the future.

In Australia, it has been pointed out that three factors exacerbate the risk of contracting HIV in prisons for Aboriginal offenders:

- the overrepresentation of Aboriginals in Australian prisons;
- the generally low standard of health of Aboriginal prisoners with a high prevalence rate of hepatitis B;
- the inappropriateness of many AIDS/HIV programs and services which are designed and delivered for and by white Australians.⁴³²

It has therefore been concluded that in developing educational or prevention programs for Aboriginal offenders, their generally lower health status has to be taken into account.⁴³³ It has further been said that "[m]easures which keep Aboriginal peoples out of prison as well as procedural reforms within the prison systems are vital to avoid increased exposure of Aboriginal peoples to AIDS risks."⁴³⁴ According to Nangala, the challenges are clear:

- finding socially acceptable alternatives to imprisonment for Aboriginal people in particular in relation to minor offences;
- improving the access Aboriginal people have to health information and education services in prison;
- providing educational material which is culturally relevant particularly in terms of language and general presentation;
- improving prisoners' access to the means by which they might protect themselves from HIV/AIDS and other STDs—for example, clean needles and condoms;
- keeping testing confidential and voluntary, and improving pre- and post-test counselling facilities;
- ensuring that Aboriginal or Torres Strait Islander people from appropriate health services are used as health educators within prisons to deliver programs to Aboriginal and Torres Strait Islander prisoners; and

- ensuring that State and Territory Governments and prison administrators consult and liaise with Aboriginal community-based health specialists, so that culturally appropriate approaches to dealing with AIDS are implemented.⁴³⁵

With regard to educational programs, Heilpern and Egger suggest that they "need to be tailored to the attitudes, beliefs and practices of the Aboriginal people and be delivered by people, usually Aboriginal, in whom the Aboriginal prisoners have trust and confidence."⁴³⁶ "The success of such programs is often achieved by negotiating with each community so that audiences, messages and materials are agreed upon and worked out jointly."⁴³⁷

An example of the development of programs for Aboriginal inmates is that of the prison of Port Augusta in Australia, where a large proportion of the inmates are Aboriginals. In that prison, drug and alcohol social workers worked with Aboriginal inmates and Elders from their communities. Following negotiations and discussions with the Elder and inmates, a workshop on HIV and Aboriginal communities was held at the prison in conjunction with a local Aboriginal Community Health Centre.⁴³⁸

C. ECAP's Assessment

In order to learn more about the needs and concerns of Aboriginal inmates, ECAP held a two-day consultation with the Native Sisterhood of the Prison for Women and representatives of the Native Brotherhoods of several nearby penitentiaries. This consultation, which was held in a setting of prayer, drumming, and dancing, included group discussions about the needs and concerns of Aboriginal inmates with regard to HIV/AIDS and drug use. ECAP was impressed by the proposals made by Aboriginal inmates to address some of their needs and concerns. Among these were a proposal to develop posters that would create AIDS awareness among Aboriginal offenders, and one to develop Aboriginal peer education programs.

ECAP strongly supports such initiatives, by and for aboriginal inmates, that recognize their special needs and cultural values and promote opportunities for them to improve their health. The proposals presented to ECAP at the consultation at the Prison for Women are examples of this approach. ECAP considered that the following initiatives would encourage and promote greater efforts to address the special problems relating to HIV infection encountered by Aboriginal inmates:

(1) Development of information and prevention programs that will respond to the specific needs of Aboriginal inmates.

(2) Inclusion of community and peer input into these programs. Aboriginal communities and Elders, as well as aboriginal inmates, should be included in the development, design and implementation of education, prevention, care and healing programs.

(3) Increased efforts, for and by aboriginal inmates, their communities and Elders, with the assistance of CSC and others, to improve the health status of Aboriginal inmates. This should include providing Aboriginal inmates with access to traditional healers, healing ceremonies, and medicines.

(4) Increased efforts to decrease the vulnerability of Aboriginal inmates to exposure to infectious diseases, in particular HIV infection, to drug use and its harms, and to imprisonment.

ECAP considers that such efforts would be consistent with, and in part are mandated by, sections 79 through 84 of the *Corrections and Conditional Release Act*.

D. Conclusions

ECAP recognizes the special needs and concerns of Aboriginal inmates with regard to HIV infection and AIDS, and considers that CSC's current efforts to respond to these needs may be improved by the following:

- (1) Educational and prevention programs targeted to the specific needs of Aboriginal offenders should be developed with input by Aboriginal inmates, their communities and Elders.
- (2) Aboriginal groups and Elders should be encouraged to deliver or supplement these programs.
- (3) CSC in collaboration with Health and Welfare Canada and others should fund Aboriginal groups and Elders to provide this education.
- (4) Because peer education has been found to be one of the most effective means of educating people about HIV infection and AIDS, Aboriginal inmates should be encouraged and assisted in developing their own peer education, counselling and support programs.
- (5) CSC in collaboration with Health and Welfare Canada and others should provide the funding necessary to support such efforts.
- (6) CSC should ensure that Aboriginal inmates have access to traditional healers, healing ceremonies and medicines, in accordance with CSC policy.

V. SUMMARY OF CONCLUSIONS

At the request of the Solicitor General of Canada, the Expert Committee on AIDS and Prisons (ECAP) of the Correctional Service of Canada is examining the problems posed by HIV infection and AIDS in Canadian correctional institutions. This Working Paper has been prepared in order to obtain further input on the issues addressed in it. ECAP has identified 14 major issues raised by HIV infection and AIDS and by drug use in federal correctional institutions. The Working Paper contains conclusions about each of these issues, but no recommendations. ECAP will incorporate the input that the Committee receives from readers of this Working Paper, and additional information that the Committee obtains, in a final report that will be released in September 1993. The Committee's conclusions will then be formulated as recommendations.

The conclusions reached by ECAP are as follows.

1. Seroprevalence Studies

ECAP acknowledges the potential utility of HIV-seroprevalence studies of inmates in federal correctional institutions. However, such studies may be expensive, may divert resources from or delay efforts to prevent the transmission of HIV and other infectious agents in correctional institutions, and are not necessary for the implementation of these efforts.

ECAP considers that such studies should not be undertaken until the seroprevalence studies underway or planned in Canadian correctional institutions have been carefully evaluated, and then only when they are cost-effective, strictly adhere to established ethical guidelines, and are preceded by extensive consultation with inmates, community groups and independent experts.

2. Testing for HIV Infection

ECAP agrees that, as is the case with testing outside correctional institutions, testing should be readily accessible to all inmates in federal correctional institutions at their own request. Such testing should always be voluntary—with the express consent of the inmate—and should always be accompanied by counselling and education before and following testing. Further, ECAP considers

(1) that all inmates should be made aware that such testing is available, in particular on entry into prison, but also while in custody and regardless of whether they have or have not been exposed to HIV (i.e., have engaged in "high-risk activities");

(2) that all inmates should have access to HIV testing from CSC health-care personnel as well as from primary-care or community clinic personnel who are independent of CSC; and

(3) that all inmates should have access to anonymous HIV testing.

3. Offender Medical Information

(1) Protecting confidentiality and preventing discrimination

ECAP considers that procedures should be reviewed in every federal correctional institution to ensure that the confidentiality of medical information is protected, in particular information regarding the HIV status of inmates. ECAP agrees with CSC's policy according to which breaches of confidentiality by staff are breaches of discipline.

ECAP recognizes both the need for and potential benefits to inmates from disclosing their HIV status to other inmates and staff. In order to encourage them to disclose and to obtain the benefits from disclosure, any inmate or staff who wrongfully harms or discriminates against inmates with HIV infection or AIDS should be disciplined.

Commissioner's Directives should be revised to include a clear statement that any workplace behaviour that wrongfully discriminates against inmates with HIV infection or AIDS will not be tolerated and that those involved in such behaviour will be subject to disciplinary action.

(2) Disclosure of offender medical information

ECAP agrees that every inmate's personal medical information should remain confidential between medical personnel and the inmate and should not be disclosed without the inmate's consent. Only in exceptional cases will such disclosure be justifiable, and then only when it is clearly necessary, is likely to be effective, and is the least invasive and restrictive means available to prevent harms that cannot otherwise be prevented.

ECAP considers the most effective means of preventing HIV transmission in correctional institutions is reliance on the stringent and universal application of procedures and practices that can prevent HIV transmission, and not reliance on knowing who in a correctional institution may or may not be infected. For both staff and inmates, the universal application of precautions to prevent HIV transmission, and access to the means to do so, are essential.

4. Housing and Activities

Housing:

ECAP agrees that inmates with HIV infection or AIDS should be housed with the general inmate population.

In order to minimize the risk of unwarranted segregation, Commissioner's Directive 821 and other applicable Directives should be revised to clearly state that decisions about housing of inmates with HIV infection or AIDS should follow the same criteria as those for any other inmate.

Activities:

The Commissioner's Directive should be revised to clearly state that inmates with HIV infection or AIDS should have the opportunity to participate in the same educational, job and vocational programs as any other inmate.

5. Educational Programs for Inmates

5.1 Education about HIV/AIDS

ECAP considers that education about HIV infection and AIDS is the most important effort to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in federal correctional institutions. ECAP recognizes that educational efforts are already in place in federal correctional institutions but it considers that these efforts may be improved by the following:

(1) On entry into the institution, all inmates should receive written information about HIV infection and AIDS that is appropriate to their level of literacy. This could be in the form of pamphlets or of a booklet such as *Get the Facts*, published by the John Howard Society.

(2) Soon after admission and as part of the reception program, every inmate should be offered educational sessions about HIV infection and AIDS.

(3) External, community-based AIDS, health or prisoner organizations should be encouraged to deliver or supplement these sessions.

(4) CSC in collaboration with Health and Welfare Canada and others should fund such organizations to provide this education.

(5) Because peer education has been found to be one of the most effective means of educating people about HIV infection and AIDS, inmates should be encouraged

to develop and assisted in delivering their own peer education, counselling and support programs.

(6) CSC in collaboration with Health and Welfare Canada and others should provide the funding necessary to support such efforts.

(7) In each institution, CSC should create or designate one or more inmate job positions as peer health counsellors, and provide for appropriate training, support and evaluation.

5.2 Education about Drug Use

ECAP considers that education about drug use is one of the most important efforts to promote and protect the health of inmates and prevent transmission of HIV and other infectious agents in federal correctional institutions. ECAP recognizes that educational efforts are already in place in federal correctional institutions but it also considers that these efforts may be improved by the following:

(1) Revision of the Drug and Alcohol Reception Induction Module to include input by external, community-based organizations and by inmates.

(2) Revision of the Alcohol and Drug Education Program to include input by external, community-based organizations and by inmates.

(3) External, community-based drug-use, health or prisoner organizations should be encouraged to deliver or supplement these programs.

(4) CSC in collaboration with Canada's Drug Strategy and others should fund of such organizations to provide this education.

(5) Because peer education has been found to be one of the most effective means of educating people about drug use, inmates should be encouraged to develop and assisted in delivering their own peer education, counselling and support programs.

(6) CSC in collaboration with Canada's Drug Strategy and others should fund of such efforts.

6. Preventive Measures for Inmates

6.1.1 Consensual Sexual Activity

ECAP considers it essential that inmates have discreet and easy access to the means to prevent the sexual transmission of infectious diseases, including HIV, in federal correctional institutions.

In order to discourage unsafe sexual activities in correctional institutions and to reduce real or perceived obstacles to safer sexual practices,

(1) condoms, dental dams and water-based lubricant should be available to inmates in locations where they regularly meet, which they pass through or have access to, and not only in the health-care centres of the institutions;

(2) a "health kit" should be given to every inmate on entry into the institution and offered to every inmate on exit from the institution. This kit should contain condoms, dental dams, water-based lubricant, educational materials about sexually transmitted diseases, band-aids, disinfectant, acetaminophen and relevant information about drug use and health services;

(3) a "health kit" should always be available in each family visiting unit.

6.1.2 Status of Consensual Sexual Activity

ECAP considers that, in order to discourage unsafe sexual activity in federal correctional institutions, consensual sexual activity between inmates should not be considered an activity that is likely to jeopardize the security of the institution.

6.2 Non-consensual Sexual Activity

ECAP agrees that preventing sexual assault and other non-consensual sexual activity between inmates should continue to be a priority for CSC. Measures to make the prison environment safer should include:

(1) continued efforts to identify sexual predators and inmates who may be vulnerable to sexual abuse;

(2) effective prosecution of inmate sexual predators, and their removal or segregation from the general inmate population;

(3) close supervision and protection, including single-cell accommodation, for inmates who may be vulnerable to sexual abuse;

(4) education of inmates, preferably by inmates, about sexual abuse and the fact that such abuse will not be tolerated in federal correctional institutions.

(5) a long-term goal of providing all inmates with single-cell accommodation.

6.3 Preventing the Harms from Injection Drug Use

ECAP considers that bleach should be made available to inmates in federal correctional institutions as a general disinfectant. In particular,

- small quantities of bleach should be included in a "health kit" given to every inmate on entry into the institution and offered to every inmate on exit from the institution;
- bleach should be made available to inmates in a manner similar to that for condoms, dental dams and lubricant; that is, small quantities of bleach should be easily and discreetly accessible.

ECAP considers that in making bleach available in correctional institutions, CSC's policies should be revised as follows:

- until bleach is made available as a general disinfectant, and thereafter, possession of small quantities of bleach should not be classified as an institutional offence, nor should it be considered to be presumptive evidence of illicit drug use;
- making bleach available in correctional institutions should be accompanied by a clear warning to inmates that possession or use of illicit drugs will not be tolerated in correctional institutions.

ECAP considers that the options for the care and treatment of drug users should include confidential access to methadone.

ECAP considers that there is a need to assess CSC efforts to prevent or reduce drug use and the harms from drug use and to care for and treat drug users in federal correctional institutions. This includes:

- the evaluation of programs already in place;
- studies on the impact of making bleach and of making methadone maintenance available and following up on their implementation; and
- research that will identify and develop measures, including access to clean injection equipment, that will further reduce the risk of HIV transmission and other harms from injection drug use in the prison environment.

6.4 Preventing the Harms from Tattooing

ECAP considers that tattooing is a serious risk for the transmission of infectious diseases, including HIV, among inmates in federal correctional institutions, and that the following would reduce this risk:

- (1) tattoo equipment and supplies should be authorized for use in the institutions;
- (2) educational materials on how to tattoo safely should be made available to inmates;

(3) inmates who would offer tattooing services to other inmates should be instructed about how to use tattooing equipment safely, and be prohibited from tattooing until they are proficient in safer tattooing procedures;

(4) in the absence of such proficiency, institutions should consider providing inmates with access to professional tattooists from outside the institution who can do this safely.

6.5 Preventing the Harms from Piercing

ECAP considers that piercing is a serious risk for the transmission of infectious diseases, including HIV, among inmates in federal correctional institutions, and that the following would reduce this risk:

(1) piercing equipment and supplies should be authorized for use in the institutions;

(2) educational materials on how to pierce safely should be made available to inmates;

(3) inmates who would offer piercing services to other inmates should be instructed about how to use piercing equipment safely, and be prohibited from piercing until they are proficient in safer piercing procedures;

(4) in the absence of such proficiency, institutions should consider providing inmates with access to persons from outside the institution who can do this safely.

7. Protective Measures for Staff

ECAP considers that education about HIV infection and AIDS is the most important effort to promote and protect the health of staff and prevent transmission of HIV and other infectious agents in federal correctional institutions. ECAP recognizes that educational efforts are already in place in correctional institutions but it considers that these efforts may be improved by the following:

(1) All staff should receive written information about HIV infection and AIDS. This could be in the form of a brief, authoritative document tailored for correctional service staff from an outside organization or expert. This would point out the low risk of contracting infections through working in the correctional environment and indicate ways in which this risk may be reduced or avoided.

(2) All staff should receive educational sessions about HIV infection and AIDS, including the subject of universal precautions, when they begin their employment and on a regular basis thereafter.

(3) External, community-based AIDS and health organizations or experts should be invited to participate in these sessions.

(4) Family members or partners of staff should be encouraged to attend the educational sessions.

Further, ECAP considers that, for staff to protect themselves, access to and the correct use of materials and equipment with which the risk of transmission of infectious diseases, including HIV, may be reduced, are essential. ECAP recognizes that materials and equipment are already available in federal correctional institutions. However, in order to reassure staff and to ensure continued proficiency in the use of such materials, equipment, and protective procedures and practices, CSC should:

(1) regularly review access to and use of protective materials and equipment;

(2) regularly review protective protocols and staff compliance with them;

(3) provide the necessary equipment for the safe provision of health care and the handling of body fluids. This includes standardizing protocols for cleaning blood spills and providing equipment for safe search procedures as well as necessary emergency supplies. In particular, CSC should consider provision of so-called puncture-resistant or cut-resistant gloves to replace latex gloves for use when handling emergency situations, dealing with aggressive or violent inmates, and carrying out searches.

(4) provide for the follow-up, including medical follow-up, of all staff exposed to the blood or blood-contaminated body fluids of any inmate or fellow staff.

8. Health Care

ECAP agrees that the care of inmates in federal correctional institutions should be comparable to that available in the community. In the context of HIV/AIDS, this includes access to new, experimental or special treatments, special diets, and peer and community-based organization counselling and support. ECAP acknowledges the efforts that CSC's health-care services have made to provide inmates with HIV infection or AIDS with care and treatment. However, in order to meet the community standard, ECAP considers that:

(1) strong and effective links with external health-care services are necessary to ensure that the care of inmates with HIV infection or AIDS is efficient and accessible, and that continuity of care is provided for whenever they are transferred, given temporary absences, or are released;

(2) incarceration should not be an impediment to accessing new or experimental or special treatments for HIV infection, AIDS or their associated diseases, or for enrolling in research studies to which those with HIV infection or AIDS would otherwise be eligible to enroll; when such services or treatments are unavailable or inaccessible, the inmate should have the opportunity to relocate to an institution in which they would be accessible, subject to security considerations;

(3) health-care services in each institution should be assessed to ensure that the expertise necessary for the medical care of inmates with HIV infection or AIDS is available, and that the services for dealing with the care of inmates with HIV infection or AIDS will be efficient and accessible;

(4) external community-based AIDS or health organizations should be readily accessible to inmates with HIV infection or AIDS;

(5) in each institution, CSC should create or designate one or more inmate jobs as peer health counsellors, and provide for appropriate training, support and evaluation.

9. Tuberculosis

ECAP commends CSC for its efforts to prevent the transmission of tuberculosis in federal correctional institutions.

The Committee considers that the issue of tuberculosis in federal correctional institutions should be monitored closely by CSC, in particular by its Health Care Services Branch and the Health Care Advisory Committee, and that CSC's policy with regard to tuberculosis should be reviewed regularly.

10. Prison Health Services

ECAP considers that CSC, and in particular its Health Care Advisory Committee, should study the feasibility of prison health services being provided by outside agencies.

11. Compassionate Release

ECAP considers that inmates with progressive life-threatening diseases, including AIDS, should regularly be released earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety.

12. Aftercare

ECAP considers that inmates with HIV infection or AIDS should have the opportunity and be encouraged to maintain or build links with the outside world, in particular with HIV/AIDS service, support and health organizations. In order to ensure this, the following should be undertaken:

(1) Parole and probation officers, workers in halfway houses, and other aftercare workers should receive educational sessions about HIV/AIDS, in particular concerning the needs of and the community resources for people with HIV infection or AIDS.

(2) A "health kit" should be offered to every inmate on exit from a correctional institution along with information about available community resources.

(3) CSC should continue to assist inmates who require ongoing medical care to organize this care before they are released.

(4) Inmates should be encouraged to arrange for the transfer of their medical records to their future care providers.

(5) External, community-based AIDS, health or prisoner organizations that provide services and education to people with HIV infection or AIDS should be encouraged to provide such services in federal correctional institutions so that, prior to their release into the community, inmates can establish links with these organizations.

13. Women Inmates

ECAP recognizes the special needs and concerns of women inmates with regard to HIV infection and AIDS, and considers that the following should be provided to them:

(1) educational and prevention programs specifically targeted to women inmates, including information about pregnancy and HIV transmission from mother to child, women's health problems, and the risk of transmission of HIV and other infections from sexual activities, including lesbian sexual activities;

(2) programs that will empower women inmates and decrease their vulnerability to abuse in general and to HIV infection and drug use in particular;

(3) community and peer input into these programs, for example, as provided in some prisons in Quebec, the United States and Australia, or as proposed in the Women's Health and Education and Support Program submitted to ECAP.

(4) counselling and support for HIV-infected pregnant inmates.

14. **Aboriginal Inmates**

ECAP recognizes the special needs and concerns of Aboriginal inmates with regard to HIV infection and AIDS, and considers that CSC's current efforts to respond to these needs may be improved by the following:

(1) Educational and prevention programs targeted to the specific needs of Aboriginal offenders should be developed with input by Aboriginal inmates, their communities and Elders.

(2) Aboriginal groups and Elders should be encouraged to deliver or supplement these programs.

(3) CSC in collaboration with Health and Welfare Canada and others should fund Aboriginal groups and Elders to provide this education.

(4) Because peer education has been found to be one of the most effective means of educating people about HIV infection and AIDS, Aboriginal inmates should be encouraged and assisted in developing their own peer education, counselling and support programs.

(5) CSC in collaboration with Health and Welfare Canada and others should provide the funding necessary to support such efforts.

(6) CSC should ensure that Aboriginal inmates have access to traditional healers, healing ceremonies and medicines, in accordance with current CSC policy.

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APPENDIXES



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Working Paper

Disclosure of Offender Medical Information: A Legal and Ethical Analysis

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Revised 14.6.1993

[T]he prima facie presumption governing confidentiality of medical information, including confidentiality in the AIDS situation, is that everyone is entitled to respect for their rights of privacy and confidentiality and that these can only be infringed upon for the most serious reasons and with adequate justification being shown. Part of any such justification must be that no less invasive, less intrusive means of protecting others which are likely to be effective are reasonably available and that the means used are necessary to achieve this aim and are likely to be effective.¹

[P]rivacy sometimes must give way to other social goods.²

A. Introduction

These two quotations illustrate the complexities of confidentiality relating to HIV infection. The problem of confidentiality becomes even more complex when it involves closed communities such as prisons. This Working Paper addresses some of the issues raised in federal correctional institutions by the generation and communication of personal medical information pertaining to

* The authors wish to acknowledge the contribution of Prof. M.A. Somerville in preparing this paper.

¹ M. A. Somerville, "AIDS: A Challenge to Health Care, Law, and Ethics", in: D. Snowden, D.F. Cassidy (eds.) *AIDS: A Handbook for Professionals* (1989) 200-220, at p. 211.

² The Privacy Commissioner of Canada, *AIDS and the Privacy Act* (Ottawa: Minister of Supply and Services Canada, 1989) at 1.

HIV infection. It examines, first, whether medical information pertaining to federal inmates - information considered confidential between medical staff and an inmate - can be disclosed absent the inmate's consent. Second, this paper examines what conditions or criteria determine whether or not such disclosure is ethically and legally justifiable, and if disclosure is justified, what conditions apply to its disclosure. Third, specific situations in which a claim for disclosure may arise are examined. Finally, the paper responds to a recent analysis of confidentiality in federal correctional institutions in Canada and the disclosure of offender medical information.³

B. Analysis of the Legal, Ethical, and Policy Background

I. The Duty of Confidentiality

1. The Law

The law establishes that physicians have a duty of confidentiality to their patients.⁴ All information generated in the course of a medical relationship must be kept confidential, and the patient has a right to, and the physician has a duty of, confidentiality.⁵ This duty is recognized at common law⁶ and is often reiterated in statutes.⁷ Moreover, the Supreme Court of Canada, in *McInerney v. MacDonald*, characterized the physician-patient relationship as "fiduciary" and

³ Memorandum from M.H. Zazulak, General Counsel, Correctional Service of Canada, to Dr. J.H. Roy, Director General, Health Care Services, dated 13.7.1992, on "Sharing of Offender Medical Information - HIV etc. - "Need to Know".

⁴ D.G. Casswell, "Disclosure by a Physician of AIDS-related Patient Information: An Ethical and Legal Dilemma" (1989) 68 *Can. Bar. Rev.* 225-258 at 228, with further references.

⁵ N. Gilmore, M.A. Somerville, *Physicians, Ethics and AIDS* (Ottawa: Canadian Medical Association 1989) at 21.

⁶ Casswell, *supra*, note 4 at 228, note 12 with reference to *A.B. v. C.D.* (1851), 14 Sess. Cas. (Second Series) 177 (Scot. Ct. Sess.); *Re Inquiry into the Confidentiality of Health Records in Ontario* (1979), 98 D.L.R. (3d) 704, at p. 714, 24 O.R. (2d) 545, at 555 (Ont. C.A.), per Dubin J.A., for the majority: "Members of the medical profession have a duty of confidentiality with respect to their patients. They are under restraint not to volunteer information respecting the condition of their patients or any professional services performed by them ...".

⁷ For a list of provincial legislation recognizing the duty of confidentiality, see Casswell (*supra*, note 4 at 228, note 13): The Health Disciplines Act Medicine Regulation, R.R.O. 1980, Reg. 448, s. 27.22; The Charter of Human Rights and Freedoms, R.S.Q. 1977, c. C-12, s. 9; The Medical Act, R.S.Q. 1977, c. M-9, s. 42; and the Code of Ethics of Physicians, R.R.Q. 1981, c. M-9, r. 4, s. 3.01). See also the Supreme Court of Canada decision in *Frenette v. Metropolitan Life Ins. Co.* [1992] 1 S.C.R. 647-696, at 666: "Hospital records in Quebec are statutorily protected by a veil of confidentiality (s. 7 of *An Act Respecting Health Services and Social Services*), as are confidences given to physicians by reason of their profession (s. 9, para. 2 of the *Charter* and s. 42 of the *Medical Act*). The right to non-disclosure of confidential information generally is also provided for in the first paragraph of s. 9 of the *Charter*." See also *ibid* at 673.

held that from the special relationship of trust and confidence between doctor and patient arise certain special duties:

Among these are the duty of the doctor to act with the utmost good faith and loyalty, and to hold information received from or about the patient in confidence. When a patient releases personal information in the context of the doctor-patient relationship, he or she does so with the legitimate expectation that these duties will be respected.⁸

The Supreme Court continued by saying that, while the doctor is the owner of the actual medical record, the information contained in it is to be used by the physician for the benefit of the patient, and that the "confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue."⁹

In *Hay v. University of Alberta Hospital*,¹⁰ the status of the right of confidentiality was described by Picard J. as follows:

The physician-patient relationship is clothed with confidentiality, a right which may be waived by the patient. Confidentiality is an important attribute of the physician-patient relationship, essential in promoting open communication between physician and patient. The patient may expressly waive this right or, by his actions, be found to have impliedly waived it. Alternatively, an overriding public interest or a statutory direction may justify a physician disclosing information about the patient. In the absence of such circumstances, the right remains and a physician who divulges confidential information could face an action for breach of confidentiality, a possibility which obviously causes physicians some concern.¹¹

As stated by the Supreme Court of Canada, the duty of confidentiality that arises from the doctor-patient relationship is meant to encourage disclosure of information by the patient to the physician and communication between them.¹² Patients must be encouraged to seek treatment without fear that their ailment, condition or treatment will be disclosed. In addition,

[e]ncouraging patients to come forward and seek treatment benefits not only patients themselves but also others who may be at risk of infection; that is,

⁸ *McInerney v. MacDonald*, [1992] 2 S.C.R. 138 at 149, with many references.

⁹ *Ibid.* at 151.

¹⁰ (1990) 69 D.L.R. (4th) 755 (Alta. Q.B.), quoted in *Frenette* at 688.

¹¹ *Hay*, *supra*, note 10 at 757-758.

¹² *McInerney*, *supra*, note 8 at 153.

maintaining the patient's confidence is not only in his or her interest but also in the public interest.¹³

The duty of confidentiality may even be constitutionally guaranteed.¹⁴ In addition, in most provinces and territories, physicians are expressly required by statute to keep confidential patient information concerning communicable diseases, including AIDS.¹⁵

At a federal level, the *Privacy Act*¹⁶ seeks to protect Canadians from the collection and dissemination, without sufficient cause, of personal information about them by federal institutions and agents. Other deterrents to disclosure of personal information, applicable to this situation, include liability resulting from unauthorized or unjustifiable disclosure and abuse of such information following disclosure, and remedies for abuses resulting from such disclosure such as protection against discrimination.

2. *Ethical Obligations*

Physicians also have an ethical obligation to maintain confidential the information that is given to them by their patients. This duty has roots that date back to the Hippocratic oath written during the fourth century BC which contains the vow:

Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.¹⁷

The Code of Ethics of the Canadian Medical Association requires that a physician keep in confidence information derived from his or her patient and divulge such information only with the permission of the patient or if required to do so by law.¹⁸

¹³ Casswell, *supra*, note 4 at 229.

¹⁴ Casswell, *supra*, note 4 at 228, note 14, with reference to E.I. Picard, *Legal Liability of Doctors and Hospitals in Canada* (2nd ed., 1984), p. 8, n. 51, referring to the Canadian Charter of Rights and Freedoms, Constitution Act, 1982, Part I, s. 7.

¹⁵ For an overview of statutes and regulations requiring patient information about communicable/reportable/infectious/contagious diseases to be kept confidential, see Casswell, *supra*, note 4 at 255 (Table A); Jürgens R, Gilmore N, Somerville M: May 1992 update of Hamblin J, Duckett M, Somerville MA, Gilmore N, Zimmerman S: *Responding to HIV/AIDS in Canada*. Carswell, Toronto, 1990.

¹⁶ R.S.C. 1985, c. P-21.

¹⁷ Hippocratic Oath, as translated by B.M. Dickens, "Confidentiality and the Duty to Warn" in: L.O. Gostin (ed.), *AIDS and the Health Care System* (New Haven: Yale University Press 1990) 98-112, at 98.

¹⁸ The Canadian Medical Association Code of Ethics, Rule 6 states: "An ethical physician will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him to do so." Cited in Casswell, *supra*, note 4 at 226, note 3.

With regard to HIV/AIDS, it has been said that "[a]s a general principle of medical ethics, a physician who has knowledge of positive test results or even a confirmed diagnosis of AIDS must protect confidentiality and avoid disclosure of this information."¹⁹

3. Prison Policy

The general principle according to which medical information is confidential also applies in federal correctional institutions. Inmates have the same rights, including those of autonomy, inviolability, and confidentiality, as any other Canadian, except where these rights must necessarily be abrogated by the fact of imprisonment.²⁰

It has been stated that "[u]nless there is clear and convincing evidence that an incarcerated person is likely to transmit HIV, then the general threat of HIV transmission in correctional institutions cannot justify compulsory testing."²¹ One reason for this conclusion was that such testing would present a grave danger to the rights of confidentiality and privacy of persons being tested and would place incarcerated persons in danger of otherwise avoidable harm, "which is unjustifiable when other alternatives to control HIV transmission are available."²²

Directives of the Commissioner of the Correctional Service of Canada ("CSC") expressly affirm that medical information relating to inmates is confidential.²³ These Directives state:

¹⁹ R. Belitzky, R.A. Solomon, "Doctors and Patients: Responsibilities in a Confidential Relationship" in: L.H. Dalton, S. Burris (eds.), *AIDS and the Law: A Guide for the Public* (New Haven: Yale University Press 1987) 201-209 at 202.

²⁰ Lord Wilberforce in *Raymond v. Honey* (1982), cited in S. Shaw, "Prisoners' Rights", in: P. Sieghart (ed.), *Human Rights in the United Kingdom* (London: Pinter Publishers, 1988) 40-49 at 40; see also the 1990 Basic Principles for the Treatment of Prisoners, United Nations, Annex to General Assembly resolution 45/111 of 14 December 1990, para. 5.

²¹ M.A. Somerville, N. Gilmore, *Human Immunodeficiency Virus Antibody Testing in Canada*. A Report Submitted to and Approved by the National Advisory Committee on AIDS (Montreal: McGill Centre for Medicine, Ethics and Law, 1988) at 53; *Canada Disease Weekly Report* 1989: 15-8:37-47.

²² Ibid.

²³ This is consistent with the 1993 WHO Guidelines on HIV Infection and AIDS in Prisons (WHO, Geneva, March 1993: WHO/GPA/DIR/93.3). These guidelines state:

31. Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel. Health personnel may provide prison managers or judicial authorities with information that will assist in the treatment and care of the patient, if the prisoner consents.

32. Information regarding HIV status may only be disclosed to prison managers if the health personnel consider, with due regard to medical ethics, that this is warranted to ensure the safety and well-being of prisoners and staff, applying to disclosure the same principles as those generally applied in the community. Principles and procedures relating to voluntary partner notification in the community should be followed for prisoners.

33. Routine communication of the HIV status of prisoners to the prison administration should never take place. No mark, label, stamp or other visible sign should be placed on prisoners' files, cells or papers to indicate their HIV status.

Offenders have the same rights to confidentiality of information obtained by a health care professional as exist in the general community. [CD 835.12]

All diagnosis of HIV infection shall be noted on the problem sheet of the medical record. Once informed, health care staff shall comply with Commissioner's Directive No. 835 which governs the confidentiality and disclosure of any information obtained by a health professional. [CD 821.19]

Upon transfer to parole jurisdiction, health care staff shall, with the inmate's consent, ensure that arrangements have been made for follow-up with an appropriately qualified community physician. [CD 821.20]

The HIV status of an inmate is medical confidential. This information shall not be released to supervisory/agency staff without the inmate's consent. [CD 821.21]

II. Exceptions to the Duty of Confidentiality

1. *The Law*

There are situations in which confidential medical information may be disclosed without breach of the duty of confidentiality, and there are exceptions to the duty of confidentiality which permit or even require a breach of confidentiality.

A physician may disclose patient information with the informed consent of the patient (when informed consent is given, confidentiality is not breached), or where legislation requires that confidentiality be breached. All Canadian jurisdictions have legislation requiring physicians to report cases of AIDS and sometimes also cases of HIV-infection, either nominally or non-nominally, to medical officers of health.²⁴ On the other hand, there is no HIV/AIDS-specific legislation requiring or authorizing disclosure by a physician of such information to a sexual or drug using partner of the patient. There is, however, legislation in some provinces and territories requiring or authorizing disclosure by a physician of patient information if such disclosure is necessary to protect a third party. "Partner notification" is required by the public health acts of Yukon and the Northwest Territories, and authorized, but not required by the public health acts of some provinces.²⁵

Absent the patient's informed consent and absent legislation requiring or authorizing disclosure, disclosure of patient information may still be justified under general law doctrines which operate to provide exceptions to the duty of confidentiality.

First, a defence of necessity may apply to justify breaching confidentiality when

the harm inflicted by the breach is clearly outweighed by the harm it avoids; the harm avoided cannot be avoided in any other less invasive way; and the harm

²⁴ See Casswell, *supra*, note 4 at 256-257; Jürgens, Gilmore, Somerville, *supra*, note 15.

²⁵ For an overview see Casswell, *supra*, note 4 at 231-235; Jürgens, Gilmore and Somerville, *supra*, note 15.

avoided is sufficiently serious to merit avoiding it through a breach of confidentiality.²⁶

Second, in rare situations, there is a "duty to warn" or "duty to protect" others. In general, such a duty applies "only to identified or readily identifiable persons, for example, those whom an HIV antibody positive person is clearly putting at risk and who have no other means of knowing about, and so avoiding, that risk or who, because of their lack of knowledge, might place others at risk."²⁷

The Supreme Court of Canada, in *McInerney*, held that the patient's right to require that professional secrets acquired by the practitioner shall not be divulged is absolute "unless there is some paramount reason that overrides it:

[T]here may be cases in which reasons connected with the safety of individuals or the public ... would be sufficiently cogent to supersede or qualify the obligations *prima facie* imposed by the confidential relation.²⁸

In another case the Supreme Court dealt with disclosure of confidential medical information in court proceedings. However, the Court also commented on disclosure in the extrajudicial context.²⁹ It held that, in an extrajudicial context, the main principle underlying the duty of a professional or a hospital to keep their medical records secret is that of the privacy of the individual:

It is, therefore legitimate for a court to give a broad interpretation to the general duty of non-disclosure imposed on hospitals and medical professionals in these circumstances and to interpret restrictively any violation of the right to confidentiality.³⁰

Courts in the United States have repeatedly held that "a physician's duty of nondisclosure is outweighed in certain circumstances by a need for public safety."³¹ Courts in some states

²⁶ Gilmore and Somerville, *supra* note 5 at 21; Somerville, *supra*, note 1 at 211-212.

²⁷ Gilmore and Somerville, *supra*, note 5 at 21.

²⁸ *McInerney*, *supra*, note 8 at 154, citing from *Halls v. Mitchell*, [1928] S.C.R. 125 at 136.

²⁹ The extrajudicial context must be distinguished from the judicial context. In the latter the issue is whether patient-physician communications are privileged when sought in court proceedings.

³⁰ *Frenette v. Metropolitan Life Ins. Co.* [1992] 1 S.C.R. 647 at 675.

³¹ Belitzky and Solomon, *supra*, note 19 at 203, note 24, with reference to *Edwards v. Lamb*, 69 N.H. 599, 45 A. 480 (1899); *Earle v. Kuklo*, 26 N.J. Super. 471, 98 A.2d 107 (1953) (landlord exposing tenants to tuberculosis); *Kliegel v. Aitken*, 94 Wis. 432, 60 N.W.67 (1896) (employer exposing employees to typhoid fever); *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612 (1921) (typhoid fever); *Skilling v. Allen*, 143 Minn. 323, 173 N.W. 663 (1919) (scarlet fever); *Edwards*, 69 N.H. 599, 45 A.480 (infectious sore);

have found physicians liable to the patient's family members for failure to disclose that the patient had a contagious disease. Belitzky and Solomon have concluded that "a physician with knowledge of a diagnosis of AIDS who fails to disclose the information to a foreseeable victim could be found liable."³² In *Tarasoff v. Regents of the University of California*,³³ the California Supreme Court imposed a duty on psychotherapists to protect third persons from the potentially dangerous acts of their patients. The court held that when a therapist determines, or should have determined, "that a patient presents a serious danger of violence to another, he or she incurs an obligation to use reasonable care to protect the intended victim against such danger."³⁴ The court concluded that "the public policy favoring protection of the confidential character of patient ... communications must yield to the extent to which disclosure is essential to avert dangers to others."

Tarasoff was the first case to impose a duty to warn potential victims of injury that might result from a patient's intentional actions. Moreover, the case affirmed that a physician can have a duty to protect identified third parties from dangers created by a patient's illness.³⁵

2. Ethical Obligations

The ethical obligation to maintain confidential the information that is given to physicians by their patients is not absolute. At its 1987 annual meeting, the Canadian Medical Association resolved that it is not unethical for a physician to "make discrete disclosure to an appropriate person with the patient's knowledge," but without his or her consent, of the fact that the patient has tested HIV seropositive, "when [the] public interest [in such disclosure] clearly outweighs the interest of the patient."³⁶ In its 1989 position paper on HIV/AIDS, the Association stressed the need to respect the confidentiality of patients with HIV infection and recommended that legal and regulatory safeguards be put in place to protect such confidentiality. At the same time, the paper advised physicians that disclosure to a spouse or current sexual partner may not be unethical and, indeed, may be indicated "when physicians are confronted with an HIV-infected patient who is unwilling to inform the person at risk."³⁷ The paper continues by saying that

Fosgate v. Corona, 66 N.J. 268, 330 A.2d 355 (1974) (tuberculosis); *Wojick v. Aluminium Company of America*, 18 Misc. 2d 740, 183 N.Y.S.2d 351 (Sup.Ct. 1959) (employer who administers regular x-rays to employee liable for failure to disclose tuberculosis).

³² Belitzky and Solomon, *supra*, note 19 at 203.

³³ 17 Cal. 3d 425, 551 P. 2d 334, 131 Cal. Rptr. 14 (1976).

³⁴ Belitzky and Solomon, *supra*, note 19 at 203-204 with reference to *Tarasoff*.

³⁵ For further discussion of *Tarasoff* and other US caselaw, see Belitzky and Solomon, *supra*, note 19 at 204-207.

³⁶ (1987), 137 *Can. Med. Ass. Jo.* 645 at 653; cited in Casswell, *supra*, note 4 at 226-227, notes 4 and 5.

³⁷ Canadian Medical Association, A CMA Position, at 64B.

[s]uch disclosure may be justified when all of the following conditions are met: the partner is at risk of infection with HIV and has no other reasonable means of knowing of the risk; the patient has refused to inform his or her sexual partner; the patient has refused an offer of assistance by the physician to do so on the patient's behalf; and the physician has informed the patient of his or her intention to disclose the information to the partner.³⁸

Similarly, the American Medical Association observed that "the confidentiality of the physician-patient relationship is vitally important but not absolute."³⁹ The Association's Interim Report on AIDS Policy proposed the basic principle that "access to patient information should be limited only to health care personnel who have a legitimate need to have access to the information to assist the patient or to protect the health of others closely associated with the patient."⁴⁰ The Report acknowledged that, in some limited circumstances, there may be a duty to warn third parties:

Physicians who have reason to believe that there is an unsuspecting sexual partner of an infected individual should be encouraged to inform public health authorities. The duty to warn the unsuspecting sexual partner should then reside with the public health authorities as well as the infected person and not with the physician of the infected person.⁴¹

3. *Prison Policy*

Commissioner's Directives explicitly acknowledge that the duty to keep confidential medical information relating to offenders is not absolute. In correctional institutions, as outside, some persons may expose others to HIV, including through the use of force, coercion or duress. Disclosure of medical information of persons who are likely to non-consensually or forcibly expose others to HIV may in some occasions be justified.⁴²

The Directives state:

[I]t is the responsibility of a health care professional, when there is reasonable cause to believe that the offender's intentions or possible actions may constitute a threat to the safety of him/herself or others, to provide information to the appropriate personnel without the offender's consent. [CD 835.12]

³⁸ Ibid.

³⁹ Dickens, *supra*, note 17 at 98, with reference to American Medical Association, Board of Trustees, "Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report", 258 JAMA 2100 (1987).

⁴⁰ Dickens, *supra*, note 17, at 2, with reference to American Medical Association, *supra*, note 36, at 2102.

⁴¹ Dickens, *supra*, note 17, with reference to American Medical Association, *supra*, note 37, at 2103.

⁴² Somerville and Gilmore, *supra*, note 21 at 53.

[I]f there is cause to believe that an offender's actions may constitute a danger to himself or others, and in accordance with the *Privacy Act*, health care staff shall provide information to the appropriate personnel without the offender's consent.

[CD 821.21]

Commenting on the issue of disclosure of medical information relating to inmates, the Privacy Commissioner of Canada said that "there may be a merit in a policy that allows disclosure where an infected inmate's conduct threatens others (for example, through unsafe sexual practices or the sharing of needles)."⁴³ The Privacy Commissioner made a distinction between disclosure of offender medical information in order to prevent HIV exposure among offenders and disclosure to prevent HIV exposure of prison staff. The report states that "disclosure to prevent HIV exposure of prison staff remains a question."⁴⁴ In part, this reflects a concern of the Privacy Commissioner that corrections officers may negligently pass the information to other inmates. The report recognizes the risk to staff of being exposed to HIV, stating that "some corrections officers may fear that inmates will attempt to infect them, given the hostile relations between the two groups." However, it concludes that "[h]ow significant a risk this is must be assessed before a decision is made about informing corrections officers of an inmate's HIV infection."

The National Advisory Committee on AIDS ("NAC-AIDS") recently recommended that the confidentiality of all HIV-related information in correctional facilities be strictly maintained, for two reasons. First, NAC-AIDS was concerned that, if the confidentiality of this information was violated, infected inmates would be placed at considerable risk of discrimination and would likely have to be removed from the general inmate population. Second, NAC-AIDS found that "there is no reason for this information to be made available either to other inmates or to the non-medical staff of the correctional facilities." Consequently, NAC-AIDS recommended that the Solicitor General implement additional measures to secure the confidentiality of all HIV-related information in correctional facilities. In particular, NAC-AIDS felt that it was necessary "to provide for disciplinary action against any employees found in violation of HIV-related confidentiality provisions."⁴⁵

III. Summary

The *prima facie* presumption governing confidentiality of medical information, including confidentiality in the AIDS situation, is that everyone, including inmates in federal institutions, is entitled to respect for their rights of privacy and confidentiality and that these rights can only be infringed upon for serious reasons and with adequate justification.⁴⁶

⁴³ The Privacy Commissioner of Canada, *supra*, note 2 at 40.

⁴⁴ *Ibid.* at 40.

⁴⁵ National Advisory Committee on AIDS. *HIV and Human Rights in Canada*, 1992 at 17.

⁴⁶ Somerville, *supra*, note 1 at 211.

Disclosure cannot be legally and ethically justified in the absence of a real potential for harm to an identifiable third party. As the Federal/Provincial/Territorial Working Group on Confidentiality in Relation to HIV Seropositivity has stated,

[i]nformation about HIV status should be disclosed only for the benefit of the person being tested, e.g. where necessary to ensure appropriate medical care, or where there is a reasonable basis for believing that the conduct of an HIV infected person constitutes an unacceptable risk to the health of others.⁴⁷

From a legal perspective, disclosure, absent informed consent, would only be justified if it could be shown that no less invasive, less intrusive means of protecting others which are likely to be effective are reasonably available and that the disclosure is necessary to achieve this aim and is likely to be effective.

Ethical and legal analysis reflect each other in this area.⁴⁸ Ethical analysis involves assessing the benefits, risks and harms to the offender whose information would be disclosed, to the person(s) to whom the information would be disclosed, and to society. Consequently, the minimum conditions that would have to be fulfilled in order to justify such disclosure from an ethical perspective include:⁴⁹

- the harm(s) to be avoided must be serious and probable, and would not be avoidable without disclosure;
- the person(s) who will be harmed must be identifiable, that is a general fear of harm to a population such as prisoners or guards would be too vague to justify disclosure;
- the benefits from disclosure must outweigh the risk(s) and harm(s) that would be inflicted by the disclosure, to society as well as to the offender;
- the disclosure must be the least invasive, least restrictive, likely to be effective means that is reasonably available to accomplish the objective for which confidentiality would be breached.

⁴⁷ Federal/Provincial/Territorial Working Group on Confidentiality in Relation to HIV Seropositivity (Health and Welfare Canada, November 1988). This Report was accepted by the Conference of Deputy Ministers of Health (June 1988) and approved by the Interprovincial Meeting of Ministers of Health (September 1988).

⁴⁸ Somerville and Gilmore, *supra*, note 21 at 13-14.

⁴⁹ Gilmore N, Somerville MA, Jürgens R, Wilson S: Is compulsory testing of a person charged with "rape" ever justified? Poster presentation PO-D27-4187 at the IX International Conference on AIDS, Berlin, 7-11 June 1993.

Furthermore, justification of an exception rests with the person claiming it, and not with the offender who enjoys the "right" of confidentiality.⁵⁰ Also, the exception only applies when the offender has not consented to (or refused to allow) the disclosure. This implies that the offender must be informed, before the information is disclosed, that medical information pertaining to the offender will be disclosed absent the offender's consent.

C. "Need to Know" or the Necessity of Disclosure

Often, the necessity for the disclosure of confidential offender medical information is referred to as a "need to know". The analysis which follows addresses this need. It examines, first, the objective that would be accomplished by disclosure (the purpose for which disclosure is needed). Second, it examines the necessity for such disclosure - in particular whether or not disclosure would be effective in accomplishing this objective - and alternatives to disclosure. This includes analysis of benefits, risks and harms resulting from disclosure. Third, specific situations are examined in which a claim for disclosure may arise.

I. The Objective of Disclosure

There are two situations in which claims for disclosure of offender medical information may arise:

- disclosure preceding exposure to HIV in order to prevent HIV transmission; and
- disclosure following exposure to HIV.

These situations are discussed separately.

1. *Disclosure Preceding Exposure to HIV*

The objective of disclosure in this situation is to avoid or minimize exposure to HIV. Disclosure would lead to an intervention aimed at preventing the exposure.

Staff in federal penitentiaries have often claimed that they "need to know" the HIV status of infected inmates in order to take adequate precautions to protect themselves and their families. In particular, some staff have maintained that the use of "universal precautions" is not practical and that it is unrealistic to believe that protective measures that can prevent HIV transmission in penitentiaries can be applied universally. They have also argued that knowing a particular inmate is HIV-infected would protect them because they would then handle the known infected offender with increased caution.

2. *Disclosure Following Exposure to HIV*

The objective of disclosure in this situation is to avoid or minimize the risk of HIV infection, or to reassure the person who was potentially exposed. Staff have claimed that health care staff may disclose medical information to a staff member or to an inmate who has suffered a significant exposure to bodily fluids or blood of an inmate who is HIV positive or is infectious with hepatitis B. Disclosure would lead to an intervention aimed at preventing infection once

⁵⁰ Gilmore and Somerville, *supra*, note 5 at 6.

exposure has occurred, or at least at reassuring the person exposed. With regard to hepatitis B virus exposure, this would mean treatment with gammaglobulin and hepatitis B vaccination; with regard to HIV exposure, this would mean zidovudine ("AZT") treatment.

II. Is Disclosure necessary?

This section examines the necessity for disclosure - in particular whether or not disclosure would be effective in accomplishing the objectives discussed above - and alternatives to disclosure.

In order to establish whether disclosure is necessary, a solid understanding of the scientific facts regarding HIV/AIDS is necessary.

1. Modes of HIV Transmission

There are three situations in which a person may be exposed to HIV. The first is by being exposed to fluids - other than blood or bloody fluids - from someone who is infected with HIV. The second is being exposed to HIV-infected blood or bloody fluids. The third situation is being exposed to semen, genital fluids or blood during sexual intercourse. The potential for being infected with HIV differs for each of these situations.

Being exposed to HIV does not necessarily result in HIV infection. While exposure to HIV implies that becoming infected with HIV is a possibility, it does not indicate the probability that HIV infection may occur. The risk or probability of HIV transmission varies greatly. It depends upon the type of exposure (skin or mucosal contact, or inoculation through the skin), the material carrying HIV such as blood, semen or other genital fluids, the volume of material carrying HIV that is involved in the exposure, and the amount of HIV in the material. For some exposures, this risk is considered to be negligible.

- Mere physical contact with an HIV-infected person and skin contact with HIV infected fluids such as sweat, tears, urine or feces have never been associated with documented HIV transmission.⁵¹ Applying universal precautions is not necessary when there is negligible risk. However, their use in such situations will eliminate the possibility of exposure to HIV and other infectious agents.

- Being exposed to HIV-infected blood or bloody fluids has resulted in some people being infected with HIV. However, this has happened only in rare cases and only when blood was deposited inside the body.

In the health care context, exposure occurs most often when a health care provider is injured and blood is introduced into his or her body through a wound, such as when he or she is punctured by a bloody needle or other hollow instrument. Solid needles such as suture

⁵¹ Lifson AR: Do alternate modes for transmission of human immunodeficiency virus exist? *JAMA* 1988; 259: 1353-1356; Friedland G, Kahl P, Saltzman B, et al: Additional evidence for lack of transmission of HIV infection by close interpersonal (casual) contact. *AIDS* 1990; 4: 639-644; Gershon RRM, Vlahov D, Nelson KE: The risk of transmission of HIV-1 through non-percutaneous, non-sexual modes - a review. *AIDS* 1990; 4: 645-650; Rogers DE, Gellin BG: Editorial comment. The bright spot about AIDS: it is very tough to catch. *AIDS* 1990; 4: 695-696.

needles, on the other hand, have not been associated with documented HIV transmission. The probability of HIV infection following such "needlestick" injuries has been quantified in prospective studies.⁵² One infection was documented for every 333 injuries; this may be overestimated because many exposure-producing injuries are not reported.

With regard to the prison environment, only one documented case of HIV transmission to prison staff has been reported. In this case, a prison officer was stabbed with a syringe filled with HIV-infected blood.⁵³

It is suspected, but unproven, that three health care providers may have been infected when splashed with HIV-infected blood.⁵⁴ However, the precise means by which the virus was introduced into their bodies is uncertain, although pre-existing skin damage may have predisposed them to HIV transmission. Bites and scratches have not been convincingly associated with HIV transmission.⁵⁵ Finally, there is only a single report of HIV transmission to a soccer player who collided with an HIV-infected player, and both players sustained serious lacerations.⁵⁶

- HIV may be transmitted from an infected person to someone by sharing needles and syringes contaminated with the HIV-infected person's blood, and by sexual intercourse when a condom is not used. Again, these activities will expose the uninfected person to HIV but will not necessarily infect the person. Not engaging in sexual intercourse or not sharing injection equipment for injection drug use or tattooing will eliminate the risk of infection, whereas using a condom during intercourse or cleaning injection equipment before each use will reduce this risk.

2. Necessary Precautions

There are two major approaches to prevent exposure to HIV. One approach is to not engage in exposure-producing activities such as unprotected sexual activity and the use of unclean injection equipment, and to avoid physical contact with an inmate who is violent. The

⁵² Mike L, Ostrowsky J, Beheny C, Hewitt M: HIV in the health care workplace. Washington, Office of Technology Assessment, Congress of the United States of America, 1991, as quoted in *AIDS Reference Guide*, Washington, AIDS Information Service, Inc., January 1992, at 907.1-907.18.

⁵³ This case occurred in Australia. It was alleged that a young officer, newly recruited to the service, was attacked and stabbed with a blood-filled syringe. The officer later tested positive for HIV. The incident was widely reported in the press. See Doyle J. Management Issues - A Prison Officers Union Perspective. In Norberry et al. (eds.), *HIV/AIDS and Prisons*. Canberra: Australian Institute of Criminology, 1991, 125-131.

⁵⁴ Centers for Disease Control: Update: human immunodeficiency virus infections in health care workers exposed to blood of infected patients. *Morb Mortal Weekly Rep* 1987; 36: 285-295.

⁵⁵ Tsoukas CM, Hadjis T, Shuster J, Theberge L, Feorino P, O'Shaughnessy M: Lack of transmission of human immunodeficiency virus (HIV) by bites and scratches. *J Acq Immune Defic Synd* 1988; 1: 505-507; Richman KM, Rickman LS: The potential for transmission of human immunodeficiency virus through human bites. *J Acq Immune Defic Synd* 1993; 6: 402-406.

⁵⁶ Torre D, Sampietro C, Ferraro G, Zeroli C, Speranza L: Letter to the Editor: transmission of HIV-1 infection via a sports injury. *N Engl J Med* 1990; 335: 1105.

second is to reduce the risk of HIV transmission when engaging in sexual activity, injection drug use or tattooing, when dealing with an inmate who is violent, and whenever an exposure-producing injury might occur such as during cell searches.

In each of these situations, knowing that a person involved in them is infected will only reaffirm the need to take precautions to reduce or eliminate the risk of exposure. When it is uncertain that a person is not infected, the same precautions would apply. They may be relaxed only when it is certain that the persons involved in situations where exposure is possible are not infected. Since this certainty is seldom possible, precautions need to be applied to everyone who might be involved in an exposure-producing situation. That is, precautions need to be applied universally.

The following is an examination of different situations arising in correctional institutions in which persons may be exposed to HIV.

(1) Exposure to blood or bloody fluids

In any situation where staff or inmates are exposed to blood or bloody fluids, universal precautions have to be taken to prevent exposure to and infection with HIV regardless of whether an inmate or staff member is or is not known, to staff, wardens, or inmates, to be infected with HIV.⁵⁷ This is consistent with the Guidelines for Infection Control that were developed for CSC staff in 1989.⁵⁸

Since it is not possible to identify every inmate who is infected, staff would not be protected against HIV transmission were protective precautions to be applied only to inmates who are known to be infected. The reasons why all infected inmates cannot be identified include the following.

- Not all inmates are tested.⁵⁹ Fear of disclosure and the risks and harms for the offender when information about their HIV status is disclosed are a strong deterrent to

⁵⁷ For a description of such precautions for the health sector, see: Health and Welfare Canada: Recommendations for prevention of HIV transmission in health-care settings. *Can Dis Weekly Rep* 1987; 13 S3: 1-10.

⁵⁸ Interim Guidelines for Infection Control—Staff. Correctional Service Canada. Ottawa: Minister of Supply and Services Canada 1989. These guidelines contain information about the general precautions to be observed by all staff to prevent the spread of infection, as well as institutional procedures for cleaning and disinfecting the environment, equipment and supplies, cleaning of cells, kitchen and laundry, and "precautions to be observed with inmates identified as having an infectious disease." These guidelines stress that blood and body fluid precautions need to be employed universally, "whether or not there is an identified risk" and that "[s]taff safety is enhanced by assuming that any individual may be infected by a communicable disease."

⁵⁹ In accordance with Commissioner's Directive 821, testing for HIV infection in federal correctional institutions is undertaken only voluntarily—that is, with the informed consent of the inmate. This is consistent with the general principle governing HIV antibody testing in Canada, according to which "HIV antibody testing should only be done when voluntary, that is with informed consent, and when counselling and education before and following testing are available and offered, and when confidentiality of results or anonymity of testing can be guaranteed." See Somerville and Gilmore, *supra*, note 21 at XIII.

testing for many inmates. A perceived lack of confidence in prison medical staff contributes to this disincentive to testing. In the absence of strong safeguards against disclosure, only anonymous testing would guarantee confidentiality of the medical information. However, anonymous testing is rarely, if ever, available to offenders, and testing is usually carried out by prison medical staff.

- Tests for HIV infection will fail to detect every infected inmate. Some inmates may have been infected too recently for their infection to be detectable, and for others false negative results will occur, although this will be rare. The delay between being infected with HIV and the infection being detectable can be as long as six months. This means that a negative test result cannot provide "useful" protective information and does not permit relaxation of protective efforts.

Because it is not possible to detect or identify all HIV-infected inmates, precautions that can prevent HIV transmission have to be applied consistently and universally. Disclosing to staff the HIV status of inmates who are known to be infected would send out the wrong message: 1) that staff need to protect themselves only when they know that an inmate is infected, rather than applying precautions universally; and 2) that staff can take "extra precautions" for known infected offenders, rather than always taking sufficient precautions. Instead, staff should be encouraged and educated to always use precautions.

Arguments that "extra precautions" could be taken with known HIV-positive inmates are misguided because the concept of universal precautions requires that sufficient precautions are to be taken for every inmate, whether or not the inmate is known to be seropositive.

Staff have sometimes argued that applying precautions universally in the prison setting is impossible or impractical. However, experience in the health-care setting has shown that people can and must learn to apply precautions universally. For example, in hospitals, where the risk of exposure to HIV is much higher than in prisons, it has long been understood that disclosure of the HIV status of patients would not increase staff safety.⁶⁰ Consequently, the HIV status of patients and doctors is not revealed to others, and strict adherence to universal precautions is enforced.

Were staff to be routinely informed about inmates known to be HIV-infected, it may create a false sense of security. Staff would know of only some of the infected inmates because not all inmates would be tested, and because inmates would not be tested repeatedly. There is also concern that if the HIV status of seropositive inmates were disclosed to staff, fewer inmates would come forward for testing or self-disclose their positive HIV status, thereby further reducing the number of inmates known to be infected.

Experience with seropositive inmates in correctional institutions has shown that most of them will sooner or later self-disclose their HIV status to fellow inmates and to staff. Such

⁶⁰ Canadian Medical Association. CMA Policy Summary: HIV Infection in the Workplace. *Can Med Assoc J* 1993; 148(10) 1800 A-1800H; Laboratory Centre for Disease Control: Bloodborne Pathogens in the Health Care Setting: Risk for Transmission. *Canadian Communicable Diseases Report* 1992;18:177-184 at 178; Gerberding JL, Littell C, Tarkington A et al. Risk of Exposure of Surgical Personnel to Patients' Blood during Surgery at San Francisco General Hospital. *New England Journal of Medicine* 1990;322:1788-1793.

disclosure is voluntary, and inmates will wait until they feel "ready" to self-disclose. On the other side, were disclosure to staff to become an automatic byproduct of a positive HIV test result, many inmates who now volunteer to be tested (and eventually self-disclose their test result) would likely not choose to be tested in the first place. As the Krever Commission stated:

[T]he primary concern of physicians, hospitals, their employees and other health-care providers must be the care of their patients. It is not an unreasonable assumption to make that persons in need of health care might, in some circumstances, be deterred from seeking it if they believed that physicians, hospital employees and other health-care providers were obliged to disclose confidential health information to the police in those circumstances.⁶¹

Similarly, it would not be an unreasonable assumption that inmates would be deterred from seeking testing were health-care staff obliged to disclose positive test results to other staff. In the end, staff would very likely know of fewer HIV-positive inmates than under the present policy.

As Casswell has said, the protection of staff may be

better achieved through education on the need for self protection [i.e. applying universal precautions] and personal responsibility than through warnings. Warnings are not necessarily effective since they may be untimely, miss partners [infected inmates] or be based on false test results.⁶²

Similarly, a study on HIV/AIDS in Australian prisons concluded:

While the desire of the custodial officers to know the identity of seropositive prisoners may be understandable, it can be argued that the knowledge may in fact be dangerous to the prison officers as well as detrimental to the prisoner. Custodial officers may be lulled into a false sense of security with regard to prisoners believed to be HIV negative. Because of the unreliability of the test (the "window" period) and the possibility of recent infection there is a risk that such prisoners may be seropositive. Universal blood and body fluid precautions provide a much higher degree of protection for custodial staff.⁶³

(2) Violence

Universal precautions will eliminate the risk of HIV transmission from blood splashes, but prevention of exposure-producing injuries is necessary to reduce or eliminate the much greater risk of HIV transmission in situations where injuries can occur. This applies to the health

⁶¹ Report of the Commission of Inquiry into the Confidentiality of Health Information [Krever Commission]. Queen's Printer for Ontario, 1980;2: at 91.

⁶² Casswell, *supra*, note 4 at 248.

⁶³ Heilpern H., Egger, S. AIDS in Australian Prisons - Issues and Policy Options. Canberra: Department of Community Services and Health, 1989 at 21.

care workplace as well as to prisons. Reducing the incidence of injuries will reduce the incidence of HIV exposure. In the prison environment this means preventing accidents such as needlestick injuries during cell searches and preventing violence that leads to injuries and exposure to blood. This would include: meticulous attention to safety practices ("safer" search practices); the use of "puncture-resistant" gloves when necessary; and controlling aggressive inmates, in particular avoiding or reducing physical contact with them when they behave violently.

With regard to controlling aggressive inmates, it is sometimes claimed that there are situations "where available precautions would not be sufficient to counter the risk".⁶⁴ One example is that of "incidents involving a violent inmate who is bleeding and must be controlled by a member of our [CSC] staff".⁶⁵ In most, if not all, of these situations, preventing physical contact between staff and a violent inmate will protect staff by eliminating injuries to them. Eliminating injuries to staff and practising universal precautions appropriately will correspondingly eliminate the risk of HIV transmission through exposure to the inmate's blood.

A working group at the CSC workshop on HIV/AIDS held in the fall of 1992 in the Ontario Region stated that "not enough emphasis has been placed on preventing needlestick injuries and other exposures to blood and body fluids in the correctional environment."⁶⁶ The working group concluded that preventing exposure has to be the first priority. While staff cannot always avoid exposure and will sometimes be unable to use precautions, such as when they are assaulted by inmates, there are many situations "where it is known in advance that the inmate will be uncooperative."⁶⁷ In such situations "the first approach would be to use something to try to subdue the aggressiveness of the inmate, thereby reducing the risk of physical confrontation with the officer."⁶⁸

Again, and for the same reasons as discussed above, any measures or procedures available to prevent or reduce exposure to HIV have to be (or should be) applied regardless of whether the inmate whose cell is being searched, or who is being aggressive, is known or not known to be HIV-infected.

(3) Consensual Activities

It has been claimed that "available precautions" may not be sufficient to counter the risk of HIV transmission through sexual or skin penetrating behaviour among offenders. CSC has undertaken efforts to educate inmates about HIV transmission by emphasizing that every inmate, when engaging in these activities, needs to behave as if his or her partner(s) was HIV-infected.

⁶⁴ Memorandum from M.H. Zazulak: note 3 *supra*, at p.4.

⁶⁵ *Ibid.*

⁶⁶ CSC Ontario Region. Seminar on HIV in the Workplace: Knowledge is the Key to Prevention. Summary of small group seminars, at 3.

⁶⁷ Draft of the Sub-Committee's Report on Protective Clothing and Equipment for Staff to Guard against the Contraction of Infectious Diseases. Prepared by Joan Gibson, A/Director, Material and Administrative Services, 3 December 1992 at 5.

⁶⁸ *Ibid.*

CSC has further acted to minimize sexual transmission of HIV by making condoms and dental dams available to inmates. In contrast, at this time, materials to cleanse injection equipment, such as bleach, are often unavailable or difficult to obtain. The most effective and least harmful means to minimize transmission of HIV through sharing of HIV-contaminated needles would be to increase efforts to reduce the harms from drug use by providing more treatment, increased education, and access to clean injection equipment or materials with which to clean this equipment.

In general, legally proscriptive, coercive or repressive approaches have been ineffective in preventing HIV-transmission and have often been counter-productive. In contrast, interventions which promote autonomy, decrease vulnerability and reduce ignorance, fear and prejudice make responsible behaviour possible.⁶⁹ Respecting confidentiality, protecting inmates from abuse, educating them about HIV infection and effective ways to avoid contracting it, ensuring easy access to condoms and to the means to clean injection equipment (or access to clean injection equipment itself) can eliminate or reduce substantially the risk of HIV transmission from one inmate to another, or to staff. In contrast, disclosing the identities of infected inmates to fellow inmates would undermine the messages of safer sex and safer needle use, namely that precautions have to be applied universally. Knowing who is infected is unnecessary when precautions are taken appropriately.

However, in situations in which a person does not know that her/his sexual or drug using partner is HIV-infected, and has no reason to suspect this, it may be necessary to inform that person about the risk of HIV transmission. Such situations arise, for example, when the person is in a long-term or monogamous relationship with a partner who refuses to disclose that she or he is infected, and they engage in activities which are likely to transmit HIV. This situation is analogous to that of partner notification outside prisons.

(4) Nonconsensual Sexual Activity

"Rape" or nonconsensual sexual intercourse represents another risk of HIV transmission in prisons. Available precautions against sexual transmission of HIV are unlikely to be used in such situations, and will therefore not protect the victim. At the same time, however, knowing that the aggressor is HIV-infected will also not protect the victim from sexual assault and the ensuing risk of HIV-transmission. Approaches are necessary which can prevent or reduce sexual assault from occurring in the first place. Only where an inmate has already committed or threatened to commit sexual assault and is known to be HIV-infected, disclosure to some staff that he has an infectious disease, but not that he is HIV-infected, in order to allow them to more closely surveil him may be justified.

(5) Intent to harm or to transmit HIV

An inmate may express to another inmate or to staff an intent to harm someone, or to "infect someone with HIV." In such situations, intervening to prevent the harm does not necessitate knowing whether or not the inmate is HIV-infected. Intervention that can prevent the intended harm will also prevent HIV exposure, regardless of whether the inmate is or is not infected. In every case where an inmate expresses an intent to harm someone or to infect

⁶⁹ Gilmore N, Jürgens R: Human rights and HIV/AIDS: strategies for action. *AIDS action* June 1992 17: 2-4; Hamblin J: The role of the law in HIV/AIDS policy. *AIDS* 1991; 5 (suppl 1): S239-S243.

someone with HIV, attempts should be made to prevent him or her from carrying out the threat, regardless of whether he or she is known to be HIV-infected. However, in individual cases, informing staff that the inmate suffers from an infectious disease and has threatened to transmit it may be justifiable because particular caution in everyday contact with the inmate may be necessary. This does not require disclosing that the inmate is HIV-infected. This approach would be consistent with the practice of the Canadian Police Information Centre (CPIC), which now forbids identification of HIV-infected persons unless they have expressly threatened to transmit this condition using physical violence.

3. Disclosure after Exposure

Exposure to HIV almost always elicits intense fear and distress, and it is often claimed that the person who was potentially exposed has a right to know the HIV status of the person who is the source of the exposure.

Again, it needs to be established whether disclosure is necessary. In general, the person who has been potentially exposed to HIV needs to act as if the source of the exposure is HIV-infected unless it is certain that the source is not infected. Such certainty is difficult to obtain.

- Disclosure of the HIV-status only provides uncertain information of limited usefulness. It may accurately confirm that the person who potentially exposed someone was infected at the time of the potential exposure, but it cannot indicate with any certainty that the person was free of infection at that time. In some cases the test result would be negative even though the person is infected and infectious (i.e., in the "window period" before antibodies to HIV are detectable). In these cases the person who was potentially exposed would be falsely reassured that exposure has not occurred.

- Disclosure will not provide the person who was potentially exposed with certainty that he or she has not been exposed to HIV. Consequently, the person should not engage in unprotected sexual activity that could transmit HIV following the potential exposure, regardless of whether the person who potentially exposed him or her has tested negative or positive.

- That the person who was potentially exposed needs this information to be able to decide about whether he or she should begin zidovudine treatment (post-exposure prophylaxis) is also questionable. If any benefits are to be obtained from zidovudine treatment, which is at best unproven,⁷⁰ it has to be begun as soon after the potential exposure as possible, and not delayed until disclosure.

⁷⁰ Weiss SH: HIV infection and the Health Care Worker. *Med Clin N Am* 1992; 76: 269-280; U.S. Department of Health and Human Services Public Health Service: Public Health Service statement on management of occupational exposure to human immunodeficiency virus, including considerations regarding zidovudine postexposure use. *Morb Mortal Weekly Rep* 1990; 39 (RR-1): 1-14; Lange JMA, Boucher CAB, Hollak CEM, et al: Failure of zidovudine prophylaxis after accidental exposure to HIV-1. *N Engl J Med* 1990; 322: 1375-1377; Anonymous: HIV seroconversion after occupational exposure despite early prophylactic zidovudine therapy. *Lancet* 1993; 341: 1077-1078; Editorial: Why anonymous. *Lancet* 1993; 341: 1059-1060.

In view of the uncertainty of the information provided, and considering that the only effective and reliable measures available to the person who was potentially exposed are education, counselling, support, and possibly zidovudine treatment, it is unlikely that disclosure of the HIV-status of persons who potentially exposed others to HIV would be necessary.

An example of a situation in which disclosure may exceptionally be justified would be the case in which the person who was potentially exposed is pregnant and may need all information that is potentially useful to her in making a decision about whether or not to terminate pregnancy.⁷¹

4. Conclusion

From the foregoing, it should be clear that in most situations disclosure of offender medical information is unlikely to accomplish the objectives for which disclosure is sought and may even be counterproductive. The reasons for this, as discussed above, are:

- the information would seldom, if ever, provide useful protective information;
- for their own interest, staff need to apply precautions universally and assume that everyone in the institution is or may be infectious;
- there are less invasive measures available that would be as effective or more effective than disclosure.

In addition, in correctional institutions disclosure has little, if any potential benefits and benefits, while risks and harms from such disclosure are substantial. Many of these are well documented in medical, scientific and popular literature.⁷² In correctional institutions risks and harms from disclosure may be increased for many reasons:

- First, the restricted mobility of prisoners can augment the risks and harms which may result from being known to be HIV infected.⁷³

⁷¹ Whenever this information is sought, the person who potentially exposed the pregnant woman should be asked to consent to the disclosure of his or her HIV-status. If this person does not know whether or not she/he is infected, the person should be asked to consent to being tested and to consent to the disclosure of the test result to the exposed person. In the event that the person whose blood has been involved in the exposure refuses to disclose the relevant information or to undergo testing and to disclose the test result, the only recourse for the exposed person would be to seek a court decision requiring this information to be obtained and disclosed.

⁷² Chateauvert M, Duffie A, Gilmore N: *Human Immunodeficiency Virus Antibody Testing: Counselling Guidelines from The Canadian Medical Association*. Ottawa, Canadian Medical Association, 1990, at 1-12.

⁷³ Gilmore and Somerville, *supra*, note 21.

- Second, in a closed community knowledge that someone is HIV-infected may spread widely, making it difficult to protect oneself against stigmatization, isolation, blaming or scapegoating.

- Third, some of the benefits or services which are readily available or discretely accessible to HIV-infected persons outside prisons may not be available or less accessible for inmates. These benefits may include peer counselling and support, special diets, and experimental treatments.⁷⁴

Disclosure of personal medical information may erode the confidence of inmates in prison health services, increase distrust of prison authorities, and deter inmates from seeking out education, counselling or health care opportunities. Importantly, fewer inmates will come forward for HIV testing or volunteer the information that they are infected. On the other hand, disclosure may sometimes benefit individuals who have been exposed to HIV unknowingly (e.g. partner notification), promote safer sex and drug using behaviour and lessen risk-producing behaviour, as well as ensure that individuals receive care and treatment which they might not, otherwise, have obtained.⁷⁵

IV. Specific Concerns relating to the Disclosure of Personal Medical Information

There are specific concerns which arise in prisons, relating to the disclosure of personal medical information. Some of these issues have been discussed above but will be summarized briefly in the sections that follow.

1. Disclosure of an inmate's medical information to staff

In general, a claim that staff "need to know" confidential medical information of inmates is not justified, and medical information relating to inmates, absent their consent, cannot be disclosed to staff. There may be exceptions to this rule when, in individual cases, and after an individual assessment of the case, it is shown that such disclosure is necessary to prevent serious harm, and there are no less invasive and restrictive means available to achieve the same goal.

The universal application of protective procedures and practices will eliminate a "need to know" in most situations in which exposure to HIV may occur. Other such situations can be avoided by efforts to prevent exposures to blood and body fluids. More importantly, disclosure would sometimes falsely reassure staff while not being effective in protecting them. The risks and harms of such disclosure would appear to outweigh whatever marginal benefits might be gained by the disclosure.

⁷⁴ Tomaševski K: AIDS in Prisons. *AIDS* 1991; 5 (suppl 1): S245-S251.

⁷⁵ Gilmore N: Human immunodeficiency virus infection and AIDS: concepts and constructs. In *AIDS Impact Assessment Modelling and Scenario Analysis*. JC Jager, EJ Ruitenberg (eds). Amsterdam, Elsevier, 1992, at 161-188.

2. Disclosure of an inmate's medical information to the warden

Disclosure of medical information to the warden or administrative staff of prisons is not, in general, justified. In order for wardens to carry out their responsibilities under the *Corrections and Conditional Release Act*, they do not need to know the HIV status of individual inmates. Rather, they need to carry out their duties as if there were HIV-infected inmates among their inmate population. However, there may be exceptional situations when disclosure to the warden of an inmate's medical information may be justified or even required. One example would be when medical staff know that a particular inmate intends to harm someone in a manner which could expose that person to HIV, and this person needs to be warned or protective action taken. In this situation, informing the warden of the intended harm or risk-producing activity may be necessary. Informing the warden that the inmate suffers from a transmissible disease would suffice for this purpose.

3. Disclosure of an inmate's medical information to case management officer/parole officer

There would appear to be few, if any, situations in which disclosure to case management or parole officers of offender medical information would be justified, absent the offender's consent.

4. Disclosure of an inmate's medical information to community authorities

There would appear to be few, if any, situations in which disclosure to community authorities of offender medical information would be justified, absent the offender's consent.

5. Disclosure of an inmate's medical information to fellow-inmates

In general, a claim that inmates "need to know" confidential medical information about other inmates would not be justified. Such disclosure, absent the inmate's consent, would have to be necessary, effective and the least invasive and restrictive means available to achieve its aim. There may be, from time to time, individual situations in which disclosure may be justified, such as partner notification. Again, justification would be on a case by case basis, as it would be with any other case of disclosure.

6. Disclosure of an inmate's medical information to family visiting partners

When prison health staff are aware that an inmate is HIV-infected, they have to ensure that this inmate will not expose her/his unsuspecting family visiting partner to HIV. In this partner notification situation, the medical staff should follow the contact tracing approach recommended by the National Advisory Committee on AIDS.⁷⁶ The inmate should be asked to inform her/his partner or alternatively to consent to someone else doing this for him or her. However, if the inmate refuses to do so, medical staff should inform partners before the visit occurs or the visit should be postponed until the partner is informed. Medical staff should meet with known infected inmate and her/his partner(s) to discuss how sexual exposure to HIV may be avoided, and to assist them to resolve any concerns they may have about this. This would apply to inmates permitted temporary absences. When it is not feasible for the partner to visit with medical staff, follow-up may be arranged through the partner's primary care physician. All

⁷⁶ Gilmore and Somerville, *supra*, note 21 at 16-19.

inmates, whether or not they are known to be HIV-infected, should be encouraged and enabled to discuss sexual exposure to HIV with their partners.

When a family visit is postponed or cancelled, the reason for this should not be disclosed to staff or to fellow inmates.

7. Disclosure of a staffperson's medical information to inmates

This situation is similar to the one described above (Disclosure of medical information regarding inmates to staff). Only rarely, and in individual cases, might a claim for disclosure of information be justified.

8. Disclosure of a staffperson's medical information to fellow staff

This situation is, again, similar to the one described above (Disclosure of medical information regarding inmates to staff). Only rarely, and in individual cases, might a claim for disclosure of information be justified.

9. Disclosure of medical information to a staffperson or an inmate who has suffered a significant exposure to the blood of an inmate or a staffperson

This situation has been discussed in detail above (Disclosure Following Potential Exposure to HIV). Only rarely, and in individual cases, might disclosure of medical information, absent the consent of the person whose blood is the source of the exposure, be justified. In a situation in which an exposure has occurred that is likely to transmit HIV, education, counselling and medical care should be readily accessible to the exposed person, regardless of whether a staff member or an inmate has been injured. It has been said that, without disclosing medical information to an inmate who was injured by a fellow inmate, "efforts to treat the affected inmate could well be impossible."⁷⁷ However, on the contrary, treatment options should be considered regardless of whether the source of the exposure is or is not known to be HIV-infected.

10. Testing of Convicted Sex Offenders

In a recent case, a man died from AIDS-related diseases eleven weeks after he was convicted of sexually assaulting a five-year-old boy. Montreal coroner Claude Paquin who performed an autopsy on the deceased issued a report recommending that CSC and the Quebec Department of Public Security study the possibility of compulsory HIV testing of convicted sex offenders.⁷⁸ The two objectives of such testing, he proposed, would be to prevent the spread of HIV infection within the prison system and to generate information in order to inform victims of sexual aggression about whether or not they may have been exposed to HIV. He stated:

⁷⁷ Memorandum from M.H. Zazulak: note 3 *supra*, at 5.

⁷⁸ Gouvernement du Québec, Bureau du coroner. Rapport d'investigation, Claude Paquin, Coroner investigateur, Montréal le 24 novembre 1992.

"Ceci afin de prendre les mesures appropriées afin que la maladie ne se propage pas dans les centres de détention. De plus cette démarche permettrait aux victimes d'agression sexuelle de savoir si elles ont pu contacter la maladie."⁷⁹

Regarding compulsory testing of sex offenders, the National Advisory Committee on AIDS adopted the following resolution:

The National Advisory Committee on AIDS strongly recommends voluntary testing of persons *accused* [charged with an offence] of sexual assault likely to transmit HIV infection and that such results must be treated as confidential, except for their limited disclosure to the victim of the crime.

The National Advisory Committee on AIDS strongly recommends voluntary testing of persons convicted of sexual assault likely to transmit HIV infection and that such results must be treated as confidential, except for their limited disclosure to the victim of the crime.⁸⁰

Compulsory testing of persons convicted of sexual assault would not appear to be justified as necessary for or effective in accomplishing any of the objectives mentioned in the Coroner's report.

- Testing for the purposes of protecting the victim and third parties or for the purpose of reassuring the victim will in most cases not be necessary, since it generally takes eight to twelve months until conviction. After conviction, testing of the sexual offender is unnecessary for any of these purposes. The victim can be tested herself and obtain reliable information on whether she has contracted HIV, whereas testing the offender would not be able to provide this information.

- Testing for the purpose of preventing transmission of HIV in correctional institutions is also not necessary. It would not be effective in achieving this goal. In addition, there are less intrusive measures to achieve this goal. There is also the risk that testing offenders and identifying those who are infected, would increase their vulnerability in

⁷⁹ Ibid. at 3. In another case, the even more difficult question of whether individuals charged with sexual assault should be compulsorily tested for antibodies to HIV has been raised: Margot B. accused a man who was out of prison on a day pass to work on a community project of raping her in the Dunham presbytery. In deciding on the request that the accused be tested for HIV antibodies, Roberge J. held that a man charged with rape cannot be forced to undergo an HIV antibody test. Margot B. has since started a national campaign to require compulsory HIV antibody testing of persons charged with sexual assault. For a more detailed discussion, see R Jürgens, N Gilmore, MA Somerville. Are compulsory HIV testing and disclosure of HIV status ever justifiable? Ethical and legal analysis using sex offenders, health care providers, patients as examples. Poster presentation at the *Third Annual Canadian Conference on HIV/AIDS Research*, Montreal, 13-15 May 1993 (*The Canadian Journal of Infectious Diseases* 1993; 4 (Suppl B): 48 B (SP-403)).

⁸⁰ Somerville and Gilmore, *supra*, note 21 at XXII.

prison. Compulsory testing of this population of inmates would be discriminatory and stigmatize them as a potential source and threat of infection in prisons.

- Testing for the purpose of collecting information on the HIV status of sexual offenders to be disclosed to potential new victims would also not be justified. First, knowing that the offender tested negative provides no information about his HIV status at the time of a new sexual assault, because of the "window period" and time elapsed between testing and the new offence. Second, knowing the offender tested positive has no advantage for the victim since she should, for her own benefit and that of third parties, act as if she had been exposed to HIV regardless of this knowledge.

- In addition, benefits from such testing are very limited and questionable, while harms from such testing include breach of a person's rights to inviolability, self-determination, autonomy, privacy and confidentiality, and the risk of discriminatory and other harmful treatment.

C. Conclusion

In federal correctional institutions, the disclosure of personal medical information absent consent of the person is seldom justifiable. In most situations, such disclosure cannot be considered to be necessary and its efficacy is questionable. Often disclosure would appear to be counterproductive or harmful in excess of any benefits or potential benefits which might result from it. Measures which can be undertaken to prevent exposure to and infection with HIV have to be undertaken regardless of whether an inmate or staff member is or is not known, to staff, wardens, or inmates, to be infected with HIV. To educate staff and inmates about precautions which can prevent HIV transmission, and to make available to them the means necessary to prevent it, is essential if transmission of HIV infection is to be prevented in correctional institutions. Only in rare, exceptional cases will disclosure be justified, when an individual assessment shows that disclosure is necessary, likely to be effective and the least invasive and restrictive means available to prevent harms which cannot otherwise be prevented. In all other situations in which claims for disclosure may arise, other means are often already available, would be less harmful than disclosure, are likely to be necessary and more effective.

APPENDIX 2

ECAP-QUESTIONNAIRE

Education on HIV/AIDS

1. Is information about HIV/AIDS (for example, pamphlets or brochures) routinely provided to inmates in your institution?

☐ yes
☐ no

If no, should it be given to each prisoner?

☐ yes
☐ no

2. Are educational programs about HIV/AIDS (for example, lectures, video presentations) available to inmates in your institution?

☐ yes
☐ no

If no, should such programs be made available?

☐ yes
☐ no

Should attendance in such programs be

- voluntary ☐
 - mandatory ☐

Who should provide such education?

- correctional workers ☐
 - prison medical staff ☐
 - fellow inmates ☐
 - outside health or community organizations ☐

Is more information or education needed for any of the following?

- "everything" (general update about HIV/AIDS) ☐
 - transmission and prevention ☐
 - symptoms ☐
 - treatment/cure ☐
 - safe needle/drug use ☐
 - HIV testing ☐
 - how to communicate with HIV infected people ☐
 - women and HIV/AIDS ☐
 - what resources/services are available for HIV infected people ☐

Education on Drugs

1. Is information about drug use (for example, pamphlets or brochures) routinely provided to inmates in your institution?

- ☐ yes
☐ no

If no, should it be given to each prisoner?

- ☐ yes
☐ no

2. Are educational programs about drug use (for example, lectures, video presentations) available to inmates in your institution?

- ☐ yes
☐ no

If no, should such programs be made available?

- ☐ yes
☐ no

Should attendance in such programs be

- voluntary ☐
- mandatory ☐

Who should provide such education?

- correctional workers ☐
- prison medical staff ☐
- fellow inmates ☐
- outside health or community organizations ☐

Condom Availability

1. How are condoms made available in your institution?

2. Should condoms also be made available by other mechanisms or channels?

☐ yes
☐ no

If yes, tell us how. Please be specific (for example, condom dispensers, condoms sold in canteen, containers of condoms in shower facilities, etc.).

3. Should condoms be given in a "condom kit" to every prisoner at entry into prison?

☐ yes
☐ no

4. Should condoms be made available to every prisoner leaving the prison in so-called "prison exit kits"?

☐ yes
☐ no

Needle Cleaning/Needle Exchange Programs

1. Should prisoners be instructed how to properly clean injection equipment (needles and syringes; tatoo needles, etc.)?

☐ yes
☐ no

2. Should bleach be made available to prisoners?

☐ yes
☐ no

If no, why?

3. Should a needle exchange program, where prisoners could trade in a used needle against a new, clean needle, be available to prisoners?

- ☐ yes
- ☐ no

If yes, how should it be set up? Please be specific (for example, who should run it, where should it be located, etc.)

If no, why? Please indicate the reasons why you oppose a needle exchange program in prison?

Testing and Confidentiality

1. Is there concern in your institution that prisoners will not seek testing because they fear their test results will not remain confidential?

- ☐ yes
- ☐ no

Should prisoners have access to testing by someone not connected with the prison system (for example, an outside doctor or agency)?

- ☐ yes
- ☐ not necessary

Should anonymous testing be available, that is testing that is done so that **only** the prisoner can know the result (but no one doing the testing or in the prison system)?

- ☐ yes
- ☐ not necessary

Are there other ways in which concerns about confidentiality of test results might be reduced or eliminated? Please specify.

Self-Help Groups

Are there self-help groups of people with HIV infection or who have AIDS in your institution?

- ☐ yes
- ☐ no

If **yes**, how are they set up? Please describe their activities.

If **no**, should self-help groups be set up?

- ☐ yes
- ☐ no

Other Issues

Are there other issues relating to HIV/AIDS and/or drug use in prisons that are of concern?

- ☐ yes
- ☐ none, at this time

If **yes**, what are they, and how might they be addressed? Please continue on next page.

APPENDIX 3**ECAP QUESTIONNAIRE (STAFF)****Education on HIV/AIDS**

1. Is information about **HIV/AIDS** (for example, pamphlets or brochures) given to staff in your institution?

- ☐ yes
☐ no

If no, should it be given to each staff member?

- ☐ yes
☐ no

Please specify the reasons for your answer.

2. Are educational programs about HIV/AIDS (for example, lectures, video presentations) available to staff in your institution?

- ☐ yes
☐ no

If no, should such programs be made available?

- ☐ yes
☐ no

Please specify the reasons for your answer.

Should attendance in such programs be

- voluntary ☐
 - mandatory ☐

Please specify the reasons for your answer.

Who should provide this education?

- CSC or Health and Welfare Canada personnel ☐
 - outside health or community organizations or individuals ☐

Please specify the reasons for your answer.

Is more information or education needed for any of the following?

- "everything" (general update about HIV/AIDS) ☐
- transmission and prevention ☐
- universal precautions (infection control procedures and practices) ☐
- counselling and employee assistance programmes ☐
- symptoms ☐
- treatment/cure ☐
- safe needle/drug use ☐
- HIV testing ☐
- how to communicate with HIV infected inmates ☐
- women and HIV/AIDS ☐
- what resources/services are available for HIV infected people ☐

Education on Drugs

1. Is information about **drug use** (for example, pamphlets or brochures) given to staff in your institution?

- ☐ yes
- ☐ no

If **no**, should it be given to each staff member?

- ☐ yes
- ☐ no

Please specify the reasons for your answer.

2. Are educational programs about drug use (for example, lectures, video presentations) available to staff in your institution?

- ☐ yes
- ☐ no

If **no**, should such programs be made available?

- ☐ yes
- ☐ no

Please specify the reasons for your answer.

Should attendance in such programs be

- voluntary ☐
- mandatory ☐

Please specify the reasons for your answer.

Who should provide such education?

- CSC or Health and Welfare Canada personnel ☐
- outside health or community organizations or individuals ☐

Please specify the reasons for your answer.

Protective Measures for Staff

1. Do you think that the protective measures available to staff (e.g., universal precautions, rubber gloves, etc.) are sufficient to protect you from contracting HIV infection on the workplace?

- ☐ yes
- ☐ no

If no, what additional measures would you suggest should be adopted? Please specify.

"Need to Know"

1. To your knowledge, are there any prisoners with HIV infection or AIDS in your institution?

- ☐ yes
- ☐ no

If yes, how many?

2. To your knowledge, are there any staff with HIV infection or AIDS in your institution?

- ☐ yes
- ☐ no

If yes, how many?

3. Do you think that staff "need to know" prisoners' HIV status?

- ☐ yes
- ☐ no

Please specify the reasons for your answer. If yes, please also indicate whether all staff or only certain categories of staff "need to know", and which categories "need to know".

4. Do you feel that staff "need to know" fellow staff's HIV status?

- ☐ yes
- ☐ no

Please specify the reasons for your answer.

3. Do you feel that prisoners "need to know" staff's HIV status?

- ☐ yes
- ☐ no

Please specify the reasons for your answer.

4. Are there other ways, apart from being given information about prisoners' and staff's HIV status, in which concerns about potential infection at the workplace might be reduced or eliminated? Please specify.

Condom Availability

1. Has availability of condoms created any problems in your institution?

- ☐ yes
- ☐ no

If yes, please specify what problems.

2. How are condoms made available to inmates in your institution?

3. Are there other ways which should be used to make condoms available?

- ☐ yes
- ☐ no

If yes, tell us how. Please be specific (for example, condom dispensers, condoms sold in canteen, containers of condoms in shower facilities, etc.).

3. Should condoms be given to every prisoner at entry into prison (e.g., in first-aid or health promotion kits)?

- ☐ yes
- ☐ no

4. Should condoms be made available to every prisoner leaving the prison in so-called "prison exit kits"?

- ☐ yes
- ☐ no

Needle Cleaning/Needle Exchange Programs

1. Should prisoners be instructed how to properly clean injection equipment (needles and syringes; tattoo needles, etc.)?

- ☐ yes
- ☐ no

Please specify the reasons for your answer.

2. Should clean tattooing equipment be made available to prisoners on an official basis to reduce the risks of infection?

- ☐ yes
☐ no

Please specify the reasons for your answer.

2. Should bleach be made available to prisoners?

- ☐ yes
☐ no

If yes, how should it be made available? Please be specific (for example, in small bottles to reduce potential security risks, etc.)

If no, why?

3. Should a needle exchange program be available to prisoners, that is a program by which prisoners could trade in a used needle for a new, clean needle, ?

- ☐ yes
☐ no

If yes, how should it be set up? Please be specific (for example, who should run it, where should it be located, etc.)

If no, please indicate the reasons why you oppose a needle exchange program in prison?

Self-Help Groups

Are there self-help groups of prisoners with HIV infection or who have AIDS in your institution?

- ☐ yes
- ☐ no

If no, should self-help groups be set up?

- ☐ yes
- ☐ no

Please specify the reasons for your answer.

Health Services

In your opinion, are there any problems with prisoners' access to health services for HIV/AIDS and/or drug use?

- ☐ yes
- ☐ no

Please specify the reasons for your answer.

Other Issues

Are there any additional issues relating to HIV/AIDS and/or drug use in prisons, and in particular, to safety of prison staff, that are of concern?

- ☐ yes
- ☐ none, at this time

If yes, what are they, and how might they be addressed?

(please continue on next page)

On this page, you are asked to provide us with some personal information. The provision of this information is voluntary. Any information you provide will be confidential, and this page will be detached from the questionnaire to make identification of the respondents impossible.

Please provide us with the following data:

1. Sex:
2. Current occupation:
3. Years of service within CSC or provincial prison systems:
4. Security level of institution you are currently working at:

Thank you very much for filling out the questionnaire and this page

APPENDIX 4

THE FOURTH INTERNATIONAL CONFERENCE
ON THE REDUCTION OF DRUG RELATED HARM
ROTTERDAM THE NETHERLANDS 14-18 MARCH 1993

CALL FOR PAPERS [OFFICIAL ABSTRACT FORM]

Author(s) (please underline the full name of the presenting author):

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Title of abstract

Reducing the Harms from Drug Use and from HIV/AIDS in Prisons

Objective: To identify and analyze issues raised by drug use and by HIV infection and AIDS within correctional facilities.

Method: In order to identify relevant issues and potential solutions to problems they pose, data has been collected by postal enquiries, interviews with selected prisoners, staff, and prison authorities, and by review of published reports and policies. The data included information on: (1) education of prisoners and staff about drug use and about HIV/AIDS; (2) confidentiality of medical information; (3) housing of prisoners with HIV infection or who have AIDS; (4) provision of health care; (5) availability of condoms; of needles and syringes and/or materials for cleaning needles and syringes; of HIV antibody testing and counselling; and of treatment of drug use; (6) occupational health and safety of prison staff.

Results: Analysis of data, by these categories, suggests common concerns and the need for approaches which can promote the health of prisoners, protect staff, and prevent transmission of HIV and other infectious agents within prisons. In addition, the data point to the need for approaches which also can effectively reduce the harms from drug use among prisoners. In particular, there is great concern about sexual activity and access to clean injecting equipment within prisons. There is also diversity in what approaches can meet these needs. This emphasizes the need for education, communication, and political and institutional commitment if effective approaches are to be implemented. Among approaches which have been implemented, such as condom availability in Canadian prisons, evaluation of their efficacy and acceptability are, at this time, incomplete or lacking.

Conclusion: Analysis of issues raised by HIV/AIDS and drug use in correctional facilities suggests no single approach is likely to meet all of the perceived needs. Nevertheless, developing and implementing different approaches, in particular harm reduction approaches, are urgently needed.