Service correctionnel Canada
Correctional Service Canada

HIV/AIDS IN PRISONS:

Background Materials

Canada

HIV/AIDS
IN PRISONS:

Background Materials

February 1994

Statements or conclusions in this Report do not necessarily reflect the views or the policies of the Correctional Services of Canada.

Produced by the McGill Centre for Medicine, Ethics and Law
for the Correctional Service of Canada

Published by the Correctional Service of Canada
under the authority of the Solicitor General of Canada

For additional copies or further information about
this publication, please contact:

Health Care Services Branch
The Correctional Service of Canada
340 Laurier Avenue West
Ottawa, Ontario
K1A 0P9
Telephone: (613) 995-5058
Facsimile: (613) 995-6277

Catalogue No. JS82-68/3-1994E
ISBN 0-662-21084-0
February 1994

Ce document est également disponible en français.

As an example of our commitment to contribute
to a healthy environment, this publication
is printed on recycled paper.

SPECIAL ACKNOWLEDGMENT

The Expert Committee on AIDS and Prisons wishes to acknowledge and thank Dr. Ralf Jürgens, Project Coordinator of the Committee, for his invaluable assistance to the Committee, including the preparation of its *Working Paper* and this *Final Report*.

EXPERT COMMITTEE ON AIDS AND PRISONS

Members

Prof. Norbert Gilmore
McGill Centre for Medicine, Ethics and Law
McGill AIDS Centre
Department of Medicine, McGill University
Division of Clinical Immunology, Royal Victoria Hospital
Montreal, Quebec, Canada
(Chair)

Dr. Christiane Richard
Physician, CLSC Ahuntsic, Montreal
Member, Health Care Advisory Committee, Correctional Service Canada

Prof. Lee Seto Thomas
Justice Consulate, Native Council of Canada
School of Social Work, Carleton University, Ottawa

Mr. Donald Yeomans
Former Commissioner, Correctional Service Canada

Project Coordinator

Dr. Ralf Jürgens
McGill Centre for Medicine, Ethics and Law
McGill University

Observers

Mr. Robert Adlard
Correctional Service Canada
(until May 1993)

Mr. Wayne Stryde
Correctional Service Canada

Ms Margaret Gillis
Health Canada

SECRETARIAT

Expert Committee on AIDS and Prisons
McGill Centre for Medicine, Ethics and Law
3690 Peel Street
Montreal, Quebec H3A 1W9

Tel: 514-398-6980 Fax: 514-398-4668

ACKNOWLEDGMENTS

The Expert Committee on AIDS and Prisons wishes to thank many people for their contributions to the *Background Materials*.

In particular, the Committee wishes to acknowledge the contributions of the many staff of the Correctional Service of Canada and of the inmate committees and individual inmates who responded to the questionnaire ECAP sent them to obtain information regarding their opinions and concerns about many of the issues raised by HIV infection and AIDS in the correctional environment.

ECAP also wishes to thank the many people and the governmental and nongovernmental organizations who responded to its solicitations and enquiries or to ECAP's *Working Paper*. Their input has been invaluable in the compiling of some of the appendices in the *Background Materials*.

The Committee would like to thank the people who made presentations at the sessions on HIV/AIDS in Prisons at the 6th and 7th Annual British Columbia AIDS Conferences and who gave permission to include slightly edited versions of their presentations in the *Background Materials*. Unfortunately, not all presentations could be included and the choice among many excellent presentations was not an easy one. Importantly, we decided to include both presentations given by Michael Linhart, a prisoner with HIV infection who provides us with a personal account of what it is like to live with HIV infection in prison. Mr. Linhart has provided the Committee with his input throughout its existence and deserves special thanks.

Finally, we wish to thank the following persons for their assistance in the preparation of the *Background Materials*: Garry Bowers for his help in editing the *Background Materials*; Glenn Betteridge for assisting in the review of Canadian and international prison policies; David Patterson for assisting in the preparation of Appendix 4; Patricia DiMeco for data input and Maria Hooey for consulting on the statistical analysis of the data of the staff and inmate committee questionnaires and for assisting in the writing of Appendices 5 and 6 of the *Background Materials*; the translators of the text into French at the Translation Services, Health and Criminology Section, Department of the Secretary of State, Montreal; and Jean Dussault for helping with the final review of the French translation.

ECAP'S FINAL REPORT

ECAP's *Final Report* consists of three documents: *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons; HIV/AIDS in Prisons: Summary Report and Recommendations of the Expert Committee on AIDS and Prisons*; and *HIV/AIDS in Prisons: Background Materials*.

HIV/AIDS in Prisons: Final Report contains an in-depth analysis of each of the 14 major issues that ECAP considered had to be addressed. For each issue, it briefly reviews CSC policy and practice pertaining to that issue (Current Situation), what others have commented on with respect to the issue (Debate), the Committee's assessment of it (ECAP's Assessment), and ECAP's recommendations about what should be done in response (Recommendations).

The *Summary Report* summarizes the work of the Expert Committee on AIDS and Prisons and contains its recommendations.

The *Background Materials* provide the following appendices:

Appendix 1: Canadian Prison Policies Relating to HIV/AIDS

Appendix 2: International Prison Policies Relating to HIV/AIDS

Appendix 3: Policies of Selected Countries Relating to HIV/AIDS

Appendix 4: Canadian Case Law and Precedents

Appendix 5: Results of the Staff Questionnaire

Appendix 6: Results of the Inmate Questionnaire

Appendix 7: Jürgens R., Gilmore N. Disclosure of Offender Medical Information: A Legal and Ethical Analysis

Appendix 8: "HIV/AIDS in Prisons": Selected Presentations Given at the Sessions on "HIV/AIDS in Prisons" at the 6th and 7th Annual British Columbia AIDS Conferences

Appendix 9: List of Submissions to ECAP and of Responses to the *Working Paper*

TABLE OF CONTENTS

HIV/AIDS
IN PRISONS: Background Materials

APPENDIX 1

CANADIAN PRISON POLICIES RELATING TO HIV/AIDS*

The McGill Centre for Medicine, Ethics and Law has collected and reviewed Canadian prison policies on HIV/AIDS for inclusion in its loose-leaf publication, *Responding to HIV/AIDS in Canada*. Policies have been analyzed with respect to:

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

In the summer of 1992, ECAP sent letters to the provincial and territorial ministries responsible for the provision of adult and young offenders correctional services, requesting information on prison policies and asking them to make submissions to ECAP. In particular, the ministries were asked to send ECAP any policies, reports or documentation relating to HIV/AIDS, prisons and relevant aspects of illicit drug use in their province or territory. ECAP requested information on the following:

- prison policies relating to HIV/AIDS and/or communicable diseases, including draft policies;
- 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 who have AIDS;
- educational programs about HIV/AIDS for inmates and staff, including whether participation in them is mandatory or voluntary, their format, duration, and who delivers them;
- 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;
- availability of bleach, including how long it has been available, and the purposes for which it is made available;
- availability of clean needles and syringes, including whether consideration is being given to making them available and how this would be implemented;

* ECAP's Project Coordinator, Dr. Ralf Jürgens, wishes to acknowledge Mr. Glenn Betteridge's assistance in the preparation of Appendix 1.

- availability of testing for antibodies to HIV at the request of prisoners, including under what conditions testing is done;
- statistics on the number of prisoners with HIV infection or who have AIDS, including whether anonymous unlinked seroprevalence studies of persons admitted to correctional facilities have been undertaken or are planned;
- policies on conjugal visits;
- names and addresses of groups or organizations working with prisoners, in particular, prisoners with HIV infection or who have AIDS, or who have a history of drug use.

A brief review of prison policies, based on the work undertaken at the McGill Centre for Medicine, Ethics and Law and on the documents sent to ECAP by the provincial and territorial ministries in response to its request for information, was included in ECAP's *Working Paper.*

The following is a more detailed review of Canadian prison policies with regard to HIV/AIDS. For each province and territory, the review consists of a brief introductory summary of existing policies, and of an examination of nine issues relating to HIV/AIDS in prison. Its structure parallels that of the *Working Paper* and the *Final Report*, and most of the issues addressed in the *Working Paper* and the *Final Report* have been included in this review. The issues of compassionate release and aftercare of prisoners with HIV infection or AIDS, and issues of particular relevance to women inmates and Aboriginal inmates have not been included because, in general, provincial and territorial policies do not address them and ECAP did not specifically request information on them.

ALBERTA

A policy directive setting out standards and guidelines for dealing with HIV infection and AIDS in the provincial prison system was issued on 1 November 1988 by the Correctional Services Division of the Office of the Solicitor General.[1] This policy directive contains provisions relating to screening of offenders for signs of HIV infection or AIDS upon first admission to a correctional centre; housing of offenders with HIV infection or AIDS; precautionary measures for staff; training of staff about infectious-disease control measures and the role of health and safety committees in assisting in this training; and the roles of the Provincial Coordinator, AIDS Training and Information, and of centre health-care coordinators.

The policy was revised on 12 July 1991 and now contains specific provisions about the housing of offenders with HIV infection or AIDS.

Surveillance and Seroprevalence Studies

No seroprevalence studies of persons admitted to correctional facilities in Alberta have been undertaken or are being planned.

According to section 15(b) of the above-mentioned policy, the Provincial Coordinator, AIDS Training and Information, shall maintain an inventory of cases of AIDS and related syndromes in correctional centres. A report on HIV/AIDS in correctional facilities in Alberta is released twice yearly. It contains statistics about the number of HIV-positive admissions to Alberta Corrections, a profile of inmates with HIV or AIDS, diagnosis and screening test results, and an update on HIV/AIDS educational programs. In the period from August 1985 to July 1993, 76 HIV-positive offenders were reported to have been admitted to correctional centres in Alberta.

Testing for HIV Infection

The 12 July 1991 policy contains the following provisions relating to screening for HIV antibodies:

1. The Alberta Attorney General and Solicitor General departments have recently been amalgamated under the Alberta Justice Department.

2. During the course of the initial health care assessment, all offenders shall be questioned about whether they have experienced sexually transmitted diseases, are intravenous drug users or have shared intravenous needles. They shall be carefully questioned for the presence of AIDS or HIV infections ... They may additionally be asked if they have any reason to believe they may have AIDS ...

3. Offenders who are claiming to be or known to be HIV positive or who are experiencing symptoms suggestive of HIV infections shall be referred immediately to the Centre Physician. The informed consent of the offender is required for HIV testing.

According to a submission received by ECAP, "[a]ny offender who requests testing for HIV antibiotics [sic] will be tested.... Health care staff encourage testing for offenders who acknowledge that they have engaged in high risk behaviour."[2]

Offender Medical Information

The provision in the 1988 policy according to which "[s]taff directly involved in custody and service delivery to an offender confirmed to have AIDS, or to be HIV positive shall be informed of the identity and the necessary precautionary measures" has been maintained in the revised policy of 1991. Further, the policy still requires the Provincial Coordinator to report to the Director, Planning and Operations Support, the name, date of birth, CoMIS number, medical diagnosis and centre location of every offender with HIV infection or AIDS. In his submission to ECAP, the Solicitor General of Alberta stated that "[t]esting results are treated confidentially."[3] The Provincial Coordinator informed ECAP that, in practice, he does "not report CoMIS number, etc. to the Director, Planning and Operations."[4]

Housing and Activities

The 1 November 1988 policy provided that asymptomatic HIV-infected inmates "may be housed in a single cell in general population." Prisoners with AIDS or symptomatic HIV infection "shall be placed ... in isolation, where the medical condition of the offender so warrants and the Centre Physician so directs" or in a designated unit that has separate sleeping and toilet facilities; or in segregation where other placement is inappropriate for reasons of the safety of the inmate, other inmates or staff.

The revised policy of 1991 contains specific provisions about the placement of offenders with HIV infection or AIDS. Most importantly, and in contrast to the previous version, which merely stated that asymptomatic HIV-positive offenders may be housed in the general prison population, and then only in single cells, the revised policy directs that these offenders be placed in the general population. The policy states that offenders with HIV infection or AIDS shall not be employed in food-handling duties.

Educational Programs for Inmates

With regard to education of inmates on HIV/AIDS, section 1 of the policy requires that new offenders be given access to brochures about HIV/AIDS and its prevention when first admitted to a correctional centre, while awaiting their initial health-care assessment.

There is no standardized educational program on HIV/AIDS for offenders in provincial institutions in Alberta.[5] Rather, each adult and young offender centre is responsible for coordinating its educational sessions. A video presentation on HIV/AIDS is included in all offender orientation programs, and attendance is generally mandatory.

2. Submission to ECAP by Stephen C. West, Solicitor General of Alberta, dated 27 August 1992.
3. Ibid.
4. Communication of 30 November 1993 to Dr. Ralf Jürgens, ECAP Project Coordinator, from John Connor, Health Care Manager, Lethbridge Correctional Centre.
5. Submission to ECAP by John Connor, Health Care Manager/AIDS Coordinator Correctional Services Division of the Solicitor General, dated 27 August 1992.

All centres coordinate formal sessions on HIV/AIDS, involving guest speakers from outside AIDS organizations or health clinics, once or twice yearly.

Preventive Measures for Inmates

CONDOMS

Condoms have been available to all adult offenders since February 1992. They are distributed by the centre physicians and at their discretion. A policy on "Issuing of Condoms to Offenders" was issued on 27 January 1992.[6] It states that, while Alberta Correctional Services correctional centre rules and regulations prohibit sexual relations between offenders, it is recognized that sexual relations may take place within a correctional centre setting, contrary to these rules. The stated goal of the policy is twofold: to reduce the likelihood of a pregnancy occurring within a correctional centre, and to reduce the transmission of infectious diseases such as AIDS. The policy stresses that staff are expected to enforce rules and regulations prohibiting sexual relations. However, offenders will be allowed "to arrange for confidential contraceptive or infectious disease counselling through Centre Physicians, and Centre Physicians will determine whether to issue contraceptives including condoms, in accordance with the intent of this policy."

The policy sets out the following standards: (1) all offenders shall be made aware upon admission to a remand or serving centre of contraceptive or infectious-disease counselling available through a confidential meeting with the centre physician; (2) offenders may forward a request form asking for a confidential appointment with the centre physician, who may issue contraceptives at the end of the scheduled meeting; (3) offenders admitted with condoms in their possession shall have them placed with their personal effects and they will not be allowed access to them until their release; (4) correctional staff who discover condoms in an offender's possession shall not confiscate them; (5) offenders suspected of utilising condoms to smuggle in contraband shall be dealt with through the normal disciplinary process; (6) nothing precludes taking administrative or disciplinary action against an offender for engaging in sexual relations contrary to rules and regulations.

BLEACH

Bleach is not made available to offenders in provincial correctional centres in Alberta. There is no plan to change this policy.[7]

CLEAN NEEDLES AND SYRINGES

Clean needles and syringes are not made available to offenders in provincial correctional centres in Alberta. There is no plan to change this policy.[8]

Protective Measures for Staff

The policy requires that all staff be educated about HIV/AIDS and states that "[t]he Centre Director is responsible to ensure all staff are oriented to the procedures of infectious disease control and the prevention of HIV and other infections, such training is updated as necessary, and appropriate steps are promptly taken where failure to comply with requirements is identified." The centre director is also responsible for ensuring that "adequate supplies of protective clothing and cleaning solutions are strategically located throughout the centre, and that staff are familiar with their availability and appropriate use." An information handout for staff on infectious diseases, including HIV/AIDS and hepatitis B, was developed in April 1993.

6. Alberta Solicitor General, Correctional Services Division (Section Health Services), Policy number 20.15.07, issued 27 January 1992.
7. Submission to ECAP by Stephen C. West, supra, note 2.
8. Ibid.

Further, the policy outlines procedures to be followed by health-care staff when dealing with blood and body fluids and sharps, sets out procedures for staff who have been accidentally exposed to blood or body fluids, and includes reporting provisions.

So-called "staff-at-risk" (correctional officers, correctional services workers, nurses, health-care managers, and operational managers) are encouraged to be immunized for hepatitis B under a policy on "Staff Immunization for Hepatitis B."[9]

A policy on tuberculosis was issued on 5 June 1990.[10] It states that employees are to be encouraged through educational programs to be tested for TB at regular intervals.

Health Care

According to a submission received by ECAP, adult and young offenders housed in Alberta facilities have access, through the centre physicians, to all health-care services in Alberta. Access to drug treatment programs and to experimental HIV/AIDS therapies would be a matter to be determined by the physician and the offender. If an offender is receiving therapy for HIV/AIDS at the time of admission, such therapy would be continued.[11]

Tuberculosis

The policy on TB states that normally only offenders who fall into identified high-risk groups will be tested for TB. According to the policy, high-risk groups may include, but are not restricted to, Aboriginals, immigrants, people with HIV infection or AIDS, and offenders with a productive cough. Correctional centres may conduct TB testing on a more generalized basis at their discretion.

BRITISH COLUMBIA

A policy on HIV/AIDS in provincial institutions was first adopted in 1985. This policy laid down procedures for dealing with so-called "AIDS Alert" inmates that differed substantially from those relating to other prisoners. In particular, it was stated that "AIDS Alert" inmates had to be "assumed to be hygiene poor" and were to be housed separately from the general prison population. There were also special procedures for the day-to-day management of "AIDS Alert" inmates. These included the "decontamination and reprocessing" of the inmates' personal property upon admission, and the permanent issue to the "AIDS Alert" inmates of their own eating utensils, which they had to wash themselves. "AIDS Alert" inmates were also to be transported separately from other inmates. In relation to HIV-antibody testing of prisoners, the policy of the Corrections Branch was that testing, even on a voluntary basis, should be discouraged. The Branch acknowledged the difficulty of keeping test results confidential, and there was concern about possible adverse consequences for the inmate should the test results become known.[12]

A revised policy was adopted on 17 May 1989.[13] It provided guidelines for the protection of staff and inmates, and emphasized that all inmates and their body fluids should be considered to be potentially infectious. The revised policy emphasized the importance of being educated about HIV/AIDS. It stated that a comprehensive educational program about communicable diseases in general, and HIV/AIDS in particular, was to be developed for all staff and inmates. The policy further stated that special or separate

9. Alberta Sollicitor General, Correctional Services Division (Section Health Services), policy number 20.15.06, revised 28 March 1991.
10. Alberta Solicitor General, Correctional Services Division (Section Health Services), policy number 20.15.05.
11. Submission to ECAP by Stephen C. West, supra, note 2.
12. British Columbia Corrections Branch. Medical Services – Manual of Operations, AIDS Alert. 5 November 1985, revised 14 April 1986.
13. B.C. Corrections Branch. Manual of Operations – Adult Institutional Services, 17 May 1989.

housing would only be considered as a final alternative and that integration with the population should be achieved wherever possible. With regard to testing for HIV, the policy stated that it would be carried out only at the inmate's request or at the direction of a health-care professional, and that ongoing counselling and support would be provided in correctional centres for those testing HIV-positive.

On 15 June 1992 a new version of the infection-control policy was adopted which significantly differs from the previous ones.[14] In particular, it states that testing for communicable diseases will be offered to each inmate upon admission to a correctional facility and that it will be made available on request to each inmate at any time. Testing will be voluntary. Further, the policy recognizes that the standard approach for dealing with all inmates is to employ universal precautions. Only "from time-to-time" may there be a need for "specific handling information." In such cases, only information that does not reveal the specific diagnosis may be shared, and only with staff who may have direct contact with the particular inmate.

Surveillance and Seroprevalence Studies

A study of HIV prevalence in provincial adult correctional facilities in British Columbia was undertaken in the autumn of 1992. Results of this study are included in Appendix 8 of the *Background Materials.*

Testing for HIV Infection

Section 12 of the policy contains the following provisions relating to testing of inmates for communicable diseases:

12.01 Upon admission to a correctional facility, testing for communicable diseases will be offered to each inmate by the intake nurse. Testing will be made available on request to each inmate both at intake and at anytime thereafter while in custody.

12.02 All testing will be voluntary. Inmates wishing to be tested for a communicable disease should make their requests known to the health centre nurse or physician.

12.04 Pre- and post-test counselling will be given to inmates requesting HIV testing. Ongoing counselling and support for those testing HIV positive will be provided at the health centre.

Offender Medical Information

According to the policy of 1989, whenever the institutional director was advised by a health care professional that an inmate was "in an infectious state" and required special housing or programming, that information was to be shared with all staff who may have direct contact with the inmate. In addition, staff having immediate responsibility for the inmate would be instructed about relevant hygiene and safety requirements. Those involved in close physical contact with the inmate, such as staff providing first aid or involved in physical confrontation, would be advised about the precise nature of the inmate's infectious disease. Also, "[i]nmates sharing a living unit with an inmate so identified [that is, an inmate in an infectious state] shall be advised of the inmate's identity and informed on precautionary hygiene and safety techniques."

The provisions relating to "Information Sharing" in the revised policy differ significantly from the 1989 policy, and emphasize the importance of applying precautions universally rather than the "need to know:"

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

14. B.C. Corrections Branch. Manual of Operations – Adult Institutional Services, section C3, p. 11, dated 15 June 1992. References to the policy of the B.C. Corrections Branch in the following text will be references to the 1992 version of the policy, if not specified otherwise.

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 that inmate.

Housing and Activities

While the policy of 1985 provided that known HIV-infected inmates were to be housed separately from the general prison population, the revised policy states that special or separate housing related to infectious disease will only be considered on the basis of a recommendation by a physician.

Educational Programs for Inmates

With regard to education of inmates on HIV/AIDS, section 11.03 of the 1992 policy states that a comprehensive educational program for inmates and staff shall be developed in all centres. All centre directors shall implement the program in conjunction with local health professionals. Educational programs have been developed that discuss communicable diseases and, in particular, HIV/AIDS and hepatitis. The policy provides that, at the minimum, the educational program shall include: (1) an information package to inmates at intake, providing information on transmission control and precautions to minimize transmission of infectious disease; (2) instructions on the proper use of condoms, lubricants and bleach; and (3) opportunities for periodic updates to ensure that staff and inmates are kept informed of current information.

According to a submission received by ECAP, all inmates admitted to regional correctional centres receive, as part of their orientation program, education on the prevention of the spread of infectious diseases. During this educational session, which is provided by health-care staff, inmates also view a video on HIV/AIDS.[15]

In the summer of 1993 the Federal/Provincial Corrections Health Education Steering Committee of British Columbia submitted a funding proposal for an educational program on HIV/AIDS and infectious diseases. In October 1993 the program received funding, and will be carried out by health educators, contracted jointly to federal and provincial correctional services. This joint effort is an attempt to ensure "uniformity and consistency of information, consistently delivered throughout all correctional facilities."[16]

Preventive Measures for Inmates

CONDOMS

A policy on condom availability and use in B.C. correctional institutions was approved by the Assistant Deputy Minister on 29 July 1992.[17] It states that the B.C. Corrections Branch recognizes a duty to attempt to reduce the risk of sexually transmitted diseases amongst inmates, and that, in meeting this responsibility, all adult correctional centres shall ensure that condoms are made available to inmates in their custody; that staff shall ensure that confidentiality is maintained to respect the privacy of inmates who request or are found to be in possession of condoms; that condoms shall be distributed to inmates free of charge in the health-care unit and shall also be freely available in the dorms/living units; that one-time-use packages of water-soluble lubricants shall be supplied with condoms; that education in the use of condoms shall be provided to all inmates; that staff who discover unopened condoms or lubricant packages in an inmate's possession shall not confiscate these articles; and that inmates suspected of using condoms to smuggle contraband shall be dealt with through the normal disciplinary process.

15. Submission to ECAP by Colin Gabelmann, Attorney General of British Columbia, dated 17 September 1992.
16. Response to ECAP's Working Paper by Dr. Diane Rothon, Director, Health Services, B.C. Corrections, dated 7 September 1993.
17. B.C. Corrections Branch – Manual of Operations, Adult Institutional Services, section C3, p. 13.

In accordance with this policy, condoms and lubricants have been available in all adult correctional centres since 4 August 1992.[18] Condoms and dental dams are available to female offenders.

BLEACH

Bleach is available in all living units as a cleaning agent (for more details, see Jim Cairns, B.C. Ministry of Solicitor General, Corrections Branch, *B.C.'s Experience with Bleach in Prisons*, Appendix 8 of the *Background Materials*).

A draft policy of 16 November 1993 (approval pending) provides guidelines for the distribution of bleach. Importantly, the policy states that, "[t]o be fully effective in reducing the spread of infectious disease, bleach used as a cleansing agent must be full strength." The policy provides that bleach for inmate use shall be readily available and distributed in any of the following manners: (1) in small (50 mL or similar-sized) bottles available in the health-care unit; (2) in small bottles freely available in living units; (3) in bulk bottles used to fill smaller bottles or paper cups in living units; and (4) with general cleaning supplies. The policy further provides that a single container of bleach as issued in the correctional centre shall not be considered as contraband, while inmates in possession of larger quantities shall be considered to be in possession of contraband.

CLEAN NEEDLES AND SYRINGES

In his submission to ECAP, the Attorney General of British Columbia indicated that the distribution of clean needles and syringes is not contemplated at this time.

Protective Measures for Staff

During initial training, all correctional officers receive training on infection control. Ongoing courses are offered through the Justice Institute of British Columbia.[19]

The policy promotes the use of universal precautions when handling bodily fluids, and deals with specific modalities of the application of blood and body fluid precautions, in particular the appropriate use of protective equipment, the cleaning of spills and the importance of personal hygiene. It also contains a list of protective items for staff: (1) all correctional staff shall be provided with, and shall carry on their person while on duty, disposable latex gloves contained in a belt-worn pouch; (2) where available, one-way valve face masks (anti-reflux) shall be used whenever mouth-to-mouth resuscitation is required; (3) the following items, identified as an Infection Control Kit, shall be available in all centres: face masks, eye shields, standard issue coveralls, cleaning materials, disposable latex gloves, and one-way valve (anti-reflux).

All staff employed in British Columbia correctional centres are given the option to receive vaccinations for hepatitis B at the employer's expense.[20]

Health Care

According to a submission received by ECAP, all inmates who are HIV-positive or who have AIDS have access to levels of health care equal to that of the general public. Drugs used to treat HIV infection and AIDS are distributed through local hospitals, and many inmates travel to local hospitals to receive treatment. Further, drug treatment programs are available to all inmates in provincial correctional centres.[21]

18. Submission to ECAP by Colin Gabelmann, supra, note 15.
19. Ibid.
20. Ibid.
21. Ibid.

Tuberculosis

Testing for TB is done "with cause": any inmate suggestive of TB is tested. Individuals with a history of recent exposure to TB, as well as HIV-positive inmates, are tested for TB. The Branch is currently reviewing the need for routine testing among high-incidence groups such as Aboriginal people and immigrants from certain countries. Only one case of active pulmonary TB was confirmed in an inmate in a British Columbia provincial correctional centre.[22]

MANITOBA

Interim Guidelines for correctional facilities and detentional facilities on "workplace prevention and management" of HIV infection and AIDS were issued in July 1987 by the Manitoba Department of Health.[23] The purpose of these guidelines is to provide information on measures that should be taken to prevent the transmission of HIV in correctional and detentional facilities. According to the Guidelines, routine screening of individuals admitted to correctional and detentional facilities is not warranted; individuals who are known to be infected with HIV may be held in "a separate area" for reasons of their own personal safety; education and counselling regarding HIV/AIDS should be provided for all inmates/residents and staff. The guidelines were replaced in 1991 by a document on workplace health and safety developed jointly by Manitoba Health and Manitoba Labour.

An Adult Corrections Branch Policy on Infectious Disease Control was adopted on 3 July 1990.[24] Its purpose is to prevent infection and the spread of communicable diseases in adult correctional facilities, and "to manage infected persons with no more intrusion or control than is necessary to protect others." The policy will be revised after a review of the 1991 Guidelines is completed.[25]

Community and Youth Corrections issued a policy and procedures for infectious disease control in January 1991.[26] These are very similar to the Adult Corrections Branch Policy.

Surveillance and Seroprevalence Studies

No seroprevalence studies of persons admitted to correctional facilities in Manitoba have been undertaken or are being planned.

In his submission to ECAP, Mr. D.J. Demers, Assistant Deputy Minister, Manitoba Justice – Corrections, stated that two to three known HIV-positive offenders are admitted to Manitoba provincial institutions every year, and that many of them have very short sentences.[27]

Testing for HIV Infection

The 1987 Interim Guidelines provided that inmates should not be routinely tested for HIV antibodies upon entrance into a facility or during their stay, but that antibody testing and counselling services should be available for any person who wishes to be tested. Individuals "in groups at increased risk" for HIV infection should be encouraged to utilize the testing and counselling services.

The Adult Corrections Branch Policy makes no reference to testing for HIV antibodies. In his submission to ECAP, Mr. Demers, Assistant Deputy Minister, Manitoba Justice – Corrections, stated that, in practice, "testing is readily available

22. Communication received from Dr. Diane Rothon, Medical Director, British Columbia Corrections Branch, dated 3 December 1993.
23. Manitoba Health. Workplace Prevention and Management of Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV): Interim Guidelines for Correctional and Detention Facilities, July 1987.
24. Manitoba Justice – Corrections. Adult Corrections Branch Policy, Infectious Disease Control, 3 July 1990.
25. Memorandum of Wayne Scarth, A/Executive Director, Adult Corrections, to D.J. Demers, Assistant Deputy Minister of Justice, dated 2 December 1993.
26. Manitoba Community and Youth Corrections, Infectious Disease Control, 9 January 1991.
27. Ibid; and submission to ECAP by D.J. Demers, Assistant Deputy Minister of Justice, Manitoba, dated 17 September 1992.

and done where medical staff feel it is indicated and frequently at inmates' request."[28] Blood is drawn by the institutional physician and sent to the provincial laboratory on a coded form to ensure privacy.

Offender Medical Information

The 1987 Interim Guidelines contained the following recommendations with regard to protection of confidentiality of medical information:

1. Information regarding who has been tested and/or who is being evaluated for an AIDS virus (HIV) infection should be limited to the medical record. Access to information in those records should be confined to medical staff who need to know.

2. Individually identifiable information regarding inmates diagnosed with an AIDS virus (HIV) infection should be limited to the medical staff. Where indicated, medical staff should inform workers that strict adherence to blood and bodily fluid precautions is necessary.

The Adult Corrections Branch Policy contains the following provisions:

6. Only those staff who need to know shall be advised of the condition, as determined by the superintendent in consultation with a physician:

   6.1 staff receiving information about suspected or infected offenders shall pass this on immediately to the medical department and not disclose it to anyone else; ...

   6.3 information will only be passed on to outside sources if the offender provides written consent, or if the Superintendent, in consultation with medical determines there is a public safety concern.

28. Ibid.

Housing and Activities

The 1987 Interim Guidelines recommended that HIV-infected inmates be housed with the general prison population, but not in "multi-person cells or rooms," and that they should be allowed standard access to recreational activities, work assignments, visitation privileges, showers and bathroom facilities, food services and other program activities. According to the Guidelines, an HIV-infected inmate may be held in a separate area only for reasons of his or her own personal safety.

The Adult Corrections Branch Policy provides that offenders shall not be segregated or denied normal routines, "even those offenders belonging to a high risk group, claiming to be infected, or having tested positive," except (1) for medical reasons, as determined by a physician or medical staff, or (2) for security reasons (irresponsible, unpredictable or assaultive behaviour), as determined by the senior in charge and reviewed by the superintendent or designate as soon as possible. The policy further provides that offenders shall be cleared by the medical department before being assigned work in the kitchen.

Educational Programs for Inmates

The Adult Corrections Branch Policy provides that as part of the orientation process all offenders shall receive written information on preventive measures to observe in the institution. Follow-up sessions shall be held with offenders, "with the focus on personalizing risks and adopting risk reduction practices," and "high risk offenders" shall be individually approached by medical staff and offered counselling "to eliminate high risk behaviours."

HIV/AIDS educational programs are given to both staff and inmates. The content of the programs varies considerably from institution to institution. Lectures are given by either physicians, staff

nurses or nurses from the Department of Health, films are sometimes shown and pamphlets are handed out.[29]

Preventive Measures for Inmates

CONDOMS

Condoms were made available to inmates in all provincial institutions in 1993. At the time of writing, institutions were trying different distribution methods. In most institutions, condoms are made available upon request of inmates through medical services.[30]

BLEACH

Bleach is currently available with staff supervision in all prisons for cleaning purposes. At the time of writing, it was being considered "making a diluted bleach solution available to inmates, at all times, which could be used to disinfect needles."[31]

CLEAN NEEDLES AND SYRINGES

Clean needles and syringes are not available and no consideration is being given to changing this policy.

Protective Measures for Staff

The Adult Corrections Branch Policy provides that staff receive mandatory training on both preventive and contingent measures, with annual refresher training thereafter, including information on: (1) means of transmission; (2) methods of preventing transmission; (3) availability and use of protective equipment; (4) search procedures that minimize risk; (5) disposal and laundering of contaminated materials; (6) legal and liability issues (specifically, obligation to perform duties and the assumption of job-related risks); and (7) testing procedures.

The policy further provides that preventive measures shall be observed by staff and offenders at all times, such as: (1) careful handling and disposal of sharp instruments; (2) using clean and dry bandages to cover open sores, wounds or abrasions; (3) careful blind searching of persons and concealed areas to avoid accidental needle-sticks or punctures by other sharp instruments; (4) observing good hygiene practices; (5) use of gloves for routine searching; (6) education and training in the use of preventive equipment; and (7) taking appropriate steps to prevent high-risk behaviours such as drug use, sexual activities, tattooing, etc.

Universal precautions for handling blood and body fluid spills, and the procedures to be taken in the event of bites and needle-stick punctures are also outlined.

Workplace safety and health committees are established that regularly monitor and review infectious disease control measures to ensure that the appropriate preventive measures are followed.

Health Care

All provincial jails have a nursing staff. Larger jails are staffed by registered nurses 24 hours a day. Medical doctors attend large jails daily and smaller jails less frequently. Psychiatrists are concentrated in Winnipeg jails and psychiatric patients at distant institutions are transferred to those in Winnipeg or use local psychiatrists. All jails offer drug and chemical abuse programs in addition to outside treatment facilities.[32]

HIV-positive inmates are treated at the Health Sciences Centre or at the Winnipeg Village Clinic.

29. Ibid.
30. Memorandum from W. Scarth to D.J. Demers, supra, note 25.
31. Ibid.
32. Ibid.

Tuberculosis

The Corrections Branch Policy does not mention the issue of tuberculosis. In practice, inmates and staff are not routinely tested, except where medically indicated, for example after an inmate has been found to be infected.

NEW BRUNSWICK

The Correctional Services Division of the Department of the Solicitor General issued a revised infection control manual in May 1991. This manual contains an "Infection Control Protocol for Offenders with Acquired Immuno Deficiency Syndrome (AIDS)." The purpose of the protocol is to "provide the health care professional with guidelines which will assist to ensure protection for the care giver, staff, offender and the community at large, while still maintaining the dignity of the client." The protocol stresses that the guidelines outlined should be carried out "within the context of a program philosophy which fosters a sense of normal functioning, and which minimizes the potential for the client to feel isolated." It emphasizes that the health-care professional must ensure that clients understand the reasons for the infection-control procedures and are "allowed the opportunity to discuss their feelings in an attempt to resolve any conflicts related to the procedures."

The protocol acknowledges that the risk to health-care workers of "acquiring HIV" is extremely low and focuses on precautions that will assist in the prevention of needle-stick injuries to health-care workers.

In January 1992 the Department of the Solicitor General established a Departmental Committee on AIDS. The Committee has developed an HIV/AIDS policy for the Department of the Solicitor General "as part of its commitment to maintain a healthy work environment, to provide quality services to its employees and clients and to respect and uphold the rights of all employees and clients."[33] At the time of writing, the policy was in draft form and had not yet been officially approved.

The new policy emphasizes the importance of protecting workers and clients from contracting infections and states that the Department of the Solicitor General will provide employees with the "necessary information, education and equipment to protect themselves adequately." The policy contains a section on the rights of employees and clients. This section provides that: (1) there shall be no discrimination in the selection of new employees on the grounds of their having tested HIV-positive or having AIDS "unless Occupational Qualifications have been approved in advance by the Human Rights Commission of the Province of New Brunswick"; (2) there shall be no discrimination against employees or potential employees based on an individual's membership in a group associated with HIV/AIDS or by reason of relationship to a person with HIV/AIDS; (3) employees with HIV or AIDS can continue to work in their present positions as long as they are able to meet the normal performance standards of the job; (4) employees with HIV/AIDS have the right to be accorded complete confidentiality concerning their HIV status; (5) employees and clients have the right to receive services without discrimination based on illness or perceived illness; (6) the Department of the Solicitor General will not tolerate discrimination or harassment of employees or clients with HIV/AIDS, nor will it tolerate any employees refusing to work with fellow employees or clients solely on the basis of his/her condition. Discriminatory acts by employees against an employee or client with HIV/AIDS are unacceptable and may be subject to disciplinary action.

33. "Clients" are defined as "persons receiving any services provided by Correctional Services, Policing Services, and Sheriff-Coroner Divisions of the Department of the Solicitor General."

Surveillance and Seroprevalence Studies

No seroprevalence studies of persons admitted to correctional facilities in New Brunswick have been undertaken.

Testing for HIV Infection

According to the Infection Control Protocol, offenders shall not be routinely screened for the presence of antibodies to HIV. Testing for HIV infection will be carried out on a voluntary basis "if warranted."[34] Offenders who wish to be tested must sign an HIV-antibody-test consent form and will obtain pre- and post-test counselling. The nurse counsellor who undertakes testing and counselling must fill out and sign a pre-test counselling form that outlines the issues addressed and discussed with the offender, and a post-test counselling form. Pre-test counselling involves an explanation of: (1) the testing procedure and its implications; (2) how HIV is and is not transmitted; (3) the distinction between HIV and AIDS; (4) the benefits and harms of being tested; (5) how to reduce the risk of contracting HIV infection. Post-test counselling for HIV-negative offenders involves a review of the significance of the test result and an emphasis on risk reduction. For inmates who test seropositive, post-test counselling addresses psychological consequences, and involves a discussion of behavioural changes required to prevent transmission, of the importance of medical and psychological follow-up, and of partner notification.

Offender Medical Information

According to the Infection Control Protocol, the HIV status of an offender is "medically confidential" and "[t]his information shall not be released to supervisory staff without the offender's consent." Only the institutional superintendent or designate may be provided without the offender's consent with such information by health-care staff if there is cause to believe that an offender's actions may constitute a danger to himself or others. However, upon the admission of an HIV-positive offender, supervisory personnel "shall be notified at the discretion of the medical advisor in order to maintain the orderly management of an institution." In practice, the medical advisor will inform supervisory personnel only in rare cases when an offender's behaviour constitutes a risk to others.[35]

With regard to notification of public health authorities, the protocol states that "HIV infection reporting shall be in accordance with relevant New Brunswick provincial public health legislation and practice" and that "[t]he institutional nurse shall be responsible for notifying the local Department of Public Health."

Housing and Activities

The Infection Control Protocol provides that HIV-positive and asymptomatic offenders shall usually be placed in the general population. However, "case by case decisions regarding institutional placement may be necessary to accommodate the specific medical and non-medical characteristics of each particular case."

According to the HIV/AIDS Policy (approval pending), "[t]he determination of whether an H.I.V. positive incarcerated offender should be permitted to remain in the general population in provincial correctional facilities shall be made on a case by case basis." Segregation is deemed acceptable if: (1) an offender's behaviour threatens to transmit the disease; (2) reactions of other inmates require that an offender with HIV infection or AIDS be put in protective custody; (3) an offender's medical condition warrants it.

34. Submission to ECAP by Bruce A. Smith, Solicitor General, Province of New Brunswick, dated 9 September 1992.

35. Personal correspondence received from Cheryl MacIntyre, Chairperson, AIDS Protocol Committee, Department of the Solicitor General, dated 30 March 1992.

With regard to activities, the Infection Control Protocol provides that offenders "with suspected H.I.V. antibody positivity or diagnosed as H.I.V. antibody positive, shall not be managed differently from other offenders unless medically indicated."

Educational Programs for Inmates

According to a submission to ECAP, some educational programs are provided by health staff to offenders in provincial correctional facilities. The content and availability of these programs varies from institution to institution.[36]

The HIV/AIDS Policy (approval pending) emphasizes that the Department of the Solicitor General is committed to provide ongoing and updated education on the subject of HIV/AIDS to inmates, and states that "[e]mployees and clients have the right to have access to educational material on the subject of H.I.V./AIDS."

Preventive Measures for Inmates

CONDOMS

According to the Protocol, condoms shall not be issued to offenders. The Protocol further states that the superintendent "may decide to isolate an offender who fails to cooperate and continues to engage in sexual activities that place others at risk for infection with H.I.V." It continues by saying that the "primary concern is that condoms will be used for illicit purposes such as smuggling and storage of contraband, mostly related to drugs and substance abuse, and that this activity will increase if condoms are made readily available, thereby endangering the maintenance of security and order in the institution. A second argument against providing condoms to offenders as a preventive measure for AIDS is that the service could be said to be implementing contradictory policies."

In his submission to ECAP, the Solicitor General of New Brunswick emphasized that the Correctional Services Division examined the characteristics of the incarcerated population before developing this policy. He noted that in 1991 "the profile of an incarcerated offender in a New Brunswick provincial correctional facility was a single 31 year old male with a grade nine education, incarcerated for an impaired driving offence. Although the average sentence length is 84 days, the average time served is 33 days. Consequently, the profile and needs of an individual incarcerated in a provincial correctional facility vary significantly from the offenders in the federal system."[37]

The HIV/AIDS Policy (approval pending) does not mention the issue of condoms.

BLEACH

As stated in the Solicitor General's submission, "the New Brunswick Department of the Solicitor General is not considering making bleach available for those using injection drugs." The Solicitor General pointed out that apprehension of needles for injection drug use had not been reported to the Correctional Services Central Office for the past two years. He further said that, although authorities were aware of some smuggling attempts relating to other drugs in provincial correctional facilities, the drug of preference of offenders incarcerated in New Brunswick appeared to be alcohol. He concluded by saying that "[d]ue to these factors as well as safety concerns, bleach shall not be made available to the offenders."[38]

CLEAN NEEDLES AND SYRINGES

Needles and syringes are not made available to offenders.

36. Submission to ECAP by Bruce A. Smith, supra, note 34.
37. Ibid.
38. Ibid.

Protective Measures for Staff

All new correctional officers receive a compulsory informational session on HIV/AIDS during their orientation. Each fiscal year, three AIDS workshops are available to all staff on a voluntary basis.

The Infection Control Protocol contains infection control guidelines.

The HIV/AIDS Policy (approval pending) emphasizes that the Department of the Solicitor General has a responsibility to employees to initiate and maintain an educational process designed to promote prevention and rational decision making, when dealing with HIV/AIDS in the workplace. The policy further states that "[a]ppropriate measures must be taken to protect the health of workers ... in occupational settings where there exists a risk of exposure to body fluids." Strict compliance with the universal precautions prescribed by the Laboratory Centre for Disease Control is recommended. Infection control guidelines will be implemented and maintained for dealing with exposure to blood and body fluids in the workplace. The section in the policy on "Protection of Workers and Clients" concludes with the statement that "[t]he Department of the Solicitor General will provide employees with the necessary information, education and equipment to protect themselves adequately."

The Policy sets out detailed procedures to be followed in case of an occupational exposure to HIV, and contains recommendations on how to conduct searches and on how to protect oneself from contracting infections in the case of an assault.

Health Care

As stated by the Solicitor General in his submission to ECAP, "offenders with HIV infection are entitled to the same level of health care as an individual in the community." They have access to substance abuse programs when provided by the provincial correctional facilities and may be referred to the appropriate community agency when required. Incarcerated offenders will have access to drugs if prescribed by the attending physician.[39]

The HIV/AIDS Policy (approval pending) states that individuals with HIV infection or AIDS will have "reasonable access to health related care and support, optimising the individual's potential for well being," and that "[e]mployees and clients shall have access to information about and referral to appropriate community agencies and organizations that offer support services."

Tuberculosis

The Infection Control Manual contains a section on Tuberculosis Control and Skin Testing. According to this section, early diagnosis is of major importance in the control of TB: "[I]t is advantageous to know the tuberculin status of a person entering a situation where he or she is likely to be exposed to the risk of transmission. Offenders in provincial institutions, particularly those housed in dormitory situations, and employees of provincial institutions, would be in this category."

The section further provides that all offenders serving sentences longer than 30 days who have not had a documented positive reaction to PPD should be Mantoux tested. Offenders who show positive reaction to Mantoux must be followed-up with a chest x-ray, but need not be isolated unless they are symptomatic. Active cases of TB, confirmed through a chest x-ray and/or positive AFB sputum cultures, must be isolated in a hospital setting.

39. Ibid.

NEWFOUNDLAND

The Adult Corrections Division of the Newfoundland and Labrador Department of Justice issued a Policy Directive on HIV/AIDS that became effective on 1 June 1988 and was revised on 1 April 1992.[40] In the revised version the outdated and misleading descriptive terms employed in the old version, such as "AIDS carrier" (as opposed to people with HIV infection or AIDS), "AIDS test" (as opposed to HIV antibody test), and "high risk groups" (as opposed to people engaging in high risk activities, such as unprotected sexual intercourse or sharing injection equipment) were replaced by more appropriate terms. With regard to its content, the policy was left unchanged.

The intent of the policy is to "provide an ongoing AIDS program for staff and inmates, to ensure that staff and inmates are reasonably protected against the transmission of the disease, that infected inmates are provided with adequate medical treatment and that confidentiality is maintained consistent with accepted medical standards and the need to maintain the security/good order of the correctional facility."

Youth Corrections:
Section V of a draft Infection Control Manual for Youth Corrections Secure Custody and Remand Services addresses issues relating to HIV/AIDS.[41] The manual emphasizes the importance of universal precautions in "afford[ing] employees and youth reasonable protection from contracting communicable diseases," because the HIV status of an offender "may or may not be known."

Surveillance and Seroprevalence Studies

Seroprevalence studies among inmate populations have not been undertaken in Newfoundland and Labrador. In her submission to ECAP, Joyce Gosse, Registered Nurse at H.M. Penitentiary in St. John's, indicated that while the number of inmates tested is readily available, the actual number of HIV-positive inmates is difficult to determine "as those inmates who have tested positive outside of prison testing may not disclose such information to the medical staff."[42]

Youth Corrections:
As of November 1993 there had been one reported case of AIDS and one known case of HIV infection in youth custody.[43]

Testing for HIV Infection

The Policy Directive provides that no person may be forced to submit to an HIV-antibody test and that such a test may only be administered by a medical professional if the patient provides informed consent. It mentions specifically that "[a]ny 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."

However, the Directive also provides that if a staff member suspects that an inmate may be HIV-infected because he or she has symptoms of the disease or engages in high-risk activities, the staff member should ensure that this information is conveyed to the medical officer. If in the opinion of

40. Newfoundland and Labrador Department of Justice. Adult Corrections Division Policy Directive (Health Care Services) 16.40.06, revised 1 April 1992.

41. Newfoundland and Labrador Department of Social Services, Division of Youth Corrections. Infection Control Manual for Youth Corrections Secure Custody and Remand Services (draft).

42. Submission to ECAP by Joyce Gosse, Registered Nurse, H.M. Penitentiary, dated 17 December 1992.

43. Correspondence from Betty Reid White, Registered Nurse, Newfoundland & Labrador Youth Centre, dated 7 December 1993.

the medical officer there is reason to believe that an HIV-antibody test is warranted, the inmate should be encouraged, but not forced, to submit to such a test.

In practice, testing is available at the request of the inmate in consultation with the physician, and "as much as possible confidentiality is insured."[44]

Youth Corrections:
According to the draft Infection Control Manual, "[v]oluntary testing will be made available, where clinically indicated or requested, but only with the informed consent of the client. Adequate pre and post test counselling will take place."

HIV infection is a reportable communicable disease and as such must be reported to the Department of Health.

Offender Medical Information

The Policy Directive states that medical information pertaining to inmates with HIV or AIDS may not be disclosed to non-health personnel without the inmate's written consent unless there is cause to believe that the offender's activities may constitute a danger to himself/herself or others.

Youth Corrections:
The provisions in the draft Infection Control Manual are very similar to those in the Policy Directive. They state that only if an offender's activities pose a danger to himself/herself or others, information about his or her health status may be disclosed by the consultant physician to those directly involved in the care of the youth.

Housing and Activities

The Policy Directive states that inmates who test positive for HIV antibodies need not be "automatically isolated from the general prison population" unless segregation is necessary either to prevent transmission of HIV to others, to protect the infected inmate from exposure to other infections, or to ensure the inmate's personal safety.

Youth Corrections:
The draft Infection Control Manual provides that residents who test positive for HIV antibodies need not be isolated unless their behaviour is threatening or high risk in nature, or their condition is such that medical isolation is necessary to protect them from other infections.

With regard to participation in programs, the Manual states that, regardless of the medical status of a young offender, he/she should not unreasonably be denied access to programming. Where regular programming is not possible, efforts should be made to provide comparable, alternative programs for the offender.

Educational Programs for Inmates

According to the Policy Directive, an ongoing HIV/AIDS educational program for both staff and inmates shall be provided whose primary objective would be "to promote a rational understanding of the disease, the actual risk level and practical precautionary measures that may apply."

In December 1993 discussions were ongoing with the Newfoundland and Labrador Department of Health and the Newfoundland and Labrador AIDS Committee with the aim of engaging them in presenting ongoing educational sessions on HIV/AIDS to both inmates and staff.

Youth Corrections:
Education for residents in secure custody is carried out on an as-needed one-to-one basis by the facility nurse or physician. A program has been developed that addresses sexuality, STDs, etc. This program is provided to all new admissions and residents who are nearing their release date. Additionally, community agencies such as the Public Health "Street Nurse" program

44. Submission to ECAP by Joyce Gosse, supra, note 42.

have provided education sessions specifically dealing with HIV/AIDS.[45]

Preventive Measures for Inmates

CONDOMS

According to the Policy Directive, condoms will not be issued to inmates because "these items represent a potential security risk since they can be used to secrete contraband." As of December 1993, there were no plans to make them available. However, a proposal to provide inmates with condoms was being discussed.[46]

Youth Corrections:
The Infection Control Manual does not mention the issue of availability of condoms. As stated in a submission to ECAP, condoms are not made available to residents in custody because sexual contact between them is not permitted. However, "it is the opinion of health care staff that condoms should be made available to residents who are granted temporary release from custody or who are released from custody." Discussions on this issue are ongoing. Health-care providers utilize condoms for health teaching purposes.[47]

BLEACH

Bleach is made available to units as a cleaning/disinfectant agent, but there has been no decision to make it available for the purpose of cleaning needles.[48]

Youth Corrections:
Bleach has been available on all units within the Newfoundland and Labrador Youth Centre since its opening. It is provided for laundry purposes and for cleaning up of blood and bodily fluids.[49]

CLEAN NEEDLES AND SYRINGES

Clean needles and syringes are not made available to inmates and there are no plans to provide a needle exchange program.

Youth Corrections:
Needles and syringes are not made available to residents.

Protective Measures for Staff

The provisions relating to education and training of staff in the Policy Directive are identical to those for inmates.

A section on "Precautionary Measures" deals with availability and use of protective clothing and emphasizes the necessity of employing precautions universally. A detailed protocol about, among other things, the use of protective clothing, disinfecting procedures, and disposal of contaminated materials, is included in the Institutional Service Operations Manual.

Health Care

Inmates who are HIV-positive or have AIDS have access to medical staff who specialize in the diagnosis and treatment of HIV/AIDS. According to a submission to ECAP, access to treatment for inmates is as good as for people outside prison, and any drug, whether experimental or not, will be given to inmates if prescribed by a physician.[50]

Youth Corrections:
Health-care staff at the Newfoundland & Labrador Youth Centre includes 1.6 nursing positions, a community physician who conducts clinics two

45. Submission to ECAP by Betty Reid White, dated 17 November 1992, and correspondence, supra, note 43.
46. Personal communication with Joyce Gosse on 1 December 1993.
47. Submission to ECAP by Betty Reid White, supra, note 45, and correspondence, supra, note 43.
48. Personal communication with Joyce Gosse on 1 December 1993.
49. Submission to ECAP by Betty Reid White, supra, note 45.
50. Submission to ECAP by Joyce Gosse, supra, note 44.

afternoons a week and a consultant psychiatrist who conducts bimonthly clinics.

Tuberculosis

There is no reference to TB in the Policy Directive. In practice, routine TB testing is not undertaken.

Youth Corrections:
According to the Infection Control Manual, routine TB (Mantoux) testing of residents and staff is unnecessary due to the low prevalence of TB in the province. Further, a screening program for staff "would be of limited value because a significant number of Newfoundlanders have had prior exposure and subclinical illness, and therefore would test positive or would have had B.C.G. Prophylaxis, thus causing difficulty in interpretation and a false high positive rate on the screening program."

On admission, each resident will be assessed on an individual basis to determine if he or she has been exposed to an active TB case. Special consideration will be given to "at risk" groups such as members of the Aboriginal population and persons with HIV or AIDS. If it is determined that a resident has been exposed to active TB infection, the nurse will obtain a complete medical history and the consultant physician will be notified regarding the health history and status of the resident. Health-care workers and administration "will determine the need to restrict the movement of residents in and out of the institution and will determine the need for preventative screening of all residents and staff."

NOVA SCOTIA

Nova Scotia Correctional Services first issued a policy on HIV/AIDS on 1 February 1989. The policy was revised on 1 February 1990.[51] According to it, correctional services shall provide for the "early identification, necessary medical treatment and safe custody" of HIV-infected prisoners, both staff and prisoners shall be provided with a comprehensive "orientation" to HIV/AIDS, and current educational materials shall be made available to staff on an ongoing basis. This policy is currently being reviewed.

Surveillance and Seroprevalence Studies

There have been no HIV seroprevalence studies in provincial prisons in Nova Scotia.

In her submission to ECAP, the Deputy Solicitor General indicated that, while there have so far been no known cases of AIDS in the provincial prison system, approximately six prisoners have been known to be HIV-positive.[52]

Testing for HIV Infection

The policy contains the following provision with regard to HIV antibody testing:

1. Where a prisoner is identified as being in an AIDS high risk group[53] and/or where the institutional physician has determined that there is sufficient reason to believe that the prisoner may be infected with HIV, a blood test for HIV infection shall be made available to the prisoner, along with appropriate counselling, to be undertaken only on a voluntary basis with the written consent of the prisoner.

Offender Medical Information

According to the policy, all personal prisoner medical information shall be maintained in the

51. Nova Scotia Solicitor General, Correctional Services (section: Medical and Health Care Services), Subject No. 13.14, 1 January 1990.

52. Submission to ECAP by Nadine Cooper Mont, Deputy Solicitor General of Nova Scotia, dated 29 September 1992.

53. According to the policy, "high risk groups have been identified as homosexual and bisexual males with multiple partners, I.V. drug abusers, transfusion recipients prior to 1985, heterosexuals with a partner in any of these risk groups and infants born to infected mothers."

prisoner's medical file, to be kept in a secure location, with access limited to the superintendent and institutional health-care staff. Further, all staff are required to adhere to strict rules of confidentiality with regard to the sharing of medical and other information about prisoners in their care. However, the institutional physician may, with the approval of the superintendent, "provide advice to those persons who need specific information in order to carry out their responsibilities." Where a prisoner informs a staff person that he may have AIDS, the prisoner shall be advised that he or she should report this information to a superintendent immediately, but otherwise maintain strict confidentiality.

Housing and Activities

Prisoners who, upon completion of the admissions medical form, are identified as either having previously tested HIV-positive or as being in an "AIDS high-risk group" are to be examined by the institutional physician. Where, following examination by the physician, it is felt that there is "sufficient reason to believe that the prisoner may be infected with HIV or where a previous seropositive test is confirmed," the prisoner shall be transferred to a designated correctional institution with "adequate medical facilities for further evaluation." A blood test shall be made available to the prisoner, to be undertaken only on a voluntary basis. Where the "prisoner at risk" refuses to provide consent to the test, he or she "may be returned to the general [prison] population" where he or she shall be closely monitored for "further manifestation of symptoms."

Prisoners who test positive shall not be transferred to the medical or segregation unit of the institution or transferred to another facility unless: (1) the inmate's behaviour is threatening in nature, so that segregation is necessary; (2) the inmate is rejected by the general prisoner population and his or her placement in protective custody is deemed necessary; or (3) the inmate's medical condition is so severe that medical isolation is necessary to protect the inmate from contracting other infections.

The policy further provides that "confirmed AIDS cases" shall not be assigned kitchen duty.

Educational Measures for Inmates

Inmates are provided with educational materials regarding HIV/AIDS during induction. "Information is available to adult inmates upon request," and a "proactive program for adult correctional facilities is being developed."[54]

Preventive Measures for Inmates

CONDOMS

Condoms are not made available to inmates, but Nova Scotia is now planning to implement a condom distribution program.

BLEACH

Bleach is not available for distribution to offenders for hygienic purposes, but is used for cleaning purposes.

CLEAN NEEDLES AND SYRINGES

Needles and syringes are not provided to inmates and there is no intention on the part of the Department to do so.

Protective Measures for Staff

A course on infectious diseases is offered to all new correctional staff.

The policy emphasizes that staff "shall exercise appropriate precautionary measures when involved in any potential at risk activities/situations, involving possible contact with blood or other body fluids," and that precautionary measures "shall

54. Submission to ECAP by Nadine Cooper Mont, supra, note 52.

include the use of protective devices such as rubber gloves, gowns, masks, goggles and artificial respiration airways, as appropriate to the given situation."

Staff or prisoners who have had any significant exposure to body fluids shall immediately report the incident to the superintendent and shall be seen by the institutional physician as soon as possible. The policy further provides that "special handling or exceptional infection control precautions required as the result of the medical condition of a prisoner with AIDS shall be implemented by the Superintendent on the advice of the institutional physician."

Health Care

As indicated in a submission to ECAP, Nova Scotia has had minimal experience with HIV-infected offenders. So far, "[a]ny medical requirements which have been identified for such offenders have been attended to by institution doctors or local hospitals."[55]

Tuberculosis

The policy contains no provisions relating to tuberculosis.

ONTARIO

In 1989 the Ontario Ministry of Correctional Services developed a new policy on communicable diseases.[56] The policy is intended to consolidate and refine the policies, procedures and standards previously practiced by the Ministry regarding the care and supervision of offenders both in correctional facilities and in the community. It is the goal of the Ministry to manage offenders with a communicable disease, where it is clinically and operationally possible, in the general population of the institution or in the community. This is seen as part of an effort to foster the sense of normal functioning and to minimize the potential for offenders to feel isolated or discriminated against.

The policy has received the approval of the Ontario Human Rights Commission, the Ontario Public Service Employees' Union and the Chief Medical Officer of Health for Ontario.

It acknowledges that the risk of infection from both HIV/AIDS and hepatitis B is low and contains the following eight "Policy Statements:"

> Standards developed in conjunction with local Medical Officers of Health will be maintained to assist medical staff in identifying and managing offenders exhibiting symptoms of communicable diseases.
>
> Voluntary testing will be made available, where clinically indicated or requested, and will be provided only with informed consent. Adequate pre- and post-test counselling will take place. Mandatory blood testing will not be initiated and is not required at the present time.
>
> Health care beds (medical or special needs unit) will be provided for infected offenders who require placement for medical reasons.
>
> Normal classification procedures will be followed in those cases where in the view of medical staff health care bed use is not necessary.
>
> Hetero or homosexual activity is not permitted in ministry facilities and in order to prevent potential breaches of security (condoms used as ligatures, potential weapons, jamming

55. Ibid.

56. Ministry of Correctional Services, Communicable Diseases Policy, dated April 1989.

locks, smuggling drugs), condoms shall not be made available in ministry facilities.[57]

In order to protect the health of the ministry employees, staff training in the care and handling of communicable diseases will continue to be provided, with a special focus on HIV/AIDS and Hepatitis B.

Specific information packages regarding the prevention of AIDS and Hepatitis B will be available to offenders.

Provision for continuity of care will be included in pre-release planning for infected offenders.

Youth Corrections:
The Ontario Ministry of Community and Social Services is responsible for the delivery of secure custody/detention of young offenders aged 12 to 15. In 1988 the Ministry developed and published the document "Understanding and Coping with Blood-Borne Infections Including AIDS"[58] and commissioned "HIV Infection and AIDS: A Policy Development Framework for Children and Youth Social Services Agencies." This document states that "no child should be denied appropriate group home or residential treatment care because of HIV infection."

A Young Offender Services Communicable Diseases Policy of 7 January 1991 states that the "[k]ey to the prevention of communicable disease is a comprehensive education plan for both residents and staff." The policy sets out standards and procedures for health education and disease prevention and control and contains provisions for staff education, an educational plan for residents, the use of universal precautions, the prevention of sexually transmitted diseases, testing for communicable diseases, provision for medical isolation, and confidentiality.

Surveillance and Seroprevalence Studies

A study on HIV prevalence in Ontario jails and detention centres was undertaken in 1992-93. It used an anonymous unlinked method to determine rates of HIV-1 infection among adult and young male and female offenders being admitted to Ontario prisons. Over 11,000 specimens were collected from 42 jails and detention centres over a six-month period. Results of this study are included in Appendix 8 of the *Background Materials.*

Testing for HIV Infection

According to the policy statement in the Communicable Diseases Policy, voluntary testing will be made available to inmates "where clinically indicated or requested," and after informed consent is obtained. Mandatory testing of all new offenders is considered neither legally permissible nor operationally practical or possible "and is not necessary at this time." However, during the initial health-assessment interview at the time of admission, health-care staff are advised to be vigilant for signs and symptoms associated with various communicable diseases.

Youth Corrections:
According to a submission to ECAP, testing is made available "as requested by the young person."[59]

The Communicable Diseases Policy provides that any staff who suspects that a resident may have a communicable disease should report this information to the attending physician, and that the physician will then make a judgment as to whether testing should be recommended. The policy further provides that consent to testing should always be obtained from the young person, and that he/she

57. This paragraph was recently amended to read as follows:

    Hetero and homosexual activity is not permitted in ministry facilities, however, in recognition of the grievous consequences of HIV infection, condoms and dental dams shall be made available in adult and secure young offender facilities.

58. Ministry of Community and Social Services. Understanding and Coping with Blood-Borne Infections Including AIDS, 6 April 1988.

59. Submission to ECAP by Patrick Ford, Project Officer, Operational Coordination Branch, Ontario Ministry of Community and Social Services, dated 8 September 1992.

should not be pressured or coerced into consenting.

Offender Medical Information

With regard to personal medical information relating to offenders with communicable diseases, the policy states that no ministry employee shall disclose such information without proper authorization and that health care confidentiality will be honoured. Generally, the collection, maintenance, use and disclosure of such information shall be governed by the Ministry's *Freedom of Information and Protection of Privacy Policy and Procedures Manual.*

Two notification requirements are set out in the policy: (1) The chief administrator shall be advised by health care personnel of any offender who requires special care due to any communicable disease or any serious medical problem. (2) The local Medical Officer of Health and the Office of the Ministry's Senior Medical Consultant shall be notified of the reportable communicable disease and shall be consulted regarding the ongoing management of the offender.[60]

Youth Corrections:
According to "HIV Infection and AIDS: A Policy Development Framework for Children and Youth Social Services Agencies," only the director of a facility, the medical consultant, and the primary care worker need to know that a client is HIV-positive or "at risk." The document emphasizes that, if universal precautions are in place, there is no need for anyone else to know, and that it would be "risky" for the client if his or her HIV status or "risk" became common knowledge of all staff and clients.

Housing and Activities

According to the "Policy Statement" in the Communicable Diseases Policy, "[n]ormal classification procedures will be followed in those cases where in the view of medical staff health care bed use is not necessary." The Policy provides that the chief administrator of an institution may place any offender in a segregated area of the correctional facility for behavioural or non medical reasons, and proposes the following four-stage process for the medical management of offenders with "serious communicable diseases" including AIDS: (1) offenders with acute cases of communicable diseases including AIDS will be treated in community hospitals; (2) offenders who do not require acute care, but "whose condition indicates more intensive monitoring and/or nursing care, will be placed in the institution health care beds"; (3) offenders who do not require hospitalization or placement in the facility's medical unit, but who cannot be placed in the general population because they have special needs, may be placed in a special needs unit; (4) HIV-infected offenders will be managed as part of the general offender population.

With regard to participation in institutional activities, the policy provides that "the access to correctional programs of offenders requiring medical precautions shall be limited only to the extent required for medical treatment and to the degree required by the risk posed both to the offender and other persons." Where admission to or maintenance in a program is not possible, efforts should be made to provide a comparable, alternative program for the offender.

Youth Corrections:
The Communicable Diseases Policy requires that each facility make provisions for medical isolation of residents who have communicable diseases or infections, but does not contain any provisions on the placement of residents with HIV infection or AIDS.

Educational Programs for Inmates

The Communicable Diseases Policy provides that the ministry "will attempt to provide offenders with information and/or education about communicable

60. AIDS is a reportable disease under regulations pursuant to the *Health Protection and Promotion Act.*

diseases including AIDS and Hepatitis B, consistent with the broad spectrum of literacy skills present in the offender population. All teachers associated with ministry programs shall provide young offenders with the AIDS Education Program which is compulsory in Ontario schools."[61]

Youth Corrections:
According to the Communicable Diseases Policy, an educational plan should be taught to residents in the context of a broader lifeskills curriculum and should be initiated upon admission. The plan should contain the following: a description of different types of communicable diseases, of symptoms, and of modes of transmission; clarification of misconceptions or stereotypes regarding modes of transmission; education about hygiene, universal precautions, and safer-sex practices, including the use of condoms.

Preventive Measures for Inmates

CONDOMS

Condoms have been made available to adult and secure facility young offenders since 18 October 1993. Dental dams have been made available to female offenders. They are available from health-care staff upon request.

Youth Corrections:
The availability of condoms in open custody residences is left to the discretion of the operators of the residences. In most residences condoms are not made available.

BLEACH

A bleach solution is available to staff for cleaning purposes. Bleach is not made available to prisoners.

CLEAN NEEDLES AND SYRINGES

Clean needles and syringes are not made available in Ontario corrections facilities.

Protective Measures for Staff

According to the "Policy Statement" in the Communicable Diseases Policy, staff training in the care and handling of communicable diseases will continue to be provided, with a special focus on HIV/AIDS and hepatitis B. The Policy states that communicable disease training shall be mandatory for all new employees who have contact with offenders and that it shall also be included in refresher courses and basic orientation. Training will be updated as new information becomes available and will emphasize the issue of confidentiality.

A section on universal precautions provides that such precautions "will be practiced throughout ministry facilities and offices," but that from time to time additional precautions "will be required" which will be determined "by physical appearance/symptoms or following clinical examinations by health care staff."

A voluntary vaccination program for hepatitis B is available to all employees whose work assignments involve personal contact with offenders.

Youth Corrections:
The Communicable Diseases Policy contains standards and guidelines according to which the service provider must ensure that all staff are knowledgeable about the facility's policies and procedures regarding communicable diseases. The service provider must also ensure that all persons working in the facility have accurate information about communicable diseases and how to prevent them.

61. For an account of some of the practical problems encountered in producing and distributing educational materials for inmates in Ontario provincial prisons, see the presentation made by Andréa Riesch Toepell at the 7th Annual British Columbia AIDS Conference, which is included in Appendix 8 of the *Background Materials.*

The policy further states that universal precautions should become routine practice within a facility regardless of whether suspected or real infections exist in the facility.

Health Care

The Communicable Diseases Policy only mentions that health-care beds will be provided for infected offenders who require placement for medical reasons, and that provision for continuity of care will be included in pre-release planning for infected offenders.

Tuberculosis

A new, comprehensive Tuberculosis Control Policy was implemented on 2 November 1993.

Youth Corrections:
The Youth Offender Services Communicable Diseases Policy makes no specific mention of tuberculosis.

PRINCE EDWARD ISLAND

In 1990 the Community and Correctional Services division of the Department of Justice and Attorney General published an Infection Control Manual for use in youth and adult custodial centres. Among other things, the Manual contains a section on "Prevention and Management of HIV Infected Residents in Residential Environments;" a policy on "Control of Blood and Body Fluids, and Transmitted Diseases among Offenders in Custody,"[62] whose purpose is to ensure that residents with blood-borne diseases or who are suspected of having blood-borne diseases be managed appropriately; and a policy on "Control of Blood and Body Fluids and Transmitted Diseases in General Line of Duty,"[63] whose purpose is to "ensure that staff have adequate information on the control of blood and body fluids and transmitted diseases."

Staff in both youth and adult corrections are required to familiarize themselves with this Infection Control Manual.[64]

Surveillance and Seroprevalence Studies

There have been no HIV seroprevalence studies among prisoners in provincial prisons in Prince Edward Island, and as of September 1992 there had been no confirmed cases of HIV infection or AIDS within provincial institutions. Only four HIV-antibody tests had been performed, all of which produced negative results.[65]

Testing for HIV Infection

According to a submission to ECAP, inmates may request HIV-antibody testing through the institutional physician. The analysis of the blood is undertaken at the provincial laboratory, and "[a]ll information is confidential to the extent that within our province, coded numbers rather than names are used to identify samples for testing. Inmates have the same rights as the public in this regard."[66]

The Infection Control Manual provides that a request for testing from a resident with a history of high-risk activities associated with HIV infection shall be carried out at the discretion of the centre physician. Those who wish to be tested have to fill

62. Department of Justice and Attorney General, Community and Correctional Services. Infection Control: Control of Blood and Body Fluids, and Transmitted Diseases Among Offenders in Custody (Policy No. 4:03:29P), amended 1 January 1991.
63. Department of Justice and Attorney General, Community and Correctional Services. Infection Control: Control of Blood and Body Fluids and Transmitted Diseases in General Line of Duty (Policy No. 4:03:30P), amended 1 January 1991.
64. Submission to ECAP by Allan J. Curley, Assistant Provincial Administrator of Adult Facilities, dated 1 September 1992.
65. Ibid.
66. Ibid.

out a consent form in which they acknowledge that, should they test positive, the centre physician and nurse, but also "the Centre manager, provincial administrator, probation officer, primary worker, director parent/guardian, and chief medical officer of the Province" need to be made aware of the results. They further acknowledge that they understand that persons who are exposed to their blood or body fluids will need to take appropriate precautions.

Offender Medical Information

According to the policy on "Control of Blood and Body Fluids, and Transmitted Diseases among Offenders in Custody," medical information about residents suspected of or diagnosed as having a bloodborne infection is to be kept in the medical file, with access limited to the centre manager, provincial administrator and medical staff. Only staff who provide direct service or care to a suspected or diagnosed resident will be informed of the resident's state of health.

When a resident is diagnosed or confides in the nurse that he/she has a bloodborne infection, the nurse must advise the resident that this information will be reported to the centre manager. A planning team consisting of nurse, doctor, primary worker, centre manager, provincial administrator, parent/guardian and probation officer, in consultation with the director, shall make decisions about placement, supervision, and medical treatment of the resident.

Housing and Activities

The policy provides that, from a medical perspective, residents with bloodborne infections need not be isolated unless in the opinion of the physician they are considered to pose a risk to other residents and/or staff. The policy states:

> If the resident is not displaying erratic behaviour, he shall not be isolated. Alternate placement will only be made where, in the opinion of the attending physician, the resident poses a risk to self or others.

With regard to activities, the policy on "Control of Blood and Body Fluids and Transmitted Diseases in General Line of Duty" provides that residents who have or are suspected of having a bloodborne infection shall have access to recreational activities, work assignments, visitation privileges, showers and bathroom facilities, food services and other activities, but not to kitchen duty.

Educational Programs for Inmates

According to the Infection Control Manual, Correctional Services will develop and coordinate an educational program directed at staff and residents. This package will include:
(a) educational materials, as part of orientation for staff and for residents entering the system, on how AIDS is transmitted, infection control measures and precautions to minimize the risk of transmission of HIV; and (b) yearly information updates to ensure that staff and residents are kept up-to-date on developments relating to HIV/AIDS.

Preventive Measures for Inmates

CONDOMS

Condoms are not made available to prisoners and there are no plans to provide them in the immediate future.

BLEACH

Bleach is not available and there are no plans to make it available in the immediate future.

CLEAN NEEDLES AND SYRINGES

Clean needles and syringes are not available and there are no plans to make them available in the future.

Protective Measures for Staff

All staff are required to familiarize themselves with the Infection Control Manual. Additional literature on HIV/AIDS is made available to both staff and inmates, and lectures about HIV/AIDS have been given by medical staff.[67]

The policy on "Control of Blood and Body Fluids, and Transmitted Diseases among Offenders in Custody" provides that staff will receive in-service training at least once a year on institutional policies and procedures "directed at promoting good health practices necessary to minimize the risk of transmitting blood borne infections." Further, all new staff will receive an information package and be trained on the control of bloodborne infections.

The policy emphasizes the importance of using precautions universally and states that "[a]ll blood or body fluid spills are to be handled as if infected regardless of source or whether the individual is to be considered high risk."

Hepatitis B immunization is provided to staff on a voluntary basis. Those who choose not to be immunized have to sign a form documenting their choice not to be immunized.

Health Care

A submission to ECAP pointed out that there had so far been no confirmed cases of HIV/AIDS in P.E.I. institutions. However, "if a case were identified and the physician indicated that certain medications of an experimental nature were warranted, that suggestion would be taken under advisement."[68]

The policy on "Control of Blood and Body Fluids, and Transmitted Diseases Among Offenders in Custody" provides for a variety of counselling and support services for infected residents. According to the policy, residents are entitled to receive counselling and support services both before and after examination and tests. A nurse or the centre managers will act as a liaison for assessing the need for medical, psychological and social support services. Infected residents are to receive counselling from medical staff about recommended precautions and prevention procedures. Medical staff are required to ensure that appropriate community, medical and other supports are in place for infected residents as part of discharge planning.

In adult centres, a 36-hour Alcohol and Drug Awareness Program is provided to inmates. This program is essentially a pre-treatment program, and the majority of inmates who take it also attend a four-week in-patient treatment through the province's Addiction Treatment Program.[69]

Tuberculosis

No specific mention is made of tuberculosis in the policies. In practice, all offenders in a custodial centre undergo a physical examination. If an offender tests positive for TB, immediate notification of the test result is made to the province's Chief Medical Officer, and Correctional Services will follow his/her medical directions.[70]

QUEBEC

The infectious diseases policy of the correctional services of Quebec[71] came into force on 1 April 1992 and will be revised every three years.

67. Ibid.
68. Ibid.
69. Ibid.
70. Ibid.
71. Gouvernement du Québec, Ministère de la Sécurité publique, Direction générale des Services correctionnels, Direction de la détention. Politique relative aux maladies infectieuses en milieu carcéral, April 1992.

Accompanying the policy are guidelines for an educational program concerning infectious diseases for inmates and staff,[72] an action plan/needs assessment for 1992-1995,[73] and guidelines for staff exposed to infectious diseases in the course of employment.[74]

The guiding principles of the policy are threefold: (1) The inmate is responsible for his or her behaviour. (2) Institutional personnel must treat all prisoners, including those with infectious diseases, in such a way as to promote dignity and respect for the inmate. (3) The provision of medical services to inmates, including those with infectious diseases, must conform with the protocol "Les services de santé et les services sociaux pour la personne contrevenante" entered into between the Ministry of Health and Social Services and the Ministry of Public Security.

Surveillance and Seroprevalence Studies

A seroprevalence study was undertaken in a provincial medium-security prison for women in Montreal over a long period of time. Testing was voluntary and anonymous. Slightly over seven percent of inmates tested HIV-positive.[75] A similar study was undertaken in two provincial institutions for men in Montreal: the seroprevalence rate among participants in the study was 3.6 percent.[76]

Testing for HIV Infection

The policy does not contain any provisions on the issue of testing.

Offender Medical Information

The policy emphasizes that the general rules governing the confidentiality of medical records apply to all inmates, and allows for only two exceptions where disclosure of information that an offender is HIV-infected or has hepatitis B is allowed: (1) where an inmate has relieved a medical professional of his or her obligation to maintain confidentiality; (2) where it is the opinion of a medical professional that the dangerous and irresponsible behaviour of an inmate known to be infected with HIV or hepatitis B represents a risk of transmission to other inmates or to staff.

Housing and Activities

The policy states that the mere fact of an inmate's being identified as having an infectious disease should not be considered a reason for classifying or reclassifying that inmate or for placing him/her in segregation, except on the advice of medical services.

Educational Programs for Inmates

The policy provides that information and awareness programs concerning AIDS and the transmission of infection in the prison setting will be available to staff and inmates. These programs will be developed locally in consultation with knowledgeable service groups, taking into account the particular circumstances of each institution.

The objectives of the program are fourfold: (1) to provide accurate information on HIV and hepatitis B infection, including the distinction between HIV and AIDS, the significance and limits of HIV testing, the modes of transmission and the

72. Programmes d'information et de sensibilisation sur la problématique des maladies infectieuses en milieu carcéral, April 1992.

73. Plan d'action: Évaluation des besoins 1992-1995, April 1992.

74. Guide de procédures sur les interventions à éffectuer à l'égard d'un intervenant qui a subi une exposition professionnelle dans l'exercise de ses fonctions, April 1992.

75. Hankins C. et al. HIV-1 Infection in a Medium Security Prison for Women – Quebec. *Canada Diseases Weekly Report* 1989; 168:15-33.

76. Hankins C et al. HIV-1 Infection Among Incarcerated Men – Quebec. *Canada Diseases Weekly Report* 1991;17-43:233. For more details about the two studies, see *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons.*

importance of asymptomatic carriers; (2) to distinguish between real and perceived risks of transmission; (3) to help inmates develop skills that can help them prevent transmission of HIV and hepatitis B both during incarceration and upon release; and (4) to help inmates develop non-discriminatory attitudes toward inmates known to be HIV- or hepatitis B-positive.

Staff and inmate educational sessions are delivered either by institutional staff, local resource personnel (departments of community health) or community organizations. Sessions vary from one to four hours and include written and audiovisual materials. Attendance is voluntary. A needs assessment is underway in this area.[77]

Preventive Measures for Inmates

CONDOMS

Condoms have been available in provincial correctional institutions in Quebec since 16 November 1992. Inmates who want to obtain them have to ask for them at the health-care centre of the institution. This method of making them available has been chosen because it makes it possible to combine condom distribution with delivery of an educational message.[78]

BLEACH

Bleach is available in the institutions for cleaning purposes. The educational sessions inform inmates that bleach can be used to disinfect needles, particularly those used for tattooing, but mention is also made of the risks involved in using unclean needles for injecting drugs.[79]

CLEAN NEEDLES AND SYRINGES

Clean needles and syringes are not available in Quebec institutions and no policy of making them available is being considered.[80]

Protective Measures for Staff

The policy states that educational programs for staff about HIV/AIDS will be made available and that they will be developed locally in consultation with knowledgeable service groups, taking into account the particular needs of each institution. Their purpose is: (1) to provide accurate information on HIV and hepatitis B infection, including the distinction between HIV and AIDS, the significance and limits of HIV testing, the modes of transmission and the importance of asymptomatic carriers; (2) to distinguish between real and perceived risks of transmission, including the identification of work-related risks; (3) to provide accurate information on methods of prevention, including universal precautions, with special emphasis on explaining how universal precautions are to be used, especially in crisis situations; and (4) to help staff develop non-discriminatory attitudes toward inmates known to be HIV- or hepatitis B-positive.

Guidelines for staff exposed to infectious diseases in the course of employment have been developed, and involve seven procedures to be followed when exposure occurs: (1) The staff member must, as soon as possible, report the nature and circumstances of the incident to his superior, using the appropriate form. (2) The administration must inform the staff member of the potential risk of transmission of the hepatitis B virus. (3) The administration must also ensure that the staff member is examined by a physician to determine if it is necessary to administer anti-hepatitis B vaccine or immunoglobulins.

77. Submission to ECAP by André Simard, Responsable des Services à la clientèle, Direction de la détention, Direction générale des Services correctionnels, dated 27 November 1992.

78. Ibid.

79. Ibid.

80. Ibid.

(4) The administration must also inform the staff member of the potential risk of HIV transmission and ensure that the staff member is examined by a physician to determine if it is necessary that he or she undergo an HIV-antibody test, including follow-up testing. If an HIV test is deemed necessary, it must be performed as soon as possible after the work-related exposure and with the informed consent of the staff member. (5) The administration must offer the staff member the possibility of appropriate psychological support through the employee assistance program. (6) The administration must ensure that the inmate at the origin of the work-related exposure is examined as soon as possible by health services concerning the potential risk of transmission of HIV or hepatitis B. The administration must also ensure that, insofar as possible, a periodic checkup is performed, where necessary, on the inmate at the origin of the work-related exposure. Any medical intervention must take place only with the informed consent of the inmate at the origin of the work-related exposure.

The guidelines further provide that all medical information concerning inmates at the origin of a work-related exposure, and staff who have had a work-related exposure, is to be kept confidential.

Health Care

Generally, health services are provided by public nursing and privately contracted physicians. In 13 institutions health care is provided, at least in part, by outside community clinics or hospital centres.[81]

Inmates have access to a full range of medical services, and in a majority of institutions they also have access to volunteer support groups such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA). Inmates also have access to public or community programs for intravenous drug users and people with HIV/AIDS on the basis of criteria for temporary absence or conditional release. The institutional physician decides what treatments are appropriate in any given case.

With respect to HIV infection and AIDS, inmates have access to the full range of treatments available in the community. Current regulations prohibit the use of experimental medical treatments on inmates where such treatments could harm the individual.[82]

Tuberculosis

No specific mention is made of tuberculosis in the Quebec policy.

SASKATCHEWAN

A revised policy directive, setting out standards and guidelines for dealing with communicable diseases in the provincial prison system, was issued on 8 August 1989.[83] According to this directive, the Corrections Division's strategy to facilitate management of inmates with infectious diseases includes early identification of "high risk infections," education and training in infection control practices, "reasonable enforcement of prohibitions against high-risk inmate behaviours associated with the transmission of infections," and protection of professional and personal information.

An interdepartmental working group that includes representatives from the Departments of Health, Social Services, Justice (including Corrections), Education, Occupational Health and Safety and the Public Service Commission, has been examining HIV/AIDS issues as they relate specifically to the service areas covered by these departments.[84]

81. Response to ECAP's Working Paper by André Simard, dated 21 September 1993.

82. Submission to ECAP by André Simard, supra, note 77.

83. Saskatchewan Justice – Corrections Division Directive, "Management of Inmates with Communicable Diseases," Directive II – 57 A.

84. Submission to ECAP by Linda Strand, Executive Director, Laboratory and Disease Control Services Branch, Saskatchewan Health, dated 23 September 1992.

Surveillance and Seroprevalence Studies

There have been no studies of HIV seroprevalence among inmates in provincial prisons in Saskatchewan, and there are no plans to undertake such studies in the future. Between 1987 and 1992, five inmates were known who were either HIV-positive or had AIDS.[85]

Testing for HIV Infection

According to the directive, "[a]t this time, no HIV screening program shall be conducted." Testing shall be performed only with the consent of the inmate and the consulting physician. In practice, inmates who request testing are seen by a physician who "determines if testing is appropriate."[86] Anonymous testing is available through the local STD clinic.[87]

Offender Medical Information

With regard to confidentiality, the directive states that "[t]he presence of a communicable disease in an institutional setting can evoke a great deal of turmoil, unnecessary fear, confusion and unprofessional conduct which jeopardizes the security and well being of the institution, as well as violate an individual's right of privacy." Staff have a duty to strictly observe the provisions of Policy Directive II-77 on "Release of Information."

Directive II-57A contains very specific provisions on "Medical Information, Records and Communication," according to which the director of an institution shall be informed as quickly as possible about an inmate who may have a "serious infectious disease for which the physician believes there is a risk of transmission." It is presumed that the director needs to know the identity of such an inmate, the medical diagnosis and the possible implications of the disease for the security of the institution, and the safety of anyone incarcerated, working or visiting in the facility.

Information from an inmate's medical record "ordinarily is limited to those with a need to know, based on medical and security concerns." According to the directive, those who have a need to know are health-care workers assigned to the correctional centre's medical unit, and deputy directors of security and programs.

The directive also contains the following "Procedures to Inform Corrections Workers:"

> Where an institution's physician believes there is a risk of an infection transmission the director shall, upon consultation with the physician, determine the nature and scope of the infected inmate's personal information which should be disclosed to corrections workers. Disclosures may be only to those staff who are in immediate contact with the infected inmate ...

This policy may change if the proposed amendments to the *Public Health Act* are passed, according to which medical information can only be released with the consent of the Medical Health Officer.[88]

With regard to notification of an infected inmate's sexual partner, the directive states that, pursuant to Minister of Health Orders under the *Public Health Act*, the consulting physician is required to report to the medical health officer persons who have certain serious communicable diseases. The institution, through its senior nurse, "shall provide reasonable assistance to the consulting physician or medical health officer in informing the inmate and the inmate's sexual partner about the inmate's

85. Submission to ECAP by Larry Wilson, Director of Institutional Operations, Solicitor General Division, Saskatchewan Justice, dated 11 August 1992.

86. Ibid.

87. Communication from Larry Wilson, Director of Institutional Operations, Solicitor General Division, Saskatchewan Justice, dated 9 December 1993.

88. Ibid.

condition." Conjugal visiting privileges will be suspended until the director of an institution is satisfied that the inmate and spouse are adequately informed about the inmate's condition. Upon reinstatement of the conjugal visiting privilege, the director shall first obtain from the infected inmate's sexual partner written confirmation that he or she has been fully informed about the inmate's infection, understands the implications of the inmate's condition, and wishes that the conjugal visit take place.

Housing and Activities

Upon admission to a provincial correctional centre, a brief inmate health history is to be taken from each new inmate. One of the questions asked is whether the inmate thinks he or she has "a serious disease which might be spread to others." Where an inmate indicates that he or she may have active infectious tuberculosis, hepatitis, AIDS, or has tested positive for HIV antibodies, the admitting officer shall notify the institution's physician or nurse. Until the inmate has been seen by the physician or the nurse, he or she shall not be assigned to a regular population cell. The inmate shall be assumed to be "hygiene poor" (for the purposes of the directive, "hygiene poor" means that the inmate may transmit infection because of poor personal hygiene practices) and housed in a holding place segregated from the general prison population until an assessment, hygiene education and case management plan is arranged. Such planning shall be done as quickly as possible. Upon its completion, inmates deemed to be "hygiene poor," in need of medical segregation, or "otherwise not behaviourally responsible in controlling the spread of his/her disease," shall be housed in a place segregated from the general prison population. Generally, every reasonable attempt shall be made to maintain an inmate who has a communicable disease, including anyone who is HIV-positive, in the general prison population to the extent the inmate's medical condition allows. Inmates may, however, be placed in segregation to protect them and other inmates from "unacceptable tensions and turmoil that could result from the fears or apprehensions of non-infected inmates."

An inmate housed in a segregated area for medical reasons "is entitled to all offender programs to the extent the individual's medical condition allows while maintaining his medical segregated status." Particular attention is to be given to the mental, emotional and social counselling needs of the inmate.

Educational Programs for Inmates

According to the directive, "[i]nmates shall be provided with information regarding the importance of awareness and prevention of infectious diseases. Due consideration shall be given the practical constraints of time and reduced exposure risk associated with short term sentences." According to a submission to ECAP, "[s]ome in-centre educational programming about HIV/AIDS is done with inmates on a voluntary basis; this is provided by medical staff or recognized AIDS groups."[89]

Preventive Measures for Inmates

CONDOMS

Condoms are not made available to inmates, except when they have been approved for conjugal visits and have requested condoms.

BLEACH

Bleach is available in all living units for cleaning-up of blood or body-fluid spills. However, close control of bleach is maintained by staff, and any inmate access to, or use of, bleach is subject to staff monitoring.

89. Submission to ECAP by Larry Wilson, supra, note 85.

CLEAN NEEDLES AND SYRINGES

Clean needles and syringes are not made available to inmates and making them available "is not considered appropriate."[90]

Protective Measures for Staff

The directive provides that every staff person shall receive approximately four hours of basic training on the management of inmates with infectious diseases in a correctional centre. Annual refresher training shall also be provided as required. The stated goal of the training is to provide staff with sufficient practical training so that they can protect themselves and others against the spread of infectious diseases.

In practice, every staff person receives a half-day compulsory training, and additional on-site briefing "may be done when an inmate is admitted who is suspected or confirmed with HIV/AIDS."[91]

The directive emphasizes the importance of employing universal precautions and directs that each program area shall be equipped with sufficient quantities of and easily accessible safety equipment, clothing and supplies.

Health Care

Health-care clinics are part of each major correctional centre; they are staffed by nurses and provide daily health-care services to offenders during the week. The weekend hours of the clinic are reduced. Physician, dental, optometric, and psychiatric services are provided by medical personnel on contract or through community-based clinics. Emergency medical services are provided by local hospitals.

All correctional centres offer drug and alcohol education programs. Offenders requiring treatment are referred to community-based programs.

Saskatchewan correctional centres have limited experience to date in the treatment of offenders with HIV infection or AIDS. Their treatment "has been based upon the physician's direction." Access to experimental therapies "will be dependent on the individual circumstances of the case, and the medical direction provided to us at the time."[92]

Tuberculosis

The directive contains no guidelines on TB testing. It provides for the isolation of patients with pulmonary tuberculosis who have a positive sputum smear or chest x-rays that strongly suggest active tuberculosis.

NORTHWEST TERRITORIES

Both the adult and the young offenders operations manuals of the Corrections Service Division contain a directive on AIDS.[93] As stated in a submission to ECAP, the Young Offender Directive is "the most recent consolidation of all divisional policy on the matter." At the time, the Adult Operations Manual was being completely revised and ECAP was advised that after the revision the Adult Directive would be virtually identical to the Young Offenders Directive.[94] The following summary will therefore focus on the Young Offenders Directive (the "Directive").

90. Ibid.

91. Ibid.

92. Ibid.

93. Department of Justice, Corrections Service Division. Adult Operations Manual, Directive 10.02, "AIDS," dated 1 October 1989; Corrections Service Division. Young Offenders Operations Manual, Directive 12.07, "AIDS," issued 15 January 1990, revised 10 August 1992.

94. Submission to ECAP from Dave Zinck, Program Development Officer, Corrections Service Division, Department of Justice, Government of the Northwest Territories, dated 26 October 1992.

Canadian Prison Policies Relating to HIV/AIDS

Surveillance and Seroprevalence Studies

There have been no seroprevalence studies of inmates in Northwest Territories institutions.

Testing for HIV Infection

The Directive provides that any young offender who has signs or symptoms of HIV infection, who had known contact with an HIV-positive person, or who requests testing "because of multiple sex partners," shall be offered counselling and shall be tested. The Directive further states that, "once testing is completed, the results are confidential," and that testing is repeated at six-month intervals for 18 months.

Offender Medical Information

With regard to confidentiality of medical information, the Directive states that test results are confidential and that they are reviewed by the medical staff only. There is no provision for disclosure of this information to anybody else, including the management of the institution. However, the Directive mentions specifically that positive results require notification to Infectious Disease Control at Public Health in Yellowknife.

Housing and Activities

According to the Directive, "offenders with confirmed HIV infection, but without any infectious secondary diseases or cancers can be housed in any NWT ... facility, and in the same type of accommodation as uninfected young persons." The Directive further states that discrimination towards any person, staff or inmate, who has tested positive for HIV is prohibited, and that segregation shall not be used, except in exceptional circumstances. These include any instance where an individual intentionally attempts "to use the fact of infection to harm or intimidate staff or other persons through mental or physical threats or actions."

Persons with HIV or AIDS shall continue to work and share in the normal routine as long as they are deemed medically fit by the medical officer.

Educational Programs for Inmates

The Directive provides that the manager shall ensure that staff and inmates receive information about HIV/AIDS and emphasizes that "[e]ducation is important to prevent the spread of the disease." Pamphlets shall be given to all offenders upon admission, but lectures shall also be provided. Information given to the inmates shall include: (1) material on HIV and AIDS; (2) how HIV is and is not transmitted; (3) how to protect oneself; and (4) how to "behave towards someone who has AIDS."

Preventive Measures for Inmates

CONDOMS

The Adult Directive of 1 October 1989 was the first Canadian prison policy to allow for the distribution of condoms to inmates. It provided that, "[i]n accordance with World Health Organization Recommendations, inmates may be supplied with condoms in order to prevent the spread of aids [sic]."

The Young Offenders Directive contains more detailed provisions:

> In accordance with World Health Organization recommendations to prevent the spread of AIDS, young offenders shall be supplied with condoms by medical staff, or, in the absence of medical staff, by the Program Coordinator. Information regarding the availability and correct use of condoms shall be included in the orientation of young offenders ...

The Directive further states that offenders should be provided with condoms on request when going on temporary or full release.

BLEACH

The Directive does not address the issue of making bleach available to offenders.

CLEAN NEEDLES AND SYRINGES

The Directive does not address the issue of making clean needles and syringes available to offenders.

Protective Measures for Staff

The Directive emphasizes the importance of education and provision of proper equipment for the practice of universal precautions.

All staff are to be given education and information regarding AIDS, with at least annual updates, and all staff are to take universal precautions.

Health Care

The Directive contains no provisions relating to health care of inmates, but provides for medical counselling of infected persons:

> HIV infected persons should be counselled by medical staff about their potential to infect other individuals and about preventative measures to reduce their risk of infecting others. Equally important, HIV infected persons should be counselled about the likelihood that they will be infected by others with diseases that their immune system will not counteract.

Tuberculosis

The Directives do not mention the issue of TB.

YUKON

An HIV/AIDS policy for adult correctional institutions is being developed and is expected to be released soon.[95] The purpose of the policy is "to outline the Department of Justice's responsibilities with respect to clients and staff who may be infected with HIV." These responsibilities include: (1) making sure that all employees are aware of a policy directive on HIV/AIDS issued by the Public Service Commission that applies to all government employees; (2) ensuring that adequate training, equipment and procedures are in place to protect employees who work with "high risk" populations; and (3) providing clients with access to education and information.

Youth Corrections:

As of September 1992, the Young Offenders Correctional Facility in Whitehorse had no written policies or reports addressing HIV/AIDS. A policy was in draft form, but was not expected to be completed soon.[96]

Surveillance and Seroprevalence Studies

No seroprevalence studies have been undertaken or are planned in Yukon institutions, and statistics on the number of prisoners with HIV infection or AIDS are not routinely collected. To the knowledge of Margaret Joe, Minister of Justice, there had been very few admissions of HIV-positive inmates, and no admission of an inmate with AIDS as of September 1992.[97]

Testing for HIV Infection

The policy states that HIV testing for inmates is not mandatory and that the Corrections Branch

95. Department of Justice, Policy and Procedures, Acquired Immune Deficiency Syndrome (AIDS) Policy, draft.

96. Submission to ECAP by Joyce Hayden, Minister of Health and Social Services, dated 16 September 1992.

97. Submission to ECAP by Margaret Joe, Minister of Justice, dated 24 September 1992.

will contribute towards the prevention of the spread of HIV by, among other things, ensuring the availability of confidential HIV testing for staff and inmates on request, as well as access to confidential follow-up counselling as required.

In practice, all inmates have access to HIV testing on request. Inmates receive pre- and post-test counselling.[98]

Offender Medical Information

The policy states that "inmates have a right to confidentiality about their HIV status" and that "staff will not be informed of an inmate's HIV status unless it is necessary for the medical or security management of the inmate concerned."

Housing and Activities

The policy provides that, since casual contact is not responsible for the spread of HIV, inmates who are known to be HIV-positive "do not need to be kept isolated from the rest of the population," with one exception: inmates who are "threatening to staff" or "indulge in behaviours that support the spread of HIV" may be isolated on the advice of the medical officer and with the approval of the superintendent.

Educational Programs for Inmates

Educational programs for inmates are not regularly scheduled, but given on a sporadic basis.[99] However, it is intended to schedule voluntary educational programs regularly in the future.

Preventive Measures for Inmates

CONDOMS

The policy states that the Corrections Branch will contribute towards the prevention of the spread of HIV by making condoms available on request to inmates on temporary absence, by reducing the likelihood of non-consensual sexual activity between inmates, and by making condoms available to inmates on a confidential basis where consensual sexual activity is occurring.

In practice, condoms are not issued routinely to inmates on admission because the institution in Whitehorse consists largely of dormitory accommodations "affording little privacy or tolerance for consensual sexual activity." However, if "there was a request for condoms, and if the sexual activity was truly consensual, we would make condoms available on a confidential basis from the nurse." Since the fall of 1991 condoms have been issued on release and on temporary absences, if requested.[100]

BLEACH

Bleach is not officially available for the purpose of cleaning tattooing or other needles. However, as indicated by the Minister of Justice in her submission to ECAP, inmates do have "unofficial" access to bleach, since bleach is readily available in the form of a diluted cleaning solution.

CLEAN NEEDLES AND SYRINGES

The policy states that the Corrections Branch will contribute towards the prevention of the spread of HIV by, among other things, "minimising access to tattooing equipment and hypodermic needles by inmates." Consequently, there are no plans to make clean needles and syringes available for drug use.

98. Ibid.

99. Personal communication with Ms. Elizabeth Lane, Superintendent, Whitehorse Correctional Centre, on 10 December 1993.

100. Submission to ECAP by Margaret Joe, supra, note 97.

Protective Measures for Staff

The policy states that the Department of Justice will ensure that adequate training, equipment, and procedures are in place to protect employees who work with "high risk" populations. Staff can voluntarily attend courses on HIV/AIDS in the workplace run by the government's Public Service Commission. A mandatory module on HIV/AIDS and hepatitis B will be included in the Corrections Officer Basic Training Program.[101]

The policy emphasizes the importance of adopting precautions universally:

> [T]he philosophy of the Corrections Branch is to develop and adopt procedures to ensure maximum safety to staff and inmates by using procedures that assume that all inmates are **potentially** HIV positive. Because it is recognized that HIV is not transmitted through casual interactions between individuals, normal institutional activities undertaken by staff and inmates do not pose a risk to inmates or staff.

The policy continues by saying that the Corrections Branch will contribute towards the prevention of the spread of HIV by: (1) using cleaning and hygiene procedures in all areas of a correctional facility consistent with universal measures for AIDS control; (2) ensuring adequate disposal procedures for hypodermic needles and similar sharp objects; and (3) ensuring proper laundry and disposal procedures and facilities for clothing and linen soiled with blood or body fluids.

Health Care

The policy contains no provisions on health care, but provides that inmates who have "full-blown" AIDS will be favourably considered for temporary absence on the advice of the medical officer.

The health-care program is operated by a nurse and a visiting physician under contract. Inmates are provided with access to counsellors and to medical staff for the treatment of drug use. Access to experimental therapies would be permitted on the advice of the institutional physician, depending on institutional and public security concerns.[102]

Tuberculosis

The policy makes no mention of TB. In practice, inmates are encouraged but not required to be tested for TB.

SUMMARY

Surveillance and Seroprevalence Studies

Seroprevalence studies have been undertaken only in the provincial prison systems of British Columbia and of Ontario, and in three provincial prisons in Montreal, Quebec. These studies have consistently revealed much higher rates of HIV infection among prisoners than among the general population. Rates of HIV infection among women inmates were higher than among male inmates, and particularly high rates were found among injection drug users.

Most provincial prison systems report relatively low numbers of known HIV-infected prisoners in their custody.

Testing for HIV infection

No jurisdiction authorizes the involuntary testing of inmates for HIV infection. 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

101. Ibid.

102. Ibid.

is often subject to the approval of the institutional physician. Some policies explicitly encourage inmates to be tested if they exhibit signs of the disease or if they have engaged in "high-risk" activities. Most 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.

Offender Medical Information

The policies generally 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 infected inmates to be informed (in more or less detail) of the inmates' condition. Other policies mandate the disclosure of medical information when there is reason to believe that inmates' conduct poses a danger to themselves or to others.

Housing and Activities

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.

Educational Programs for Inmates

The policies generally stress the importance of establishing educational programs about HIV/AIDS for inmates. 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. 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.

Preventive Measures for Inmates

CONDOMS

The policy of the Northwest Territories was the first policy to allow for making condoms available to inmates. Since the fall of 1991, condoms have been issued to inmates in Yukon on release and on temporary absences. Only after the Solicitor General of Canada decided to make condoms available in federal correctional institutions as of 1 January 1992, did a growing number of provinces, including Alberta, British Columbia, Manitoba, Quebec and Ontario, also start distributing condoms. Each of the provinces has established its own system for making condoms available. Only in provincial correctional institutions in British Columbia (and in some federal institutions), are condoms easily and discreetly available. In Saskatchewan, condoms 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.

BLEACH

The provision of bleach is mentioned only in the draft policy of the British Columbia Corrections Branch. According to this policy, full-strength bleach for inmate use shall be readily available in the institutions. However, bleach is made available to inmates as a general cleaning agent in many institutions.

STERILE NEEDLES AND SYRINGES

The provision of sterile needles is not mentioned in any of the policies. Making them available is generally not being considered.

Protective Measures for Staff

The policies generally stress the importance of establishing educational programs about HIV/AIDS for staff, and 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 conducting 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.

Health Care

Prison policies on HIV/AIDS are generally silent on the topic of medical care. Only a few comment that prisoners have the right to receive adequate medical care. Some provinces have not as yet had any, or have had only very few, prisoners with HIV infection or AIDS in their custody. Generally, prison authorities claim that, in practice, prisoners have or would be given access to medical care equivalent to that outside the institutions.

Tuberculosis

Only few prison systems have policies on TB in place that set out in detail the requirements for testing and procedures to be followed in case a prisoner or staff member has active TB. In all provinces and territories, testing will only be undertaken if medically indicated.

CONCLUSION

This review shows that policies setting out standards and guidelines for dealing with HIV infection in prisons have been issued by all provinces and the Northwest Territories and exist in draft form in Yukon. These policies vary widely in content, but common to all of them 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.

However, in most prison systems, prisoners' access to the means necessary for preventing HIV infection is limited or nonexistent. In a growing number of systems, condoms are now made available to prisoners, but only in British Columbia are they easily and discreetly available. Bleach is informally available to prisoners in many prisons, but rarely is it made available for the purpose of cleaning injection equipment. British Columbia's draft policy on bleach distribution is a model that should be followed by other jurisdictions. Finally, efforts should be made to coordinate provincial and federal programming with regard to HIV/AIDS in prisons. For example, the development of common educational initiatives and of a common model HIV/AIDS policy that could then be adapted to the particularities of the individual systems could be important steps in the effort to prevent

HIV infection in Canadian prisons, and to protect prisoners, staff, and the public from contracting HIV infection.

APPENDIX 2

INTERNATIONAL PRISON POLICIES RELATING TO HIV/AIDS

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.

United Nations

The Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held 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 (World Health Organization) 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."[1] 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.[2] The Latin American and Caribbean Regional Preparatory Meeting proposed basic principles for the treatment of prisoners, including that "[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[3] Finally, the European Preparatory

1. United Nations. Report of the Interregional Meeting for the Eigth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Vienna, 30 May-3 June 1988. U.N. Doc. A/CONF.144/IPM/4, 9 June 1988, para. 50.
2. African Regional Preparatory Meeting for the Eigth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Addis Ababa, Ethiopia, 5-9 June 1989. U.N. Doc. A/CONF.144/RPM.5, 14 August 1989, para. 98.
3. Latin American and Caribbean Regional Preparatory Meeting for the Eigth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, San José, Costa Rica, 8-12 May 1989. U.N. Doc. A/CONF.144/RPM.3, 25 Aug. 1989 at 4.

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.[4]

World Health Organization

1987 STATEMENT FROM THE CONSULTATION ON PREVENTION AND CONTROL OF AIDS IN PRISONS

WHO convened a meeting on prevention and control of AIDS in prisons in November 1987 that resulted in a formal WHO statement.[5] 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 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 those making up the prison population were thought to be "unlikely to have recieved such education in the general community." This corresponds with the view that prisons offer important opportunities for prevention of HIV transmission because a large proportion of high-risk populations pass through them.[6] 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."

4. The Rome Declaration. U.N. Doc. E/AC.57/1990/L.13 at 6.

5. WHO. Statement from the Consultation on Prevention and Control of AIDS in Prisons. Geneva: WHO, 1987.

6. Brewer TF. HIV in Prisons: The Pragmatic Approach. *AIDS* 1991; 5:897.

1993 GUIDELINES ON HIV INFECTION AND AIDS IN PRISONS

At the IXth International Conference on AIDS, held in Berlin from 7-11 June 1993, WHO released revised guidelines on HIV infection and AIDS in prisons. These guidelines were prepared on the basis of technical advice provided to WHO prior to and during a consultation of experts convened in Geneva in September 1992. The consultation included representatives of international and nongovernmental organizations and government departments with a wide range of experience and background in the health, management, and human rights aspects of HIV/AIDS in prisons.

According to the document, "[t]he guidelines provide standards – from a public health perspective – which prison authorities should strive to achieve in their efforts to prevent HIV transmission in prisons and to provide care to those affected by HIV/AIDS."[7]

Nine general principles are listed:

1. All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality.
2. The general principles adopted by national AIDS programmes should apply equally to prisoners and to the community.
3. In each country, specific policies for the prevention of HIV/AIDS in prisons and for the care of HIV-infected prisoners should be defined. These policies and the strategies applied in prisons should be developed through close collaboration among national health authorities, prison administrations, and relevant community representatives, including nongovermental organizations. These strategies should be incorporated into a wider programme of promoting health among prisoners.
4. Preventive measures for HIV/AIDS in prison should be complementary to and compatible with those in the community. Preventive measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injecting drug users and unprotected sexual intercourse. Information and education provided to prisoners should aim to promote realistically achievable changes in attitudes and risk behaviour, both while in prison and after release.
5. The needs of prisoners and others in the prison environment should be taken into account in the planning of national AIDS programmes and community health and primary health care services, and in the distribution of resources, especially in developing countries.
6. The active involvement of nongovernmental organizations, the involvement of prisoners, and the non-discriminatory and humane care of HIV-infected prisoners and of prisoners with AIDS are prerequisites for achieving a credible strategy for preventing HIV transmission.
7. It is important to recognize that any prison environment is greatly influenced by both prison staff and prisoners. Both groups should therefore participate actively in developing and applying effective preventive measures, in disseminating relevant information, and in avoiding discrimination.
8. Prison administrations have a responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike.
9. Independent research in the field of HIV/AIDS among prison populations

7. WHO. WHO Guidelines on HIV Infection and AIDS in Prisons. Geneva: WHO, 1993.

> should be encouraged to shed light on – among other things – successful interventions in prisons. Independent examination by an ethical review committee should be carried out for all research procedures in prisons, and ethical principles must be strictly observed. The results of such studies should be used to benefit prisoners, for example by improving treatment regimens or HIV/AIDS policies in prisons. Prison administrations should not seek to influence the scientific aspects of such research procedures, their interpretation or their publication.[8]

Guidelines were issued for each of the following issues: HIV testing in prisons; preventive measures; management of HIV-infected prisoners; confidentiality in relation to HIV/AIDS; care and support of HIV-infected prisoners; tuberculosis in relation to HIV infection; women prisoners; prisoners in juvenile detention centres; foreign prisoners; semi-liberty and release; early release; contacts with the community and monitoring; resources; and evaluation and research.

Many of the recommendations issued by WHO have been included in the debate sections of *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. The following is a brief summary of some of the most relevant parts of the guidelines.

With regard to HIV testing in prisons, the guidelines stress that voluntary testing should be available in prisons when available in the community, together with adequate pre- and post-test counselling, and that testing should only be carried out with the informed consent of the prisoner. Compulsory testing would be "unethical and ineffective, and should be prohibited."[9] On the issue of preventive measures, the guidelines strongly support making condoms available in prisons. While the 1987 statement recommended that "[c]areful consideration should be given to making condoms available,"[10] the new guidelines unequivocally state that, "[s]ince penetrative sexual intercourse occurs in prison, even when prohibited, condoms should be made available to prisoners throughout their period of detention" and "prior to any form of leave or release."[11] The new guidelines also recommend that:

- in countries where bleach is available to injecting drug users in the community, diluted bleach or another effective viricidal agent should be made available in prisons;
- in countries where clean syringes and needles are made available to injecting drug users in the community, "consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this;"[12]
- prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison; and
- in countries in which methadone maintenance is available to opiate-dependent individuals in the community, this treatment should also be available in prisons.

The guidelines stress the importance of keeping medical information pertaining to inmates confidential. They state that information regarding the HIV status of an inmate 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." In particular, "[r]outine communication of the HIV status of prisoners to the prison administration should never take place."

8. Ibid. at 1-2.
9. Ibid. at 2.
10. WHO 1987, supra, note 5.
11. WHO 1993, supra, note 7 at 3.
12. Ibid. at 4.

As stated by Dr. Michael Merson, Director of the Global Programme on AIDS, the new guidelines "emphasize the link between prisons and the world outside." He added that "[i]ndividuals have the right to health care, including preventive care, whether they are incarcerated or not" and that "if prisoners have access to the same effective prevention methods that are available outside prison, this will benefit everyone." Dr. Merson concluded by saying that "many national AIDS programmes are making encouraging headway in their efforts to prevent new HIV infections and to provide care to people with HIV or AIDS. But these advances in the community now need to be matched by AIDS prevention and care in prisons. Our new guidelines take a realistic approach to what can and should be done in prisons. If they are used to help formulate prison policies, they can make a major contribution to slowing the spread of HIV infection."[13]

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.[14]

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."[15]

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.[16]

In 1993, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) devoted a chapter of its third report to defining "the main issues pursued by CPT delegations when examining

13. WHO Urges Prison Reform to Help Control the Spread of HIV. Press Release Published in Berlin on 10 June 1993 during the IXth International Conference on AIDS (7-11 June 1993).

14. Council of Europe – Recommendation 1080 (1988) on a co-ordinated European health policy to prevent the spread of AIDS in prisons, 30 June 1988, paras. 14A(i) to 14A(viii).

15. Council of Europe – Recommendation No. R (89) 14 of the Committee of Ministers to member states on the ethical issues of HIV infection in the health care and social setting, 24 October 1989, Art. 24.

16. Select Committee of Experts on Criminological and Prison Aspects of the Control of Transmissible Diseases, including AIDS and related Health Problems in Prison (including the problem of treating prisoners who are addicts or AIDS victims). Summary report of the fourth meeting, Strasbourg, 5-7 November 1990. Council of Europe. Doc. PC-R-SI (90)8.

health care services for prisoners."[17] As pointed out by Bertrand and Harding,[18] the Committee has thus created a *de facto* set of guidelines for prison medical services, whose essential elements are: access to a doctor with the direct support of a fully equipped hospital service; equivalence of care to that available in the community; respect of the principles of confidentiality and patient's consent to treatment; and adequate preventive health care. With respect to transmittable diseases, the report contains the following provisions:

54. A prison health care service should ensure that information about transmittable diseases (in particular hepatitis, AIDS, tuberculosis, dermatological infections) is regularly circulated, both to prisoners and to prison staff. Where appropriate, medical control of those with whom a particular prisoner has regular contact (fellow prisoners, prison staff, frequent visitors) should be carried out.

55. As regards more particularly AIDS, appropriate counselling should be provided both before and, if necessary, after any screening test. Prison staff should be provided with ongoing training in the preventive measures to be taken and the attitudes to be adopted regarding HIV-positivity and given appropriate instructions concerning non-discrimination and confidentiality.

56. The CPT wishes to emphasise that there is no medical justification for the segregation of an HIV+ prisoner who is well.

17. Council of Europe. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. 3rd general report, Strasbourg, 1993.

18. Bertrand D., Harding T. European Guidelines on Prison Health. *The Lancet* 1993; 342:253-254.

APPENDIX 3

POLICIES OF SELECTED COUNTRIES RELATING TO HIV/AIDS*

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, if it is 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 sterile 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;

* ECAP's Project Coordinator, Dr Ralf Jürgens, wishes to acknowledge Mr. Glenn Betteridge's assistance in the preparation of Appendix 3.

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 HIV or 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.

ECAP obtained responses to its request for information from Australia, Austria, England and Wales, Finland, France, Germany, Iceland, Italy, the Netherlands, Norway, Portugal, Spain, Switzerland, and the United States.

The following is a review of the information ECAP received. Whenever possible, this information has been supplemented with data from a survey of international literature on HIV/AIDS and prisons undertaken at the McGill Centre for Medicine, Ethics and Law. For each country, the review consists of a brief examination of nine issues relating to HIV/AIDS in prison. Its structure parallels that of the *Working Paper* and the *Final Report*, and most of the issues addressed in them have been included in this review.

Due to time constraints, this review could not be more comprehensive. Those who would like to obtain additional information about other countries' prison policies and practices are referred to the literature mentioned in the text.[1]

AUSTRALIA

In Australia, since criminal law falls mainly within the jurisdiction of the States, it is the State governments and not the Commonwealth government who administer the prisons. It is estimated that the Australian prison population in 1992 was in excess of 14,000,[2] with an incarceration rate, based on 1991 data, of 79 per 100,000 population.[3]

There has been a substantive amount of research undertaken about issues raised by HIV/AIDS in Australian prisons. The information in this section has been taken primarily from three publications that summarize the findings of this research. These are: the report on *AIDS in Australian Prisons* by Hans Heilpern and Sandra Egger,[4] the conference proceedings of a conference on HIV/AIDS and Prisons held on 19-21 November 1990,[5] and a volume on *Issues in HIV/AIDS in the Australian Prison System* edited by Judi Fortuin.[6]

Surveillance and Seroprevalence Studies

As reported in Heilpern and Egger, information on the prevalence of HIV infection and AIDS is not

1. Among others, the following publications can be consulted: Harding TW, Schaller G. HIV/AIDS and Prisons: Updating and Policy Review. A survey covering 55 prison systems in 31 countries, 1992 (can be obtained from the Institute of Legal Medicine, 9, av. de Champel, 1211 Geneva 4, Switzerland); Thomas PA, Moerings M (eds.). *AIDS in Prisons.* UK: Dartmouth, forthcoming (this book will be released in spring of 1994; it contains an in-depth analysis of prison policies and practices in many prison systems); Tomaševski K. *Prison Health. International Standards and National Practices in Europe.* Helsinki: Helsinki Institute for Crime Prevention and Control, 1992 (this book contains an in-depth analysis of the issues raised by provision of health care to prisoners).
2. Kerr S. Management of HIV Antibody Positive Offenders. In Fortuin J (ed.), *Issues in HIV/AIDS in the Australian Prison System.* Canberra, Australia: Australian Institute of Criminology, 1992, 45-64 at 46.
3. Mauer M. *Americans Behind Bars: One Year Later.* Washington, D.C.: Sentencing Project, 1992 at 5.
4. Heilpern H, Egger S. *AIDS in Australian Prisons – Issues and Policy Options.* Canberra: Department of Community Services and Health, 1989.
5. Norberry J, Gaughwin M, Gerull S-A. *HIV/AIDS and Prisons. Proceedings of a Conference held 19-21 November 1990.* Canberra: Australian Institute of Criminology, 1991.
6. *Issues in HIV/AIDS*, supra, note 2.

systematically reported in any one source. Further, different methodologies are used to collect seroprevalence data: compulsory screening of all receptions, voluntary testing of receptions, testing of individuals considered to be at high risk, and voluntary testing on request. The prevalence of HIV infection was reported to be between zero and 2.9 percent, with the highest rate found in women inmates in New South Wales.[7] The cumulative total of known HIV-positive prisoners from 1985 to October 1990 was estimated to be 206, and on 9 November 1990 there were a total of 39 known HIV-positive prisoners in Australian prisons.[8]

A study of HIV prevalence and risk behaviours for HIV transmission in South Australian prisons revealed that during the latter half of 1989, HIV prevalence in South Australian prisoners was 1.4 percent. It was estimated that about 42 percent of prisoners engage in risk behaviours at least once while incarcerated. Prisoners estimated that 36 percent of all prisoners inject drugs intravenously at some stage during their stay and that 12 percent engage in anal intercourse at least once. Interviews with former prisoners who had a history of injection drug use revealed that about half had injected themselves while in prison, that 60 percent shared needles and that most did not clean shared needles adequately.[9]

Testing for HIV Infection

As of late 1990, compulsory testing programs were operating in the prison systems of South Australia, Queensland, Northern Territory and Tasmania for all prisoners and remandees entering the prisons. In New South Wales, mass compulsory screening was introduced in November 1990. In Victoria, prisoners are encouraged to volunteer for the HIV test as part of the reception program. Reluctant prisoners are counselled and encouraged to volunteer. The compliance rate is 99 percent. In Western Australia testing is voluntary, but prisoners who are assessed by medical staff at reception as having engaged in high-risk activities have to undergo compulsory testing. The provision of medical care, the monitoring and management of HIV-positive prisoners, and the collection of statistics on the epidemic are the most often stated objectives of the testing programs. However, as shown by Egger and Heilpern, these objectives are often not being met because of deficiencies in the data collected, lack of adequate monitoring, and failure to systematically collect information on risk factors.[10]

In all States, some pre-test counselling is provided to inmates. However, this is usually limited to information about the test and fails to address medical, psychological and behavioural implications of either a positive or negative test result. All States provide post-test counselling for seropositive prisoners, yet only South Australia and Western Australia offer post-test counselling for prisoners who test negative.[11]

Offender Medical Information

In Victoria, only the medical superintendent is informed if a prisoner tests HIV antibody positive. At the other extreme, in the Northern Territory all prison staff are informed, particularly those who might have direct contact with the infected prisoner. In most other States, the medical superintendent, departmental head and prison superintendent are informed and there is limited disclosure to medical and custodial staff on a "need to know" basis only. In South Australia, in order to advise staff concerning the appropriate management of an infected prisoner, the prison medical service provides written medical advice that is available to staff. This advice merely

7. Heilpern and Egger, supra, note 4 at 29-30.
8. Egger S, Heilpern H. HIV/AIDS and Australian Prisons. In *HIV/AIDS and Prisons*, supra, note 5, 65-83 at 67.
9. Gaughwin MD et al. HIV Prevalence and Risk Behaviours for HIV Transmission in South Australian Prisons. *AIDS* 1991, 5:845-851 at 845.
10. HIV/AIDS and Australian Prisons, supra, note 8 at 66.
11. Ibid. at 72-73.

indicates that the prisoner has a communicable disease but does not specify the precise nature of that illness.

In South Australia, relatives are informed of a prisoner's HIV status if that prisoner applies and is eligible for either home detention, unescorted leave, or a family visit in which the possibility of sexual activity may occur.

Egger and Heilpern have pointed out that in Australia the issue of confidentiality has not assumed such a high profile as in the U.S. Two reasons were given for this: first, the segregation of HIV-positive prisoners or other administrative policies in some States leads to automatic disclosure of prisoners' HIV status; second, in some States the numbers of HIV-infected prisoners have been so small that a case-by-case approach has been possible. The authors concluded by saying that "[t]his situation may change in future and more carefully defined policies will need to be developed."[12]

Housing and Activities

Segregation of HIV-infected prisoners is the favoured option in Australian prison systems. While South Australia, Tasmania, and New South Wales have policies that provide for integration of seropositive prisoners into the general prison population, the other States have policies providing for their segregation. In two systems, HIV-positive prisoners are segregated and accommodated with selected volunteers who have a history of intravenous drug use. This policy is aimed at "reducing the isolation previously experienced by segregated seropositive prisoners and alleviating the financial costs of maintaining a separate AIDS unit."[13]

Educational Programs about HIV/AIDS for Inmates and Staff

All Australian prison systems have HIV/AIDS educational programs in place, and some innovative programs have been developed, in particular peer education programs. However, there are great variations in structure and regularity. In addition, programs are often "hampered by numerous restrictions placed upon them [those responsible for implementing the programs] by their respective departments. While prison authorities have attempted to provide information, education and training to prisoners and prison officers it is unfortunate that the more difficult issues surrounding harm minimisation and drug use and sex in prisons have not been tackled."[14] The following are a few examples of existing programs:

In New South Wales, the HIV/AIDS education program is divided into two stages: information awareness and behavioural change. The first stage involves ongoing lectures and strategy discussions; the second involves setting up staff and prisoner AIDS action committees in each prison, training prisoners in peer-support programs, and encouraging prisoners to participate in ongoing educational strategies such as orientation and pre-release programs, videos, plays and discussion groups. The main theme of the project is self-ownership and self-management of AIDS issues by staff and inmates in every prison. Programs have been tailored to the needs of Aboriginal inmates and to inmates with developmental disabilities. Both safer sex and needle cleaning information is provided.[15]

In Tasmania both entering inmates and new prison officers are required to attend mandatory HIV/AIDS education courses. Staff receive education at primary training, while prisoners receive education within 24 hours of admission

12. Ibid. at 72.
13. Ibid. at 71.
14. Chappell D, Norberry J. HIV/AIDS: Policy Trends in Prisons. In *Issues in HIV/AIDS*, supra, note 2, 23-43 at 39.
15. Heilpern and Egger, supra, note 4 at 52.

and prior to testing. Other voluntary sessions are provided. A mixture of lectures, discussions incorporating videos, and written material is used. Medical staff, psychological staff and community health educators deliver the material.[16]

In South Australia HIV/AIDS education is part of the prison officer training course, and is provided to new inmates. The program for inmates is based on the "Experimental Learning Model," which is grounded in the theory that people learn most effectively when they are involved in deciding what and how they will learn, and are allowed to take responsibility for their learning.[17] Contacts with community groups assist inmates in developing resource contacts with other agencies when released from prison.

Preventive Measures for Inmates

CONDOMS

As of 1990, no Australian system provided condoms or any other safer sex materials, and such distribution was vigourously opposed by prison officers. In 1988 a pilot program was announced by the Health Department in New South Wales to distribute condoms in one institution. The Health Department also delivered condoms to one other institution in the following year. Both initiatives were met by threats of strike by the prison officers and were not implemented. Thousands of condoms delivered to the institution were subsequently destroyed, never having been made available.[18]

BLEACH

According to one source, bleach is not made available for the cleaning of drug injection equipment in most Australian prison systems. According to the source, the only exceptions are New South Wales, where Milton Tablets, a form of concentrated bleach, are available through the prison medical service, and Victoria, where general purpose bleach is available.[19] However, Egger and Heilpern report that bleach is available for other purposes in most systems,[20] and according to Harding and Schaller's survey of 55 prison systems worldwide, disinfectant is available in four Australian prison systems.[21]

STERILE INJECTION EQUIPMENT

No prison system in Australia makes sterile injection equipment available in prisons. The *Prisons (Syringe Prohibition) Amendment Act (1991)* provides increased penalties for the introduction or supply of syringes in prisons, in addition to the already existing penalties for contraband.

Health Care

Heilpern and Egger stated in 1989 that prison medical services had yet to be challenged by the AIDS epidemic because in most systems the number of prisoners with HIV-related illnesses was still very small. The prison medical services in all States and Territories were involved in the pre-test counselling, testing and diagnosis of HIV, but there was little planning for treatment services following diagnosis. In New South Wales and Victoria, there was reliance on community AIDS services for ongoing medical treatment.[22] A unit

16. Ibid.
17. Fitzsimmons L. AIDS Education and Prevention Progams in Correctional Institutions Worldwide. Ottawa: AIDS Information and Education Services Unit, Health Promotion Directorate, Health Services & Promotion Branch, Health and Welfare Canada, 1992 at 8.
18. HIV/AIDS and Australian Prisons, supra, note 8 at 74.
19. Chappell and Norberry, supra, note 14 at 38.
20. HIV/AIDS and Australian Prisons, supra, note 8 at 76.
21. Harding and Schaller, supra, note 1, Table 4.1.
22. Heilpern and Egger, supra, note 4 at 103.

offering a "Lifestyles Program" for HIV-positive prisoners was developed by the Prison AIDS Project of the New South Wales Department of Corrective Services. The program is offered on a voluntary basis to all HIV-positive prisoners, and is organized into three main parts: health and well-being (nutrition and diet, lifestyle, stress management, group work, medical management, spiritual needs), prison management (support networks, work issues, peer education, prison survival kit), and community management (health, support networks, family issues). Importantly, the strategies related to medical management involve full medical screening, prophylactic care where indicated, education and information on HIV treatments, consideration of drug trials, and access to methadone.

Conjugal Visits

As of 1989, no Austalian prison system provided conjugal visits. However, in South Australia private visits at minimum security institutions were allowed, and resocialization leave programs were available to long-term prisoners approaching the end of their sentences.[23]

Early Release of Prisoners with HIV or AIDS

No information was made available to ECAP on this issue.

AUSTRIA

The following information was made available to ECAP by Dr. Jörg Pont, one of the correspondents from the HIV/AIDS in Prisons Information Exchange Network.

Surveillance and Seroprevalence Studies

In 1988-89, 1989-90 and 1991-92 respectively, 19 percent, 15 percent and 10 percent of all inmates admitted to prison in Austria were tested for antibodies to HIV. In 1988-89, 1989-90 and 1991-92 respectively, 0.5 percent, 1.3 percent and 0.9 percent of new admissions to institutions in which more than 80 percent of all new admissions were tested, tested positive.[24]

Fifty-six of 6,854 inmates in Austrian prisons on 27 February 1992 were HIV-infected.

Testing for HIV Infection

HIV-antibody testing is voluntary and available on request in Austrian prisons. Mandatory testing would be against Austrian law. In some correctional centres "surprisingly high" rates of testing on admission are reported, 100 percent in some institutions.

Offender Medical Information

All medical information is confidential, and HIV test results are disclosed only to medical staff. Results may extraordinarily be disclosed to other staff if there is "a *concrete* danger of transmission of the infection (sexual violence for instance) to another inmate." [emphasis in the original]

Housing and Activities

HIV-positive prisoners are housed in the general prison population. With few exceptions, this has not resulted in any problems for the management of the institutions.

23. Ibid. at 89.

24. Institutions in which less than 80 pecent of new admissions were tested were excluded from the study because it was assumed that in these institutions testing had been undertaken primarily of people at increased risk of having contracted HIV infection.

Educational Programs about HIV/AIDS for Inmates and Staff

Educational activities about HIV/AIDS have been provided to prisoners and to staff since 1985. For prisoners, participation in these activities is voluntary, but has been accepted with great interest. For staff, participation is mandatory. Information is provided through group discussions, printed materials and in a face-to-face session between the doctor and the inmate upon admission. Education is delivered by prison doctors, medical experts from the Ministry of Justice and by members of the Austrian "AIDS-Hilfe," a community-based AIDS service organization.

Preventive Measures for Inmates

CONDOMS

In some institutions condoms are available through medical services. Generally, there still is "great concern" about providing prisoners with condoms, and discussion about whether condoms should be made available in all institutions is ongoing.

BLEACH

Bleach is not available in Austrian institutions. However, discussions about whether it should be made available are ongoing.

STERILE INJECTION EQUIPMENT

Sterile needles and syringes are not officially available. However, a black market for clean needles and syringes has grown up in some prisons.

Health Care

Health care is provided to all prisoners by at least one general practitioner in each prison and, whenever necessary, inmates have access to treatment by specialists and in public hospitals. The Pulmonary Centre of the Community of Vienna has five beds in a secured ward for the treatment of inmates with AIDS.[25] In addition, all large correctional facilities have a psychiatrist on permanent staff.

One penal institution (the "Sonderanstalt Wien Favoriten") serves as a special treatment centre for inmates with drug addiction problems. Inmates are either sentenced to detention and treatment in this institution or may request to be transferred to the institution. The methadone substitution program, which in Austria is promoted for treatment-resistant persons dependent on heroin, "is to be maintained during detention" under the supervision of psychiatrists familiar with the program.

Austrian law does not allow for the participation of prisoners in experimental therapies or clinical trials.

Conjugal Visits

Conjugal visits are not permitted in Austrian prisons.

Early Release of Prisoners with HIV or AIDS

No information was provided to ECAP on this issue.

ENGLAND AND WALES

Much of the following information was taken from materials submitted to ECAP by Dr. Roger A. Ralli, Principal Medical Officer at the Directorate of

25. AIDS in Austria: Facts and Legal Situation with Special Regard to the Situation in Prison (1988, Dok.Nr. 5384F) at 8, as submitted to ECAP by Dr. Pont.

Health Care of HM Prison Service.[26] This information was supplemented by a number of articles and reports on HIV/AIDS in prisons in England and Wales.[27]

A policy on HIV/AIDS was issued in October 1991 and is currently under review.[28]

Surveillance and Seroprevalence Studies

During the period March 1985 to April 1991, 344 notifications of HIV-positive prisoners were made to the Prison Service Directorate on the basis of voluntary HIV-antibody screening,[29] and in 1990-91 there were 52 prisoners in custody known to be HIV-positive. On the basis of these data, the Home Office estimated that 0.1 percent of the prison population is infected. However, it has been said that, as the number of tests conducted is unknown, it is impossible to calculate a rate for HIV prevalence in English and Welsh prisons,[30] and that it seems likely that actual rates of infection are much higher. For example, the former Director of Prison Medical Services estimated that between 350 and 500 prisoners were HIV-positive, and the spokesman for the National Association of Probation Officers stated that "the real figure for HIV in prisons is ten times the government's figure."[31]

Testing for HIV Infection

According to the HIV/AIDS Policy, an HIV test will only be carried out if requested by an inmate or if the medical officer advises it on clinical grounds. In either circumstance informed consent is required and pre- and post-test counselling are provided. Prison Service guidelines rule out any form of pressure on inmates to be tested against their will.[32] However, in practice, all prisoners are questioned on reception to establish whether they have engaged in "high risk" activities, and some "high risk" prisoners have been isolated until such time as they "volunteered" to be tested. Those who were found to be seropositive were placed under a Viral Infectivity Restriction (VIR) order, isolated from other prisoners and withdrawn from kitchen work or any other form of work where blood spillage was possible. A report investigating conditions in prisons in England stated the following:

> It is hardly any wonder that, given the prospect of such conditions prisoners who may be concerned about the possibility of having the AIDS virus may be reluctant to express that concern to the prison authorities. We could not imagine conditions more likely to deter a prisoner from doing all in his power to avoid revealing that he was or might be HIV positive than those we saw at Wandsworth. The conditions were a travesty of justice.[33]

In a study of 452 ex-prisoners in 1990, 66 people reported that they were tested for HIV antibodies when last in prison. Thirty-six percent found it an unpleasant experience, 17 percent had not taken the test voluntarily and 55 percent said that they received no counselling.[34]

26. Submission to ECAP by Dr. Roger A. Ralli, Principal Medical Officer, Directorate of Health Care, HM Prison Service, London, dated 28 August 1992.
27. See, e.g., Turnbull PJ, Dolan KA, Stimson GV. *Prisons, HIV and AIDS: Risks and Experiences in Custodial Care.* London: Avert, 1991; Thomas PA. AIDS in Prisons: England and Wales. In *AIDS in Prisons*, supra, note 1.
28. HIV/AIDS: Organization and Procedures at Establishment Level (Circular Instruction 30/1991). Annex A: HIV/AIDS: Prison Service Policy and Practice in England and Wales, October 1991. See also Annex B: Coordinated Care Management of HIV Infected Individuals; Annex C: HIV + AIDS: A Booklet for Prisoners (London: Terrence Higgins Trust, 1991); Annex D: Viral Infectivity Restrictions; and Annex E: HIV/AIDS Operational Guidance Checklist.
29. *AIDS and HIV Infection: A Multidisciplinary Approach In The Prison Environment.* London: H.M. Prison Service, Medical Directorate, 1991 at Section 2, Table C.
30. Turnbull et al., supra, note 27 at 5.
31. AIDS in Prisons: England and Wales. In *AIDS in Prisons*, supra, note 1.
32. HIV/AIDS: Prison Service Policy and Practice in England and Wales, supra, note 28 at 4, para. 16.
33. AIDS in Prisons: England and Wales. In *AIDS in Prisons*, supra, note 1, with reference to the Woolf Report.
34. Turnbull PJ, Dolan KA, Stimson GV. HIV Testing, and the Care and Treatment of HIV Positive People in English Prisons. *AIDS Care* 1993; 5(2):199-206 at 199.

Offender Medical Information

The HIV/AIDS Policy states that "Government policy is strict on the need to preserve medical confidentiality in relation to HIV/AIDS cases, and guidance to managing medical officers and their health care staff is fully in line with that policy." The Policy continues by saying that "[s]ince viral infectivity restrictions may in practice be applied to both HIV and Hepatitis B infected inmates, and disclosure of VIR status does not entail disclosing a diagnosis, it is arguable that disclosure of VIR status on an operational "need to know" basis is not inconsistent with a strict code of medical confidentiality." The document recognizes, however, that this is not a universally held view, and that therefore a decision was made to review viral infectivity restrictions.[35] In practice, given that most prisoners who are suspected of being or who are HIV-positive are isolated, confidentiality is not maintained, and units in which such prisoners are held have been called "AIDS wings."[36]

Housing and Activities

Operating guidelines to prison management recommend that HIV-positive inmates should generally be located in an ordinary prison wing or landing, have access to the same facilities as other inmates, and should not routinely be excluded from particular kinds of employment, education or recreation.[37] Prison management may depart from this recommended practice in individual cases for reasons of good order, discipline, health or safety, including the use of Viral Infectivity Restrictions.[38] These were introduced in 1985 and enable prison medical officers to apply to HIV-positive prisoners a range of discretionary restrictions and precautions that had been developed in the context of hepatitis B. These include location in a single cell or communal cell with prisoners sharing the same VIR status, provision of personal razor, toothbrush and towel, exclusion from employment programs involving machinery, needles, knives and other sharp objects, and any connection with food preparation or distribution.

A study of ex-prisoners in England found that most prisoners who were, or were assumed to be, HIV-positive were accommodated in a "special location," not allowed to associate with other prisoners, and denied access to work or recreational facilities.[39] However, in July 1993 it was announced that segregation of HIV-positive prisoners would be formally abolished soon.

Educational Programs for Inmates and for Staff

An educational package developed by the AIDS Advisory Committee of the Prison Medical Service, "AIDS Inside and Out," was introduced in 1989 and includes a video, a tutor's manual and a pamphlet. The risks from unsafe injection drug use and sexual activity are addressed "in the clearest term both to those who may have had a risky lifestyle before coming into custody and to those who might become involved in HIV risk behaviour in the custodial setting." Leaflets with information about HIV/AIDS targeted at inmates were developed by the Health Information Trust and the Terrence Higgins Trust. They are made available to inmates in the reception area, prison hospital and other suitable locations. Individual counselling is offered as an alternative to group educational programs.

An educational package, "AIDS Inside," has been developed for prison staff and includes a video, a tutor's manual and a pamphlet. Prison officers who volunteer to become HIV educators receive

35. HIV/AIDS: Prison Service Policy and Practice in England and Wales, supra, note 28 at 5, para. 22.

36. AIDS in Prisons: England and Wales. In *AIDS in Prisons*, supra, note 1.

37. HIV/AIDS: Prison Service Policy and Practice in England and Wales, supra, note 28 at 4, paras. 17 to 21.

38. Viral Infectivity Restrictions, supra, note 28.

39. Turnbull et al., supra, note 34 at 199.

four-day training courses covering HIV awareness, HIV and prisons, attitudes, safer sex, safer drug use and an examination of inmate training modules. The tutors are encouraged to develop educational programs lasting one and a half to two hours that address the specific needs of inmates in a particular institution with respect to age and gender and the expected length of incarceration.

Preventive Measures for Inmates

CONDOMS

The HIV/AIDS Policy states that, while "Home Office Ministers have taken the view that everything possible must be done to prevent the spread of HIV infection they have not been convinced that making condoms available for use in prison would be appropriate or helpful." However, some prisons have introduced schemes under which all inmates who are released, and in some cases those going on home leave, have discreet access to a small supply of free condoms.

BLEACH

Bleach is not made available to inmates.

STERILE NEEDLES AND SYRINGES

Sterile needles and syringes are also not made available. In this regard, the HIV/AIDS Policy states that the Prison Service cannot contemplate establishing needle exchange schemes in prisons, and that the Advisory Council on the Misuse of Drugs "has accepted that it would be quite inappropriate in a prison setting to supply needles and syringes for unsupervised use." The Policy continues by saying that in recognition that some inmates will gain access to drugs and continue to share injection equipment in prison, inmates are advised to clean their equipment using soapy water.

Health Care

The Prison Medical Service has for many years been subject to intense criticism that included concern over poorly trained medical and nursing officers. In 1992 the prison health program was radically restructured, and the equivalence principle, according to which prisoners shall receive health care at a level no lower than that available outside prison, was formally recognized. Clinical guidelines have been prepared which recommend that care for HIV-positive inmates should be "proactive, not reactive." According to a working manual entitled "HIV and AIDS: A Multi-Disciplinary Approach in the Prison Environment," all HIV-positive inmates should be monitored physically and psychologically at least every three months; inmates should be given access to AIDS service organizations; early intervention therapy, including prescription of zidovudine (AZT) or other antiretrovirals, as well as primary prophylaxis for pneumocystis carinii pneumonia, should be undertaken; and regular monitoring of haematological and immunological parameters should be performed on HIV-positive inmates on arrival and every six months thereafter.[40]

Conjugal Visits

There are no conjugal visits in prisons in England and Wales, but home leave is currently available for low- or medium-risk offenders irrespective of the nature of their offence, after a third of their sentence has been completed.[41]

Early Release of Prisoners with HIV/AIDS

There are no specific provisions for the early release of prisoners with HIV or AIDS, but there are arrangements for any person who is terminally ill to be released from prison. The HIV/AIDS Policy

40. *AIDS and HIV Infection: A Multidisciplinary Approach*, supra, note 29 at 12.3 to 12.5.

41. AIDS in Prisons: England and Wales. In *AIDS in Prisons*, supra, note 1.

provides that removal from prison to an outside National Health Service hospital or other suitable facility shall be arranged when a patient's condition is such that it cannot be effectively managed in prison.

FINLAND

The following information was made available to ECAP by Dr. Leena Arpo, Chief Medical Officer of the Finlandic Prison Administration. Dr. Arpo pointed out that the HIV epidemic in Finland has not reached the same proportions as in other Western European countries, owing in part to the fact that there are relatively few intravenous drug users. The estimated total number of HIV-positive individuals in the country is 600 (Finland has a population of 5 million). The average number of prisoners is 3,500, and approximately 8,800 persons are sent to prison each year.

There is no official policy statement on HIV infection or other communicable diseases in prisons in Finland. The national AIDS policy and the recommendations of the Council of Europe and of the World Health Organization are followed. These guidelines have been discussed in meetings with prison governors, health-care personnel and other staff. Official guidelines on condom and disinfectant availability have been issued. Guidelines on the prevention of communicable diseases and the management of infected prisoners are under consideration.

Surveillance and Seroprevalence Studies

Approximately 1,000 HIV tests are performed each year in prisons in Finland, of which, on average, one has been positive. Of those tested, 25 percent report a history of injection drug use, but all but one HIV-positive prisoner so far have had such a history.

Testing for HIV Infection

Testing is voluntary, available on request, and is only performed after informed consent has been obtained. It may be recommended to prisoners who have engaged in behaviour that could have put them at risk of contracting HIV infection.

Offender Medical Information

Medical information is confidential and may only be disclosed with the prisoner's informed consent or if provided by law. Test results are known only to health-care personnel.

Housing and Activities

HIV-infected prisoners are housed among the general population.

Educational Programs about HIV/AIDS for Inmates and Staff

Staff receive HIV/AIDS information as part of their basic training and occasionally in lectures in the prisons and seminars. Pamphlets on HIV/AIDS and on drug use are available to prisoners. On arrival and annually thereafter, prisoners also receive a "hygiene kit" containing basic information on health care and risk behaviours. Occasionally, lectures are provided on a voluntary basis to prisoners by prison doctors or outside experts. Health-care staff have expressed the feeling that the level of knowledge concerning HIV among prisoners and staff is good.

Preventive Measures for Inmates

CONDOMS

Condoms have been available to prisoners on release and for prison leave since 1987, and for conjugal visits shortly thereafter. Since the fall of 1991 condoms have been available in prison. It is recommended that they should be available at

least from health-care staff, because condom distribution is considered to be part of health education.

BLEACH

Since January 1992, prisons have to make sure that effective and safe disinfectant is available in the washrooms, and health-care staff should be consulted before selecting the disinfectant. Nurses and other health-care staff have also been advised to teach prisoners how to disinfect needles and syringes.

STERILE INJECTION EQUIPMENT

Clean needles and syringes are not available. As stated by Dr. Arpo, "experience from countries where this is already experimented or will be in the near future, is awaited."

Health Care

The main principle of health care in Finnish prisons is equality with services in the community. Expert consultation both inside and outside the prison is available, and treatment may be provided in a prison hospital or in a hospital outside. Prisoners with HIV go to outside polyclinics for consultation and have access to the same treatments as HIV-infected individuals outside prison. HIV-positive prisoners may participate in clinical trials provided they give informed consent.

There are some drug-free units in the prisons and prison hospitals. Methadone treatment is not available.

Conjugal Visits

Conjugal visits are permitted between steady partners, including partners of the same sex. Condoms are available in the visiting rooms.

Early Release

Early release is possible for prisoners suffering from serious illnesses.

FRANCE

Information about HIV/AIDS in prisons in France was submitted to ECAP by the National Commission on AIDS, which at its plenary session of 12 January 1993 adopted a report and recommendations on prisons, AIDS and confidentiality,[42] and by two correspondents from the HIV/AIDS in Prisons Information Exchange Network.[43]

Surveillance and Seroprevalence Studies

In 1991, 4.3 percent of inmates in French institutions were known to be HIV-infected. This represents an increase of 0.7 percent from the 1988 rate of 3.6 percent. In some institutions, rates of 10 to 15 percent have been reached. The percentage of prisoners with clinically diagnosed AIDS has also risen, from 0.11 percent of the prison population in 1988 to 0.33 percent in 1991.[44]

Testing for HIV Infection

Testing cannot take place without inmate consent but must be offered by medical services to all

42. Conseil national du sida. *Prison, Sida et Confidentialité. Rapport et Avis du Conseil national du sida sur les situations médicales sans absolue confidentialité dans l'univers pénitentiaire.* Paris: The Council, 1993.

43. Submission to ECAP by Mr. Pierre Darbéda, Direction de l'Administration Pénitentiaire, Ministère de la Justice, Paris, dated 14 October 1992; and by Dr. Yves Bissuel, Service Médico-Psychologique Régional, Lyon, dated 16 September 1992.

44. Conseil national du sida, supra, note 42 at 8.

inmates on their arrival at institutions. In 1991, 29,631 tests were made (the total penal population was 50,035 on 31 December 1991). In over a third of French institutions, anonymous testing is now available in so-called "Centres de Dépistage Anonyme et Gratuit." It is planned to increase the availability of such testing.

Offender Medical Information

The National Commission's report contains a comprehensive analysis of confidentiality with respect to HIV/AIDS in French prisons. It acknowledges the importance of respecting confidentiality in prisons as outside, identifies obstacles to ensuring confidentiality in the prison environment, and includes a number of recommendations on how to overcome these obstacles. Emphasis is placed on education of health-care staff, correctional officers, and administrative staff about the importance of respecting the confidentiality of medical information.[45]

Housing and Activities

HIV-infected prisoners are housed in the general prison population and have access to work and other activities.

Educational Programs about HIV/AIDS for Inmates and Staff

Information programs about HIV/AIDS have been carried out in every prison for both inmates and personnel since 1987.

Preventive Measures for Inmates

CONDOMS

According to a survey conducted by the Prison Administration in 1991, condoms were available in 75 percent of institutions. In most institutions, condoms are also given to inmates leaving the prisons on permanent or temporary release. The National Commission on AIDS has recommended that condoms be made more easily and discreetly available and that they be given to every inmate at entry into the prison system.[46]

BLEACH

Bleach is not made available in prisons in France for the purpose of cleaning needles.

STERILE INJECTION EQUIPMENT

Sterile injection equipment is not made available to prisoners.

Health Care

Agreements have been signed between large prisons and hospitals and so-called "centers of information and care for HIV-infected patients" to ensure that HIV-positive inmates enjoy the same level of care as people outside prison.

Conjugal Visits

No information was submitted to ECAP regarding the availability of conjugal visits in French prisons.

Early Release of Prisoners with HIV Infection or AIDS

In the case of serious medical problems and if the conditions of imprisonment have a detrimental

45. Ibid. at 38-41.

46. Ibid. at 36-37.

effect on a prisoner's state of health, pardon and liberation can be granted.[47]

GERMANY

Information about HIV/AIDS in German prisons was sent to ECAP by correspondents from six prison systems. Additional information was taken from an article about "AIDS in German Prisons" by Feest and Stover.[48]

There are 16 "Land" (state) prison systems in Germany, and each has its own rules and policies about HIV/AIDS.

Surveillance and Seroprevalence Studies

It has been estimated that about 1,000 inmates in German prisons are HIV-infected. This estimate is based on large-scale testing in some systems which has shown that on average one to three percent of inmates test HIV-positive. However, HIV prevalence varies considerably from prison to prison. Prisons in rural areas seem to have no HIV-positive inmates, while rates of infection in metropolitan areas can be as high as nine percent. Rates of infection among women are higher than among men, and the vast majority of HIV-positive prisoners have a history of injection drug use. In the prisons in Berlin 95 percent of male and more than 99 percent of female HIV-positive inmates are drug users.

In a survey conducted by the Deutsche AIDS-Hilfe (the main AIDS-service organization) among HIV-positive prisoners, more than 90 percent of these prisoners claimed to have had experience with drugs; more than 80 percent said that illegal drugs are available in their prison; more than 70 percent claimed that they had been infected through syringe- or needle-sharing. Empirical data show that 40 to 50 percent of injection drug users with prison experience continue injecting drugs while in prison.

Nearly 20 percent of injection drug users who participated in a large epidemiological study were HIV-infected, and about 60 per cent of them had served a prison sentence. While only 10 percent of participants with no prison experience tested HIV-positive, 26 percent of those with prison experience tested HIV-positive, and 67 percent of participants indicated that they continued to inject while in prison. Another study found that HIV prevalence among injection drug users with prison experience was nearly twice as high (23.7 percent) as among users with no prison experience (12.5 percent).

In the survey conducted by the Deutsche AIDS-Hilfe, about 17 percent of HIV-positive participants stated that they believe that they acquired HIV infection while in prison. The author of the study commented: "Probably many justice ministries will say that this is a subjective opinion not supported by hard evidence. I ask myself, however, why these prisoners should give false testimony."[49]

Testing for HIV Infection

Only in Bavaria does the law allow for compulsory testing of persons belonging to "high-risk groups." In practice, in Bavaria testing is carried out on a "voluntary" basis, but with the explicit threat that forced testing is permitted by law. Almost all prisoners "volunteer" to be tested. Prisoners are tested during the intake medical examination and also at the time of release from prison. In other German states prisoners are encouraged to be tested, and up to 90 percent agree to take the test. However, the main reason why so many prisoners agree is that those who refuse are

47. Art.17 of the Constitution of 1958. The power is vested in the President of the Republic.

48. Feest J, Stöver H. AIDS in German Prisons. In *AIDS in Prisons*, supra, note 1.

49. Ibid.

treated as if they were HIV-positive. This is the explicit policy in some systems.[50]

On the other hand, in the prison system of Bremen testing is not only truly voluntary but also anonymous.

Offender Medical Information

Rules regarding confidentiality of offender medical information vary from one prison system to the other. In some systems, test results are disclosed to the prison administration, which will then decide, on a case-to-case basis, whether there is a "need to know" for other staff. It has been said that "in practice confidentiality of health status is not honoured," and that staff "are either informed officially and directly or acquire this information through the rumour network."[51]

Housing and Activities

The restrictions that identified HIV-positive prisoners may experience vary from state to state. Originally in many systems they were excluded from certain types of work, such as in kitchens or barber shops. These restrictions have been lifted in some states.

With regard to housing, prisoners with HIV infection are normally placed in single-occupancy cells, and may share a cell only if they inform the other occupant of their health status. Prisoners have found it more difficult to receive "relaxations" such as home leave, and it has been claimed that this may be because of fear of adverse press coverage. However, seropositive prisoners may receive a special diet that includes dairy products and fruits. Special medical attention may be provided and in some systems they are given preferential access to the prisons' methadone programs. They may also be offered preferential access to "drug-free areas."

Educational Programs about HIV/AIDS for Inmates and Staff

There exists a variety of educational programs for inmates and staff in German prisons, but in many systems these are limited to provision of written information.

Preventive Measures for Inmates

CONDOMS

All respondents reported that condoms are available to inmates in their respective prison systems. In some systems condoms are available free, for example at medical services, while in other systems condoms have to be purchased.

BLEACH

Bleach is not made available in German prisons for the purpose of cleaning needles.

STERILE INJECTION EQUIPMENT

Needles and syringes are not made available in prisons. However, as pointed out by Feest and Stover, "there is a growing body of opinion which favours the distribution of clean needles as a way of controlling the spread of the HIV virus [sic]." The movement is assisted by the acceptance of needle exchange programs outside prison as a regular feature of HIV/AIDS prevention. Supporters of needle provision argue that needles are already available in prisons and that the shortage of such equipment does not deter prisoners from using or starting to use drugs. They have stated: "Indeed, the reverse is true in that the shortages lead to extensive needle sharing or the manufacture of even more dangerous equipment such as sharpened ball point pens. Prison life is such as to bring people inevitably into contact with drugs either through officially administered psychotropic

50. Ibid.

51. Ibid.

or sedative drugs or through the culture of prison life. The introduction of clean needles would safeguard existing drug users from HIV and hepatitis B infection."[52]

Health Care

No information was available to ECAP on quality and accessibility of medical care.

Methadone has become part of prison medical treatment by some physicians for injection drug users. It is seen as an alternative HIV/AIDS prevention strategy in that oral application and the blocking of the craving for heroin is supposed to stop drug injecting and needle sharing.[53]

Conjugal Visits

Conjugal visits are not available in German prisons. However, so-called "long-term" visits by families of long-term prisoners are now being practised on an experimental basis in a few prisons.

Another important feature of the German prison systems is the development of what is known as "Lockerungen" (relaxing of the rules). These include home leave and work furloughs. There are now on average more than seven home leaves per prisoner per year. More than a third of all prisoners go on home leave for the maximum 21 days per year allowed by law. It has been said that these "Lockerungen" affect nearly every aspect of prison life, from sexual activity to availability of drugs.

Early Release of Prisoners with HIV or AIDS

Prisoners can be "paroled" after having served two-thirds or, under exceptional circumstances, half of their sentence. A clause in the German *Code of Criminal Procedure* allows for the release of prisoners with grave illnesses, particularly if their lives are in danger. However, this clause is rarely used, and prisoners are normally sent to prison hospitals in such cases. Even with terminally ill prisoners early release is not guaranteed, especially if new offences cannot be excluded.[54]

ICELAND

The following information was sent to ECAP by Dr. Sigurdur Arnason, Medical Officer of the Icelandic Correctional Administration.[55] Dr. Arnason pointed out that Iceland is a small country with a population of less than 250,000 people and that, accordingly, HIV/AIDS is a relatively minor problem in Icelandic prisons. He further said that the prison system has developed policies together with the "HIV/AIDS team" in the general community and that the policy was to treat persons with HIV or AIDS the same way on both sides of the prison walls.

Surveillance and Seroprevalence Studies

At any one time, of the approximately 120 prisoners in Iceland, one or two is HIV-positive.

52. Ibid.

53. Ibid.

54. Ibid.

55. Submission to ECAP by Sigurdur Arnason, M.D., Medical Officer of the Icelandic Correctional Administration, dated 26 November 1992.

Testing for HIV Infection

The medical examination undertaken shortly after entry into the prison system has included an HIV test since 1985. However, informed consent needs to be obtained as a precondition for carrying out the test. During imprisonment, retesting is available on request. Pre- and post-test counselling is given by the medical staff and/or the HIV/AIDS team "as needed or on request."

Offender Medical Information

All medical information, including HIV test results, is strictly confidential. Test results are not disclosed to prison staff or family members.

Housing and Activities

Prisoners with HIV or AIDS are housed among the general prison population.

Educational Programs about HIV/AIDS for Inmates and Staff

At entry into prison all inmates are educated about HIV/AIDS by the prison doctor and nurse. Thereafter, written materials are available to all inmates, and "verbal" education is available on request.

Preventive Measures for Inmates

CONDOMS

Condoms have been available on request since 1987.

BLEACH

Bleach is only accessible to prison staff.

STERILE INJECTION EQUIPMENT

Prisoners have no legal access to syringes or needles. As stated by Dr. Arnason, "known intraprisonal iv abuse is a very rare thing in Iceland."

Health Care

Every prisoner undergoes a medical examination by a prison doctor shortly after arrival. This includes a general physical examination and blood tests, including blood count, liver test, and test for hepatitis B. All prisoners have access to medical specialists both in the community and in general hospitals, and to alcohol and drug use treatment programs. Prisoners have access to experimental treatments, and the same rules apply to them with regard to eligibility, consent, etc. as to people in the general population.

Conjugal Visits

Conjugal visits are permitted.

Early Release

Prisoners with AIDS have the same possibility to be released on medical grounds as persons with other grave diseases such as cancer.

ITALY

Information about HIV/AIDS in Italian prisons was submitted to ECAP by Ms. Morelli of the Centre for AIDS Studies of San Raffaele Hospital in Milan.[56]

56. Submission to ECAP by Daniela Morelli, Centro Studi AIDS, H San Raffaele, Milan, dated 27 October 1992.

Surveillance and Seroprevalence Studies

Of the 46,968 inmates in Italian prisons on 31 December 1992, 3,530 (7.1 percent) were known to be HIV-infected. In 1992, 40,848 of 94,363 new admissions to prisons were tested, and of these 5,054 were HIV-infected.

Testing for HIV Infection

Italian law does not allow for compulsory testing.[57] Testing is offered to every inmate in the course of the intake medical examination on a voluntary basis. However, Italian prison physicians, in agreement with the prison administration, have maintained that it would be beneficial to submit all inmates to compulsory testing for HIV infection. They claim that objections to compulsory testing expressed by the Italian National Commission on AIDS and by the Council of Europe are "due to a scarce knowledge of the effective living conditions in Italian prisons."[58]

Offender Medical Information

Test results are only available to medical staff.

Housing and Activities

All HIV-positive inmates are housed among the general population and are assigned to all working activities. However, they are excluded from kitchen work and food distribution. This is done not because of risk of transmission but because of fear of reaction from other inmates and staff.[59]

Educational Programs about HIV/AIDS for Inmates and Staff

In most regions, educational sessions about HIV/AIDS have been given to staff. No information was provided to ECAP regarding education of inmates.

Preventive Measures for Inmates

CONDOMS

Condoms are made available in some institutions on a trial basis.[60]

BLEACH

No information was provided to ECAP regarding availability of bleach.

STERILE INJECTION EQUIPMENT

Such equipment is not made available to inmates in Italian prisons.

Health Care

Italian law requires that inmates be given medical care of the same quality as is available to people outside prison. The prison administration guarantees access to basic medical care in prison, while for specialized or diagnostic treatment agreements have been made that allow for access to private medical specialists or to the National Health System.

Conjugal Visits

Conjugal visits are not permitted in Italian prisons.

57. Art. 5, legge 135/1990.

58. Monarca R. *et al.* HIV Infection Among Italian Prisoners. The Incompatibility of AIDS Diagnosis and Imprisonment. Presentation made at the IXth International Conference on AIDS in Berlin, 6-11 June 1993 (WS-D11-2).

59. Ibid.

60. Submission to ECAP by D. Morelli, supra, note 56.

Early Release of Prisoners with HIV or AIDS

In 1993, two laws were adopted establishing that the presence of AIDS in an individual is incompatible with that person's imprisonment. These laws also apply to all seropositive inmates with a "serious" or "considerable" immunodeficiency.

THE NETHERLANDS

Most of the following information was made available to ECAP by Dr. Hans de Man, Medical Inspector at the Dutch Ministry of Justice in The Hague.[61]

A policy document on HIV/AIDS in prisons was released in August 1987 and is still in effect. According to the policy, "every prisoner, male, female or young adult, should be considered as seropositive, and all measures of prevention should be taken in every contact with blood or other bodily fluids."[62]

Surveillance and Seroprevalence Studies

The 1991 Annual Report of the Ministry of Justice's Medical Inspectors reported that 172 of approximately 21,000 detainees admitted being HIV-positive when they entered prison; 405 detainees requested HIV-testing during their detention; 348 requests were granted by the prison physician, and 22 of those tested were HIV-positive. On 35 occasions a doctor took the initiative and proposed that a particular detainee consent to being tested, and of these persons six proved to be HIV-positive. In 1991, 24 prisoners were registered as having AIDS: in 18 instances, the diagnosis was established outside prison, while the other six were diagnosed inside. In comparison with the preceding year, these figures show an increase across the entire range of categories. Based on the numbers of injection drug users who are in prison and the high prevalence of HIV infection among them, it has been claimed that the actual rates of HIV infection in prisons are much higher, and that about 500 inmates (eight percent of the prison population) are HIV-infected.[63]

An unlinked seroprevalence study of over 1,000 male and female prisoners in eight different correctional institutions in the Netherlands was initiated late in 1992. Results of this study were not available to ECAP at the time of writing.

Testing for HIV Infection

Voluntary, on-demand testing is available, and is accompanied by pre- and post-test counselling. Doctors may advise testing on the basis of clinical indications or risk behaviour.

Offender Medical Information

Test results are available only to doctors and nurses. Results are not reported to correctional officers, or to prison or other government officials.

Housing and Activities

HIV-positive prisoners are housed among the general prison population, and may be segregated only if their behaviour warrants it.

Educational Programs about HIV/AIDS for Inmates and Staff

HIV/AIDS educational programs, as well as those relating to drug use, are offered in all institutions.

61. Submission to ECAP by Dr. Th.J. Hans de Man, Medical Inspector, Ministry of Justice, dated 22 September 1992.

62. Ibid.

63. Moerings M. Prisons and AIDS in the Netherlands. In *AIDS in Prisons*, supra, note 1.

All programs are voluntary, but attendance is strongly encouraged. Local consultation bureaus for alcohol and drugs assist in organizing the programs. In 1990 the Dutch Prison Administration began training nurses in all institutions, with the aim of developing a skilled network of teachers.

Preventive Measures for Inmates

CONDOMS

According to the 1987 policy, condoms shall be made available in prisons at regular shop prices to any prisoner who wishes to obtain them. In practice, they are available from prison shops or medical services, and are "meant to be used during the unwatched conjugal visits." However, "the interest of the inmates for condoms has been very disappointing."[64]

BLEACH

As of September 1992, bleach was not available for the purpose of cleaning syringes. However, there were plans to introduce diluted bleach for cleaning sanitary facilities in prison cells.[65]

STERILE INJECTION EQUIPMENT

Clean needles and syringes are not available. The possession and use of needles and syringes is severely punished.

Health Care

To the extent possible, health services to the prison population are equal to those in the community. All prisons and remand houses have a medical service with nurses and part-time general practitioners. Where indicated, inmates may be admitted to the prison hospital in Scheveningen or taken to specialists in a civilian hospital. Inmates have access to experimental therapies.[66]

Some prisons have developed so-called "drug-free units" for persons dependent on drugs. Anyone wishing to be placed in such a unit must sign a contract permitting urine-testing for drugs. The prisoners, in groups of 12 to 24 inmates, reside in units that have treatment facilities but do not provide methadone. Demonstrable involvement with drugs results in transfer back to a standard-regime unit/prison. It is also possible, under Section 47 of the Prison Regulations, that prisoners be transferred to a drug-withdrawal or treatment centre for the last six months of their sentence. A number of so-called "withdrawal farms" have been established for this purpose. Prisoners can choose to continue treatment in such an institution even when their period of detention is over.[67]

Conjugal Visits

Monthly conjugal visits in an unsupervised room are permitted in prisons housing long-term prisoners. In open prisons, where residents can spend the last few months of their sentences, weekend leaves of absence are granted.

Early Release of Prisoners with HIV or AIDS

Prisoners with AIDS may be admitted to a prison hospital or released on parole in the final stages of illness.

NORWAY

The following information was compiled from two sources: a submission to ECAP received from Ms.

64. Submission to ECAP by Dr. Hans de Man, supra, note 61.

65. Ibid.

66. Ibid.

67. Prisons and AIDS in the Netherlands, supra, note 63.

Sundrehagen, Acting Assistant Director General, Directorate of Health of Norway;[68] and the article on AIDS in Norwegian prisons by Lill Scherdin from the Department of Criminology of the University of Oslo.[69]

There were about 12,000 persons in prison in Norway during 1992, with a daily average number of about 2,500.

Surveillance and Seroprevalence Studies

The entire population in the national prisons Ullersmo, Bredtveit and Ila were tested during the years 1985 to 1989. The tests were voluntary. Of those tested, 65 percent admitted to using drugs. All the HIV positives were found in this latter group. A minimum prevalence of 10 percent was found among the drug users. At this time the official estimate was that 70 to 80 percent of drug users outside prison had been tested and the prevalence in the entire group was estimated at around 7 percent. The higher percentage in prison accorded with the belief that the hardest, most active users with the longest user careers were in prison.[70]

In January of 1993 the Directorate of Health estimated that there are between ten and twenty HIV-positive inmates (among approximately 2,500 inmates) in Norwegian prisons at any given time.

Testing for HIV Infection

Testing for HIV infection can only be undertaken with the informed consent of the prisoner.

Offender Medical Information

ECAP received no information about the issue of confidentiality of offender medical information.

Housing and Activities

In one prison, for a short period in 1985, the prisoners demanded that inmates with HIV infection be housed in a special section of the prison. However, education and awareness reduced the alarm of prisoners and the demand for isolation was withdrawn.[71]

Educational Programs about HIV/AIDS for Inmates and Staff

Employees responsible for the care of prisoners and prison health services have all received information and training on HIV and AIDS. Information and teaching material has been developed for both employees and inmates.

Preventive Measures for Inmates

CONDOMS

In 1990 the Prison Board issued instructions on HIV/AIDS in prisons. In accordance with these instructions, condoms have been made available. However, they are not always discreetly available, and in some institutions inmates have to request sheets and condoms from a correctional officer outside the visiting room.

BLEACH

In January of 1993, the Directorate of Health acknowledged that, despite measures to prohibit it,

68. Submission to ECAP by Hilde Sundrehagen, Acting Assistant Director General, Directorate of Health, Oslo, dated 6 July 1993.

69. Scherdin L. AIDS in Norwegian Prisons. In *AIDS in Prisons*, supra, note 1.

70. Ibid.

71. Ibid.

injection drug use is found in prisons and that, because access to sterile injection equipment "is not easy," situations involving serious risk of infection may arise. Already in 1987 it had been stated that "in conneection with general preventive measures in relation to the HIV-epidemic, the prison health personnel should instruct the prisoners individually on the rinsing of needles." The Directorate of Health stated that it would continually emphasize the importance of making chlorine available to inmates, in accordance with the instructions issued in 1990 by the Prison Board.

Prisoners who were interviewed about availability of bleach indicated that nowhere was it easily or widely available, although access to it was possible through the prisoner in charge of cleaning. Prisoners generally thought that there would be no difficulty in obtaining bleach, though none had tried.[72]

STERILE INJECTION EQUIPMENT

Sterile injection equipment is not made available in prisons in Norway.

Health Care

The prison health-care system is at present undergoing great changes. The responsibility for health care of prisoners was transferred from the Ministry of Justice to the Ministry of Health and Social Affairs in 1988 with the objective of ensuring that inmates would receive the same standard of care as the general population. The prison health-care services are now an integrated part of the ordinary public health services, and are run by the municipal and regional health administrations.

Conjugal Visits

The Prison Law of 1958 does not forbid conjugal visits. In practice, prisons have suites for such visits. However, these are not totally private, as correctional officers may look in from time to time. The situation, limited time, tension and uninviting accommodation often result in the room being used as an opportunity solely to talk.[73]

Early Release of Prisoners with HIV or AIDS

Leave is granted from prison after one-third of the sentence is completed. This is a discretionary process exercised by prison authorities. However, reasons must be given if leave is denied. The maximum period is 18 days a year and 24 days for those on contract wards. The maximum block of leave is five days, which is normally unsupervised.

Leave for medical treatment is based on the right to receive such treatment as if prisoners were members of the public. If the prison medical service is unable to provide treatment, the prisoner may be given leave.[74]

In a document produced by the Directorate of Health in January 1993, it is stated that "HIV-positive persons with serious HIV-infection or AIDS require special attention. Such patients should not be in prison. The Prison Board points out that ... early parole, transfer to hospital or institution where the prisoner can be given proper medical treatment, should be considered."

PORTUGAL

The following information was made available to ECAP by Ms. Teresa Alves Martins, one of the

72. Ibid.

73. Ibid.

74. Ibid.

correspondents of the HIV/AIDS in Prisons Information Exchange Network.

Surveillance and Seroprevalence Studies

In 1987, the whole prison population in Portugal was screened "in order to evaluate the health condition of the prison population." Testing for antibodies to HIV was voluntary and anonymous, and questionnaires were handed out to obtain data on risk behaviours of prisoners prior to their entry into the prison system. Approximately 90 percent of inmates underwent testing. From 1988 to 1990 screening was undertaken only in selected prisons in Portugal. Results from the last screening, undertaken in 1990, are as follows:

- In one prison in northern Portugal, 0.9 percent of 1651 inmates tested HIV-positive. Ninety-two percent of inmates underwent testing.
- In two prisons in the region of Coimbra, 0.3 and 1 percent respectively of inmates tested HIV-positive.

In prisons in the region of Lisbon, results were as follows:

- In the prison of Caxias, 86 percent of inmates underwent testing and 3.4 percent were HIV-positive.
- In the prison of Linho, all prisoners were tested and 1.1 percent tested HIV-positive.
- In the prison of Tires, a prison for women, all prisoners were tested and 3.8 percent were HIV-positive.

Testing for HIV Infection

Testing may occur, upon medical order, on the basis of a "suspicion of the disease." Testing will also be undertaken before a prisoner undergoes surgery. Furthermore, as established in the penitentiary law, inmates are entitled to any medical exams and tests at their own expense.

Offender Medical Information

Portuguese law requires that medical information not be disclosed without the consent of the patient. In prisons, only the physician and nurses have access to the information contained in the medical files.

Housing and Activities

HIV-positive prisoners are not segregated and remain in the general prison population. Prisoners who require treatment for HIV-related illnesses are sent to the prison hospital and, if they recover, they return to the general population.

Educational Programs about HIV/AIDS for Inmates and Staff

In 1987 the Prison Administration undertook HIV/AIDS education campaigns in all institutions, with the aim of informing both prisoners and staff about HIV/AIDS, risks of infection, and prevention methods. Informal meetings, conducted by a medical team composed of physicians from outside and prison physicians, were held in each prison. These meetings were held separately for inmates and for staff, and attendance was voluntary. Videos were shown and inmates and staff were encouraged to participate and discuss their problems and to raise questions. Educational programs were delivered until 1991, but on a much smaller scale. Recently, a commission for the promotion of health in prisons was established, and it is expected that educational initiatives will be carried out on a more regular basis in future.

Preventive Measures for Inmates

CONDOMS

In 1989 the Director General of the Prison Administration instructed the prison governors of all institutions to make condoms available for sale. Condoms are usually available in the canteens,

and in one prison they are sold in cigarette vending machines. In her submission to ECAP, Ms. Martins reported that it was being planned to include condoms in an "exit kit" to be given to every inmate leaving an institution. Prisoners would also be given condoms in a "hygienic kit" at entry into the prison system, and they will be made available on the ranges and in the toilet areas.

BLEACH

In 1992 bleach was made available to inmates for "hygienic reasons" in some institutions. It is planned to extend the initiative to the remaining institutions.

STERILE INJECTION EQUIPMENT

Sterile needles and syringes are not available, and there are no plans to make them available in the future.

Health Care

According to Portuguese law, all prisoners have to be examined within 72 hours of their entry into prison. They have access to the same health care and treatment as the general population, including treatment in civil hospitals. Prisoners may participate in experimental therapies or clinical trials, provided they give informed consent.

Conjugal Visits

Conjugal visits are only available as a pilot project in one prison near Lisbon.

Early Release of Prisoners with HIV or AIDS

Early release is granted within the provisions of existing law.

SPAIN

In 1989 a program for the prevention and control of AIDS was implemented in all Spanish prisons. A summary of the components of this program was submitted to ECAP, and most of the information contained in the following section has been taken from it.[75]

Surveillance and Seroprevalence Studies

According to a document prepared for the seminar on prison health care held in Tampere, Finland from 24-27 September 1991[76] 24 percent of male prisoners, 26 percent of female prisoners, 31 percent of prisoners under 21 years of age, and 55.4 percent of injection drug users in Spanish prisons, test positive for antibodies to HIV at entry into the prison system.

Testing for HIV Infection

HIV-antibody testing is offered to all inmates on a voluntary basis at entry into prison and while incarcerated. Pre-test counselling can often not be given to inmates who are tested at entry into the prison system because of time constraints, but all inmates are informed about the test and their right to refuse being tested. Post-test counselling is always provided by the prison primary-care physician.

75. Program for the Prevention and Control of AIDS in Spanish Prisons. Ministry of Justice, Director General of Penitentiary Institutions, May 1992.

76. Ministerio de Justicia, Secretaria General de Asuntos Penitenciarios. La salud en las prisones – objetivos, normas y etica – servicios medicos en los centros penitenciarios espanoles. Informe para el Consejo de Europa. Seminario de Tampere (Finlandia), 24-27 de Septiembre. July 1991.

Offender Medical Information

HIV-antibody test results are kept strictly confidential. Only the inmate and a physician have access to medical information.

Housing and Activities

Seropositive inmates are not isolated or segregated in any way, and they are not excluded from any work, educational or recreational activities, unless segregation is necessary for medical reasons, for example when an inmate has pulmonary tuberculosis.

Educational Programs about HIV/AIDS for Inmates and Staff

Health education activities about HIV/AIDS, risk factors, and prevention of infection are provided in all Spanish prisons. Such activities are varied, and include distribution of written materials, conferences, and individual counselling. Several videos produced by the Department of Corrections are also available.

Preventive Measures for Inmates

CONDOMS

Condoms are distributed free of charge in all Spanish prisons. They are included in sanitary kits that inmates receive at entry and monthly thereafter, in the rooms used for conjugal visits, and on the ranges in such a way that inmates do not have to ask for them.

BLEACH

Bleach is also included in the sanitary kits prisoners receive upon entry and monthly thereafter. Additional supplies are provided whenever needed. Instructions on use are given as part of the prison health education activities.

STERILE INJECTION EQUIPMENT

Sterile needles and syringes are not made available in prisons in Spain. With the exception of two cities that have introduced syringe exchange machines, needle and syringe exchange programs or distribution are not in existence outside prisons either.

Health Care

All known HIV-positive prisoners undergo a complete examination by the prison primary-care physician in cooperation with an AIDS specialist. Treatment and follow-up are provided in accordance with community standards. Where hospitalization is required, inmates are taken to the closest National Health System hospital.

Conjugal Visits

Conjugal visits are permitted in Spanish prisons.

Early Release of Prisoners with HIV or AIDS

Spanish law allows for early release of prisoners in case of serious illness. Accordingly, prisoners in the terminal stage of HIV infection are granted early release.

SWITZERLAND

ECAP received most of the following information from two correspondents in Switzerland, Dr Bolli from the prison in Regensdorf, and Ms. Bernasconi from the AIDS Section of the Health Promotion Division of the Federal Office of Public Health in Bern.[77] As Ms. Bernasconi pointed out,

77. Submissions to ECAP by Ms. S. Bernasconi, AIDS Section, Division Health Promotion, Federal Office of Public Health, dated 17 August 1992 and 19 July 1993; and by Dr. Karl Bolli, Kantonale Strafanstalt Regensdorf, dated 25 August 1992.

the prison system in Switzerland is mainly under the jurisdiction of the Cantons. Due to the lack of federal influence on policies related to prisons, it is difficult to obtain complete information or have a general overview of the situation with regard to HIV/AIDS in Swiss prisons. She further pointed out that some of the 167 Swiss prisons have good prevention and counselling programs, and that these should be evaluated. The Federal Office of Public Health considers that in prison the same public health strategies and AIDS policy and preventive measures as well as the same level of medical and psychosocial care as in the community should be available.

Surveillance and Seroprevalence Studies

Reliable and representative epidemiological data about HIV-seroprevalence and risk behaviour of prisoners are incomplete or missing. It is estimated that between two and ten percent of prisoners are HIV-infected.[78] Data exist for a few selected prisons:

- In 1988, approximately 6.5 percent of inmates in the prison of Lenzburg were HIV-infected.
- In 1991, 40 percent of inmates in prisons in Bern who were on methadone maintenance tested HIV-positive.
- In 1991, 18.8 percent of the women inmates in the prison of Hindelbank tested HIV-positive.[79]

Testing for HIV Infection

In the prison of Regensdorf, testing is voluntary and at the prisoners' request. Pre- and post-test counselling are undertaken.[80] A survey undertaken by Harding et al. in 1990 shows that this is consistent with the practice in most of the prisons that took part in the survey.[81]

Offender Medical Information

HIV antibody test results are confidential medical information and disclosure to third persons must be authorized by the prisoner.

Housing and Activities

HIV-positive prisoners and those living with AIDS are housed among the general population.[82]

Educational Programs about HIV/AIDS for Inmates and Staff

In 12 of 16 institutions surveyed by Harding et al. information sheets have been provided to personnel since 1985 outlining modes of HIV transmission and procedures to be used when coming into contact with body fluids. In other institutions texts prepared by the prison administration and medical services are distributed. Correctional officers also receive additional information during courses offered by the École Suisse de Formation Pénitentiaire.

In most institutions, information for prisoners was made available one to two years after that for prison staff. In almost all institutions surveyed by Harding et al. information is provided to prisoners by way of written information sheets upon entry. The content of information varies from institution to institution, with some preparing their own information sheet while others distribute material intended for the general population and developed by the Federal Office of Public Health. Most institutions require that prisoners sign the bottom

78. HIV-Prevention in Switzerland: Targets, Strategies, Interventions. Bern: Federal Office of Public Health and National AIDS Commission, 1993.

79. Ibid.

80. Submission to ECAP by Dr. Bolli, supra, note 77.

81. Harding TW, Manghi R, Sanchez G. Le SIDA en milieu carcéral: Les stratégies de prévention dans les prisons suisses. Geneva: Institut Universitiaire de Médecine Légale, 1990 at 16.

82. Submission to ECAP by Dr. Bolli, supra, note 77.

of the information sheet to attest to the fact they have been informed. Certain prisons also display information posters. Opportunities for group discussion are available at relatively few institutions.[83]

One of the priority targets identified in the national strategy for AIDS prevention is to make sure that information about HIV/AIDS is provided to inmates.[84]

Preventive Measures for Inmates

CONDOMS

By 1990, most prisons were making condoms available to inmates or were planning to do so in the near future.[85] By the end of 1997, condoms and lubricants should "be available so that all inmates can help themselves discretely."[86]

BLEACH

In the prison of Regensdorf, bleach has been available in first-aid kits since June 1991.[87] Information about other prisons was not available to ECAP. One of the priority targets of the national strategy for AIDS prevention is to make disinfectant material available to drug users in prisons by the end of 1997.[88]

STERILE INJECTION EQUIPMENT

A pilot project that includes the distribution of syringes will be started in 1994 in a prison for women in the Canton of Berne. By the end of 1997, "AIDS preventive pilot projects based on the distribution of syringes should be evaluated and the results from these projects should be incorporated into the framework of existing programme models for injecting drug users."[89]

Health Care

No information was made available to ECAP about health care available to prisoners in Swiss prisons.

Conjugal Visits

Conjugal visits are permitted in some institutions.

Early Release of Prisoners with HIV or AIDS

Swiss constitutional law provides for liberation of inmates in terminal phases of illness.

UNITED STATES

Compiling comprehensive information pertaining to prison policies in the United States is made difficult by the fact that federal, state and city authorities are all responsible for operating certain types of correctional institutions. Hammett et al. have carried out seven surveys of HIV/AIDS in correctional facilities in the United States, and most of the information contained in this section

83. Le SIDA en milieu carcéral, supra, note 81 at 24.
84. HIV-Prevention in Switzerland: Targets, Strategies, Interventions (short version). Bern: Federal Office of Public Health and National AIDS Commission, 1993 at 51.
85. Le SIDA en milieu carcéral, supra, note 81 at 30.
86. HIV-Prevention in Switzerland (short version), supra, note 84 at 51.
87. Submission to ECAP by Dr. Bolli, supra, note 77.
88. HIV-Prevention in Switzerland (short version), supra, note 84 at 51.
89. Ibid.

has been taken from their excellent *1992 Update: AIDS in Correctional Facilities.*[90]

Surveillance and Seroprevalence Studies

The following information was issued in September 1993 as a special report by the Bureau of Justice Statistics at the U.S. Department of Justice:[91]

- In 1991, 2.2 percent (17,479 of 792,176) of federal and state prison inmates were infected with HIV; 0.6 percent exhibited symptoms of HIV infection, including 0.2 percent who had AIDS.
- State prisons reported 2.3 percent of inmates as HIV-positive, while federal prisons reported 1.0 percent.
- States reporting the highest percentage of federal and state prisoners with HIV were New York (13.8 percent), Connecticut (5.4 percent), Massachusetts (5.3 percent), New Jersey (4.0 percent), Rhode Island (3.5 percent), and Georgia (3.4 percent). Northeastern states averaged an 8.1 percent seropositivity rate. The lowest rates were Maine (0.1 percent) and Kansas (0.2 percent).
- In 1991, 28 percent of all deaths in state and federal prisons were attributable to AIDS (528 of 1,863 deaths). In New York and New Jersey, two-thirds of reported deaths were caused by AIDS.
- A higher percentage of women than men (3.3 percent compared to 2.1 percent) tested HIV-positive. An estimated 6.8 percent of Hispanic women, 3.5 percent of black women, and 1.9 percent of white women tested positive.
- Overall, 3.7 percent of Hispanics, 2.6 percent of blacks, and 1.1 percent of whites were HIV-positive.
- An estimated 0.8 percent of tested prison inmates who said they never used drugs were HIV-positive, as were 2.5 percent who had ever used drugs, 4.9 percent who used needles to inject drugs, and 7.1 percent who shared needles.
- Maximum-, medium-, and minimum-security prisons had essentially the same rates of HIV infection.

According to Hammett et al., a total of 11,565 AIDS cases had been reported among inmates in U.S. federal, state, and larger city/county correctional systems as of November 1992-March 1993. Of these cases, 8,525 occurred among inmates of 48 state prison systems (two state systems reported no cases) and the Federal Bureau of Prisons, while 3,040 cases were reported by 31 city/county jail systems. These figures should be considered minimum estimates of the cumulative incidence of AIDS among U.S. inmates.[92]

Testing for HIV Infection

As stated by Hammett et al., "[i]n the world beyond prison walls, the discussion of HIV antibody testing seems to have shifted completely in the past years from a debate over testing as a tool for preventing the spread of infection to a widespread acceptance of *voluntary* counseling and testing as an integral part of medical intervention. ... In corrections ... the shift from arguments for testing based on prevention to arguments based on medical intervention has

90. Hammett TM et al. *1992 Update: AIDS in Correctional Facilities – Issues and Options.* Abt Associates Inc.: Cambridge, MA, 1993. A mail survey of HIV/AIDS in correctional facilities in the United States was undertaken. Between November 1992 and March 1993, responses were received from all 50 State correctional departments and the Federal Bureau of Prisons. Thirty-seven questionnaires were sent to large city and county jail systems in the United States and 31 responded. ECAP also received submissions from Stephen Machon, AIDS in Prison Project, The Correctional Association of New York, dated 28 September 1992, and from Jackie Walker, AIDS Information Coordinator, The National Prison Project of the ACLU Foundation, dated 11 September 1992.

91. Reprinted in *AIDS Reference Guide.* Atlantic Information Services, Inc., November 1993 (Insert 1722). Because testing policies differ sharply across correctional systems, the numbers reported by some systems contributing to this national seroprevalence estimate may be suspect. For example, the minority of systems with mandatory testing policies are likely to have much more accurate estimates of HIV seroprevalence than those with voluntary testing policies. See, Hammett et al., supra, note 90 at 36.

92. Hammett et al., supra, note 90 at 27-28.

been less thorough. Indeed, in some systems, there is persistent support for *mandatory* testing as part of an infection-control strategy."[93] [emphasis in the original] Sixteen state prison systems and the Federal Bureau of Prisons report having mandatory mass screening for HIV among their inmates.[94] The 16 state systems screen all intakes, while the Federal Bureau of Prisons screens all inmates who enter or are released from a federal institution during November of each year, and carries out a 10 percent stratified random sample of all inmates in the system each August. In one state, screening of all inmates at intake was legislatively mandated, but medical staff in the institutions disagreed with the policy and have failed to implement it. No responding city or county jail systems have mass mandatory screening policies.

Some correctional systems have policies of attempting to identify and screen those inmates with histories of high-risk behaviour.

Seventy-seven percent of state/federal systems and 87 percent of responding city or county systems make HIV testing available to all inmates on request. Another 14 percent of state/federal systems and 10 percent of city or county systems offer testing on request to some categories of inmates. Sixty-one percent of state/federal systems and 90 percent of city or county systems require written consent of all inmates who receive HIV testing.

Anonymous testing through public health departments is available to New York State inmates.

Ninety percent of state/federal and 87 percent of responding city/county systems report that they provide some kind of pre-test counselling, and 75 percent of state/federal systems and 94 percent of city or county systems report that they provide individual, face-to-face post-test counselling to all tested inmates. In 29 percent of state/federal systems, the average session was 5 to 20 minutes, in 50 percent the average session was 21 to 45 minutes, and in 21 percent it was more than 45 minutes.

Offender Medical Information

Very few correctional systems have official policies for notifying line correctional officers of inmates' HIV status. Indeed, less than 50 percent of systems officially notify any correctional administrators at the central-office or institutional level. As stated by Hammett et al., "[p]olicy does not necessarily translate into practice, however. Staff and inmates in many institutions report that the identities of HIV-infected inmates are widely known."[95] The authors suggest that, in order to preserve confidentiality and prevent unauthorized disclosure, sound and detailed confidentiality policies regarding HIV-related information need to be established. They point out that such policies should not be based on vague "need-to-know" formulations, "because in prisons and jails virtually *everyone* thinks they have a need to know." [emphasis in the original] Rather, they should spell out who has such a need and in what specific circumstances.[96] Several states have passed laws regarding confidentiality of inmates' HIV test results. Some of these are vague, while, for example, the New York State correctional system's policy on release of HIV/AIDS information is well-defined. It begins with the premise that there be no disclosure of HIV status other than to the patient without his or her written authorization. The policy then makes some specific exceptions to this premise and lists individuals who may receive information without a written release from the

93. Ibid. at 82.

94. Mandatory screening is defined as mandatory HIV antibody testing, generally identity-linked, of all new inmates, all releases, and/or all current inmates, regardless of whether they show clinical indications of HIV infection. See ibid. at 82-83.

95. Ibid. at 90.

96. Ibid. at 92.

inmate. Notably, line correctional officers and other institutional security staff are absent from this list.[97]

Twenty-eight percent of state/federal systems and 19 percent of responding city or county systems have policies providing for reporting inmates' HIV status to spouses or sexual partners. As noted by Hammett et al., "[n]otification of sexual partners raises complex issues for correctional officials. On the one hand, confidentiality is important, and in many jurisdictions unauthorized disclosures of HIV status are prohibited by law. On the other, a number of correctional officials conscientiously believe that inmates will not be responsible about informing their sexual partners and that authorities who are in possession of the information should ensure that notification occurs. Officials are also clearly concerned about possible litigation should they fail to inform a sexual partner who is later infected by a released inmate, although it is highly questionable whether such litigation would succeed."[98]

Housing and Activities

The survey undertaken by Hammett et al. shows that for several years correctional systems in the United States have been moving away from policies calling for blanket segregation of inmates with HIV infection or AIDS. More and more, these inmates are being housed in the general population and are allowed to participate in the same programs and activities as other inmates. While in 1985, 42 percent of state/federal systems and 60 percent of responding city or county systems had policies calling for segregation of at least some HIV-infected inmates, by 1992-93 only eight percent of state/federal systems and no city or county system had such policies. Only Alabama and Mississippi currently segregate all known HIV-infected inmates. The vast majority of systems now "mainstreams" inmates with HIV infection or AIDS, or makes housing decisions for them on a case-by-case basis. In New York State segregative housing of inmates living with HIV/AIDS is illegal.[99] As stated by Hammett et al., "[t]he arguments for integration and against blanket segregation of HIV-infected inmates are compelling," while "it appears reasonable to offer separate housing if requested and to reserve the possibility of segregating particular inmates on the basis of behavior."[100]

Educational Programs about HIV/AIDS for Inmates and Staff

The vast majority of correctional systems provide at least some form of HIV/AIDS educational sessions or informational materials. This has been the case in most systems for a number of years. As stated by Hammett et al., "[t]he near hysteria surrounding AIDS in correctional facilities has dissipated since the mid-1980's. However, there is still evidence of misinformation among inmates and staff, clearly demonstrating the need for more and better HIV/AIDS education and intervention in correctional facilities."[101] The Centers for Disease Control and Prevention address the continuing need for HIV/AIDS education in prisons and jails by funding programs in health departments in 20 states and the District of Columbia that provide HIV/AIDS education and risk-reduction services in correctional facilities. These programs may be offered by the health departments themselves or by community-based organizations. Indeed, CDC requires all health departments applying for fiscal year health education/risk-reduction cooperative agreements to include programs for persons in correctional facilities and those otherwise involved with the criminal justice system.[102]

97. Ibid. with reference to New York State Department of Correctional Services. Release of AIDS/HIV Information. In: *Policies, Procedures, and Guidelines Manual*, Records Section, Item #71, 23 May 1990.

98. Ibid. at 93-94.

99. Submission to ECAP from Stephen Machon, supra, note 90.

100. Hammett et al., supra, note 90 at 103.

101. Ibid. at 52.

102. Ibid. at 54, with reference to Centers for Disease Control and Prevention (CDC). HIV Prevention in the U.S. Correctional System, 1991. *Morbidity and Mortality Weekly Report* 41, no. 22 (June 5, 1992): 389-391, 397.

The survey conducted by Hammett et al. noted a slight decline between 1990 and 1992-93 in "live" HIV/AIDS educational programs, but an increase, particularly state/federal systems, in peer educational programs. The percentage of state/federal systems providing "live" education in *all* institutions decreased from 80 percent in 1990 to 57 percent in 1992-93. In contrast, the percentage of state/federal systems offering peer HIV education for inmates increased from 22 percent in 1990 to 33 percent in 1992-93. According to Hammett et al., "[s]trong anecdotal evidence indicates that peer education is an invaluable tool to reach inmates with information about HIV/AIDS. Peer educators speak the same language as their audience and are available to answer questions and provide support 24 hours a day. They can develop a degree of trust and credibility with the inmates that outsiders may never achieve. Peer educators may also have high levels of awareness regarding risky activities occurring in the facility and be able to respond to them with accurate and clear information. Inmates can discuss their concerns about prohibited activities with peer educators without fear of reprisal or disclosure. ... The cost-effectiveness of peer education programs should also appeal to correctional administrators. Peer education programs are less costly to establish and maintain than traditional education programs that employ outside professionals."[103]

A common medium for inmate education is through inmate-produced newspapers. In Connecticut, Illinois, and other jurisdictions, correctional medical directors print responses to inmates' questions relating to HIV/AIDS. Such questions and answers cover basic information about HIV infection and offer practical guidelines for HIV prevention in the prison setting.[104]

The vast majority of correctional systems (98 percent of state/federal systems and 90 percent of city or county jail systems) provide some "live" education for their staff. Typically, HIV education is part of orientation for new correctional employees. In the survey conducted by Hammett et al., a median 94 percent of staff (range 0-100 percent) were reported to have received at least one hour of "live" HIV education in the past year. As stated by Hammett et al., "[i]n correctional institutions, there may be a danger of violence or transmission of infectious diseases. Correctional staff are and must continue to be aware of the potential threat of infection. However, it is equally important that staff vigilance and awareness of danger not become unreasoning fear. In this context, education and re-education regarding HIV transmission and infection control are essential."[105]

Preventive Measures for Inmates

CONDOMS

Six prison systems distribute condoms: Mississippi, New York City, Philadelphia, San Francisco, Vermont, and the District of Columbia. Distribution of condoms varies by correctional system. In New York City and Vermont, inmates can receive only one condom per medical visit. Mississippi inmates can buy unlimited supplies of condoms at the canteen for 25 cents each. Two systems have tied condom distribution to services: condoms are available at HIV/AIDS educational programs in San Francisco and at HIV-antibody-test counselling sessions or during sick call in Philadelphia. Condoms are available in the infirmary and available at counselling and education sessions in District of Columbia prisons.

As stated by Hammett et al., "a small number of systems make condoms available in the context of continuing prohibitions against sexual activity and punishment of inmates found to engage in these activities."[106] The authors further noted that in the

103. Ibid at 64. For a description of a variety of peer education programs for female and male inmates, see at 65-68.

104. Fitzsimmons, supra, note 17 at 25.

105. Hammett et al., supra, note 90 at 57.

106. Ibid. at 78.

systems with condom availability, few if any problems have occurred with condoms being used as weapons or for smuggling contraband; and that many correctional systems have held discussions or considered proposals regarding condom availability and that, in the debates that occur, correctional medical staff often advocate condom availability while correctional administrators and security staff oppose it.

BLEACH

While some correctional systems have discussed or received proposals regarding bleach availability and many address needle-cleaning procedures in their educational programs, no systems make bleach available explicitly for cleaning injection equipment, and no systems plan to do so in the future. However, in several systems bleach is readily available in the institutions without strict controls on its use. In these institutions, inmates may have de facto access to bleach for cleaning injection equipment.[107]

STERILE INJECTION EQUIPMENT

No correctional systems make sterile needles or syringes available. However, needles are present in many facilities, and their scarcity "tends to foster sharing and other risky practices."[108]

Health Care

Courts in the United States have generally required correctional systems to meet community standards of medical care but not to provide state-of-the-art services. Paradoxically, inmates are virtually the only class of persons in the United States with a constitutional right to health care.

Nevertheless, many observers consider medical care for inmates in general, and HIV-infected inmates in particular, to be totally inadequate. As reported in Hammett et al., a number of witnesses before the National Commission on AIDS in 1990 described serious impediments to proper care: inadequate facilities, poorly trained staff, high costs of medications and care, and severe budget constraints. One expert on prison medical care stated that "a dangerously inadequate prison health care system is being overwhelmed by two epidemics: one, the mass incarceration of poor black and Hispanic drug users, and the other, the extraordinary medical demands of the AIDS epidemic."[109] Based on its hearings and site visits to several New York State facilities, the National Commission issued a report in 1991 concluding that most inmates with HIV disease receive inadequate care and treatment.

It has been concluded that the quality of medical care varies greatly among correctional systems, and that concerns raised about some systems can obscure the fact that exemplary care is offered in many jurisdictions. Commonly the quality of medical care in prisons "suffers in the conflict between correctional and health priorities."[110] B. Jaye Anno of the National Commission on Correctional Health Care stated:

> Care providers report that it requires constant vigilance, self-awareness, and periodic reexamination to avoid being co-opted by and developing an identification with correctional authorities, their goals, modes of thinking, conception of and relationship to inmates. This feeling of alliance with correctional authorities is problematic, because the medical model is often fundamentally at odds with the correctional model. This dissonance should be recognized and respected. Both points of view should be taken into account when making policy.[111]

107. Ibid. at 80.

108. Ibid.

109. Ibid. at 110 with reference to "Prisons's Care Systems Swamped by AIDS Epidemic, Panel Told," *AIDS Policy and Law*, 5 September 1990, at 3.

110. Ibid. at 112.

111. Anno BJ. *Prison Health Care: Guidelines for the Management of an Adequate Delivery System.* Washington: National Institute of Corrections, March 1991, at 53-54.

With regard to prophylactic and therapeutic drugs, the 1992-93 survey conducted by Hammett revealed that zidovudine (AZT) is available to inmates in all but one of the participating correctional systems but that other antiretroviral therapies are less available.

Inmates have been largely excluded from clinical trials by 1983 federal regulations that were intended as safeguards against exploitation of inmates in medical research. Some have called for continued exclusion of inmates, maintaining that obtaining informed consent and securing confidentiality are impossible in correctional institutions. Others have called for liberalization of the regulations to allow enrollment of inmates in Phase II-III (efficacy) trials without placebo.[112]

Some form of drug treatment is available to inmates in all but two state/federal systems and in 77 percent of city or county systems responding to the survey conducted by Hammett et al. However, actual participation in drug treatment in correctional facilities falls far short of the need, and a 1991 General Accounting Office report estimated that state correctional systems have the capacity to treat fewer than 20 percent of the estimated numbers of inmates with drug use problems.[113]

Conjugal visits.

Some systems offer conjugal visits.[114]

Early Release of Prisoners with HIV or AIDS

As stated in Hammett et al., "[i]nmates in the advanced stages of HIV disease are unlikely to pose a threat to the community. Most are seriously ill and unable to commit violent or other criminal acts, even if they wished to do so. Therefore, a strong argument can be made for granting such individuals early or compassionate release from prison."[115] However, despite the strong case for early release and the fact that a substantial number of systems have policies permitting early release for inmates with HIV/AIDS, relatively few inmates have been granted such release.

112. Hammett et al., supra, note 90 at 114.

113. Ibid at 122-23 with reference to U.S. General Accounting Office. Drug Treatment: State Prisons Face Challenges in Providing Services. Report to the Committee on Government Operations, House of Representatives. September 1991, GAO/HRD-91-128.

114. Hammett TM. The Policy Response to HIV/AIDS in Prisons Worldwide. Paper presented at the VIII International Conference on AIDS. Amsterdam, 1992.

115. Hammett et al., supra, note 90 at 103.

APPENDIX 4

CANADIAN CASE LAW AND PRECEDENTS[1]

The McGill Centre for Medicine, Ethics and Law analyzed 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, to identify patterns of problems related to HIV/AIDS in Canadian prisons.

COMPLAINTS TO HUMAN RIGHTS COMMISSIONS

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.[2]

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... ."[3] 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.[4]

1. 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.
2. Personal correspondence with Bruce Drewett, Policy Analyst, Ontario Human Rights Commission, dated 28 March 1990.
3. Ibid.
4. Submission to ECAP by Calvin Bernard, Acting Director, Policy Unit, Ontario Human Rights Commission, 14 October 1992.

Quebec Human Rights Commission

In 1990, the Quebec 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.*[5] the complainant, an inmate in the Montreal Detention Centre commonly known as the "Bordeaux jail," 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 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.[6] 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.*,[7] 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.

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*,[8] 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 twenty-four

5. Re: "Sylvain A.", File #8906005371-0001-0; COM-351-5.10 (Quebec H.R.C.).
6. The policy of segregating known HIV-positive inmates was abandoned at the Montreal Detention Centre in mid-1990.
7. Re: "Pierre M.", File #8906005490-0001-0; COM-351-5.9 (Quebec H.R.C.).
8. *R.* v. *Downey*, (1989) 42 C.R.R. 286 (Ontario District Court).

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 1991, Downey assaulted a correctional officer at Guelph Correctional Centre, biting him "on the arm." Downey was charged with assaulting a peace officer under s. 270 of the *Criminal Code* and sentenced to three months imprisonment by the Ontario Court (Provincial Division).[9] In its judgment, the Court stated that this was "not a simple assault on a peace officer," but "could have resulted in very detrimental circumstances." In sentencing, the Court emphasized the principle of general deterrence and said that it was concerned with trying to "at least give a message in support of the matter of general deterrence to give some degree of protection to custodial officers who are really at the mercy of the system."

(3) In the case of *Ratte* v. *Kingston Penitentiary*,[10] 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.

(4) In the case of *R.* v. *McAllister*,[11] 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.

(5) In the case of *R.* v. *Johnston*,[12] the fact that the accused had AIDS was taken into account in mitigation of the sentence.

(6) In the case of *R.* v. *Marjerrison*,[13] the accused, who was HIV-positive, was convicted of fraud. The Court chose not to follow *R.* v. *Newby*.[14] In that case, the Alberta Court of Appeal dismissed an appeal by the Crown against a suspended sentence for fraud committed by a person suffering from chronic fatigue syndrome. In sentencing, the Alberta Court of Appeal took into account that the accused could only be treated in the United States and would, if incarcerated, possibly commit suicide. The Court in *Marjerrison* sentenced the accused to four months imprisonment, citing UK decisions in which the accused's HIV status had not been considered a mitigating factor in sentencing.

9. *R.* v. *Downey*, Ontario Court (Provincial Division), unreported judgment of 31 October 1991.

10. *Ratte* v. *Kingston Penitentiary (Warden)*, Ontario Judgments: [1991] O.J. No. 1745 (Ontario Court of Justice – General Division).

11. *R.* v. *McAllister* [1990] B.C.J. No. 2534 (British Columbia Court of Appeal).

12. *R.* v. *Johnston*, Ontario Judgments: [1991] O.J. No. 25 (Ontario Court of Appeal).

13. *R.* v. *Marjerrison*, Ontario Court – General Division, 22 June 1993, unreported decision.

14. (1991) 14 *W. Crim. Bul.* 544.

(7) In *R.* v. *Clement*,[15] the Court refused to take the accused's HIV status into account as a mitigating factor in sentencing and dismissed as a "handy excuse" his assertion that at the time of the relevant offenses he was depressed, having tested HIV-positive. The accused was later told that he did not in fact have HIV infection.

(8) In *R.* v. *Lee*,[16] the Court refused an appeal against a sentence of six months imprisonment in the case of an HIV-positive prisoner with a history of intravenous drug use.

(9) In the case of *R.* v. *Lesieur*,[17] 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.[18]

COMPLAINTS TO THE PUBLIC SERVICE STAFF RELATIONS BOARD OF CANADA

In *Walton* v. *Treasury Board (Correctional Services Canada)*,[19] 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.

15. *R.* v. *Clement*, Alberta Provincial Court, 31 August 1992 (unreported).
16. British Columbia Court of Appeal, 11 May 1993 (unreported).
17. *R.* v. *Daniel Lesieur*, Quebec Superior Court, District of Quebec, Docket No. 200-01-008541, unreported, 1993.
18. 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.
19. *Walton* v. *Treasury Board (Correctional Services Canada)* (1987), 16 C.C.E.L. 190 (P.S.S.R.B.).

APPENDIX 5

RESULTS OF THE STAFF QUESTIONNAIRE*

BACKGROUND

Introduction

To ECAP's knowledge, there are so far no published data available on the attitudes of staff working in correctional institutions with regard to the issues raised by HIV/AIDS in their workplace. There has been a study of knowledge, attitudes and behaviour of inmates in Canadian prisons. The study, which was undertaken by Toepell in two provincial prisons in the Toronto region, examined prisoners' attitudes toward HIV-infected inmates, toward correctional staff and community groups, and toward HIV testing.[1]

One of the major issues studied by the Expert Committee on AIDS and Prisons (ECAP) is the safety and security of Correctional Service Canada (CSC) staff. ECAP is very aware of the concerns of staff with regard to infectious diseases. CSC has responded to these concerns by implementing a variety of measures to protect staff from exposure to and transmission of HIV and other infectious agents. These measures include education about infectious diseases, provision of protective equipment, and development of infection-control guidelines. 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." They emphasize that blood and body fluid precautions need to be employed universally, "whether or not there is an identified risk," and that "staff safety is enhanced by assuming that any individual may be infected by a communicable disease." Staff have also been provided with protective clothing and equipment. Despite these measures undertaken by CSC, staff concerns about and fear of being infected with infectious diseases, in particular with HIV, during the course of their work persist.

Therefore ECAP examined a variety of other measures that could be undertaken by CSC to provide staff with increased protection and to alleviate their concerns and fears. These include improving educational and training programs,

* ECAP's Project Coordinator, Dr. Ralf Jürgens, wishes to acknowledge Maria Hooey's assistance in the preparation of Appendix 5.

1. Toepell, AR. Prisoners and AIDS – Knowledge, Attitude and Behaviour. John Howard Society of Metropolitan Toronto, 1992.

regular review and, when appropriate, revision of infection-control guidelines, increased training on how to react to "risky situations," follow-up of any incident involving exposure to blood or body fluids, and support for families and/or partners of staff.[2]

The Committee strongly felt that, in order to achieve its goal of reducing harms through promoting and protecting the health of inmates and of staff, and preventing transmission of HIV and other infectious agents in federal correctional institutions, not only prisoners' concerns, but also the concerns of staff for their safety had to be taken into account. Any measure undertaken to prevent transmission will have to be acceptable to prisoners, to staff, and to the public.

Rationale for the Study: Goals and Objectives

ECAP undertook this study to obtain more input from CSC staff into its work, and in particular into its recommendations, that would directly or indirectly affect the safety of staff in their working environment. ECAP felt that staff should have an opportunity to raise any concerns they might have with regard to many of the issues raised in ECAP's report and make suggestions, recommendations or comments regarding HIV/AIDS and drug use in prisons and measures to address the problems created by them. A further objective was to raise awareness about the issues involved and about ECAP's work in general. Finally, the Committee wanted to gain knowledge about acceptance of measures that had already been undertaken in prisons to prevent HIV infection, such as condom distribution, as well as about some of the measures that the Committee was considering should be undertaken or studied, such as making bleach or sterile needles available to inmates. Because the Committee believes that education will be an important component of any effort to prevent HIV transmission in prisons, it included a variety of questions on the perceived educational needs of staff. Responses to these questions will assist CSC in the development of future educational programs for staff.

METHODOLOGY

Instrument

The instrument chosen to collect the data was a questionnaire. It was developed by ECAP's Project Coordinator to address the specific goals of the study. The questionnaire was reviewed by ECAP's members and observers and some CSC staff. A copy of the questionnaire is presented at the end of this appendix.

Design and Survey Distribution

The questionnaire was sent to staff in federal correctional institutions and district parole offices to obtain information about their opinions and concerns regarding the issues raised by HIV/AIDS and by drug use in their institutions. In particular, staff were asked about: (1) their educational needs with regard to HIV/AIDS and drug use; (2) whether in their opinion the protective measures available to them are sufficient to protect them from contracting HIV infection in the workplace; (3) whether they "need to know" inmates' and fellow staff's HIV status; (4) whether availability of condoms has created any problems in the institutions; (5) whether inmates should be instructed how to properly clean injection equipment; and (6) whether bleach or clean needles should be made available to inmates.

On March 5, 1993, Dr. J.H. Roy, Director General of CSC's Health Care Services, sent a memorandum to wardens of institutions and to parole offices. He solicited their assistance in distributing a supply of questionnaires, and asked them to encourage staff to complete and return the questionnaires to ECAP's Project Coordinator. A second memorandum was sent to the deputy

2. For more information, see *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons.*

commissioners by Mr. Irving Kulik, Assistant Commissioner, Correctional Programs and Operations. The memorandum pointed out that the information obtained through the survey of staff attitudes is "a key component of ECAP's work and essential to their formulation of final recommendations on HIV/AIDS issues to the Commissioner of the Correctional Service." It requested the deputy commissioners' cooperation in encouraging regional staff to complete and return the questionnaire to ECAP's Project Coordinator.

CHARACTERISTICS OF STAFF

The following information was self-reported by staff: sex, current occupation, years of service within CSC or provincial prison systems, and security level of institution where they are currently working. Provision of this information was voluntary, and any information received has been treated confidentially. Initially, approximately 2,200 questionnaires were distributed, which consititutes about 20% of the institutional and parole staff of CSC. A total of 462 staff members responded to the questionnaire, which represents about 5% of the population of CSC staff.

Sex

A greater number of the respondents were male, as is representative of the entire staff population of CSC. The breakdown of respondents is as follows:

- Male 71%
- Female 29%

Current Occupation

Of the respondents who indicated their current occupation, the breakdown is as follows:

- Correctional Officers 31%
- Health Care Personnel 11%
- Other Employment Categories 58%

Statistics obtained from CSC indicate that this sample of staff members by current occupation is representative of the actual CSC population. Responses from health-care personnel were compared with those from correctional officers to establish whether there are significant differences in how the issues raised by HIV/AIDS and drug use are seen by these two groups of employees. In general, responses from health-care personnel did not differ significantly from those given by correctional officers. Responses are therefore presented by employment category only where significant differences occur.

Years of Service

The amount of time that staff members responding to the questionnaire had been working for CSC ranges greatly – from as little as 2 months to as many as 30 years. The average employee responding to the survey had been working for CSC for about 11 years (SD=7).

Institutions

Questionnaires were received from 37 institutions and 7 parole offices. As little as one questionnaire was received from one institution, and as many as 49 from another (M=10.43). In three cases, the origin of the questionnaire could not be identified. Although the questionnaires did not ask for this information, the envelopes containing the questionnaires returned to the Project Coordinator allowed for identification of this information, and therefore it was also collected. After data was entered, the envelopes were destroyed. Distribution of responses per region of CSC is as follows:

- Atlantic 6%
- Quebec 34%
- Ontario 22%
- Prairie 21%
- Pacific 18%

Results of the Staff Questionnaire

Security Level of Institution

Staff members were grouped according to the security level of the institution that they worked at. The distribution of staff surveyed, by security level, is reasonably representative of the actual statistics provided by CSC. However, it should be noted that staff working in minimum security institutions were slightly over-represented (by 10%), whereas staff of parole offices were slightly under-represented (by 7%). The breakdown of staff surveyed by security level is as follows:

- Maximum Security Institution 30%
- Medium Security Institution 47%
- Minimum Security Institution 21%
- Parole Offices 2%

RESULTS

Introduction

The results of the staff questionnaire are presented according to the following categories:

1. Education on HIV/AIDS
2. Education on Drugs
3. Protective Measures for Staff
4. "Need to Know"
5. Condom Availability
6. Needle Cleaning/Needle Exchange Programs
7. Self-Help Groups
8. Health Services
9. Other Issues

For each category, this section briefly presents the answers given to the question on the category; and contains selected, slightly edited responses provided by staff when asked to specify the reasons for their responses. A table summarizing the results of the questionnaire is included at the end of this appendix.

EDUCATION ON HIV/AIDS

Information about HIV/AIDS

Most respondents (79%) stated that information about HIV/AIDS (for example, pamphlets or brochures) is given to staff in their institution. The majority (85%) of the respondents who reported that information about HIV/AIDS is not given to staff in their institution said that such information should be provided.

When asked to specify why such information should be provided, the majority of respondents said that they felt they should be informed about HIV/AIDS. Some staff members commented that the "inmates know more than staff." Another concern raised was that staff "were given pamphlets quite a while ago," indicating that an update on this information is due.

Education about HIV/AIDS

While a majority of respondents (67%) said that educational programs about HIV/AIDS (for example, lectures, video presentations) are given to staff in their institution, responses still indicate that "live education" for staff is less frequent than the handing out of educational brochures. Nearly all respondents (96%) who reported that "live" educational programs are not provided to them said that such programs should be made available.

When asked to specify why such programs should be made available, staff often said that they do not hear enough about the issues raised by HIV/AIDS and that they need to be kept up-to-date on them. It was felt that "education could help prevent HIV/AIDS and clear misunderstandings regarding this controversial subject."

HIV/AIDS Education Program Attendance

Approximately two-thirds of the respondents (65%) said that attendance in educational programs should be mandatory for staff.

Many reasons were given why participation should be mandatory. Many staff members feel that "it is essential that staff have a good understanding of HIV/AIDS and the implications this has in how we deal with inmates. Good up-to-date information prevents false rumours and alleviates fears; it also ensures that we deal with inmates and other staff appropriately." Another concern raised was that "a lot of staff in the institution do not volunteer their time for anything and this issue is important enough to make it mandatory." It was also suggested that "the staff that complain most about risk to health etc. are the ones who never show when education is given."

The few staff members who expressed the view that participation should be voluntary claimed that many staff are already well-informed. One staff member stated that he "believes that the various sources of media provide adequate information on this subject. I feel that I am well informed and feel a great number of other staff are also." Other staff members questioned the efficacy of educational programs when they are imposed on people. It was thought that "if staff are not interested enough to go on a voluntary basis, they probably would not learn much on a mandatory basis."

Providers of HIV/AIDS Education

Slightly less than half of the respondents (47%) stated that CSC or Health Canada personnel should provide HIV/AIDS education. About one-quarter of staff (28%) stated that outside health or community organizations or individuals should do it, and a smaller number (20%) said that both CSC or Health Canada personnel and outside organizations should provide educational programs. Only 6% of respondents said that whoever is most qualified should be asked.

The majority of those in favour of CSC or Health Canada personnel providing education reported that providing staff education is a responsibility borne by CSC and should therefore be undertaken by CSC or other government employees. "The government organizations would know the working conditions and would easily relate to our concerns."

Those in favour of outside agencies providing information most often said that these organizations "may have more expertise in the field" than CSC or Health Canada staff. It is felt that "education provided by outside agencies would be believed more" and would therefore be more credible.

A small number of staff said that both CSC or Health Canada employees and outside agencies should provide educational programs. "Both perspectives would increase knowledge and insight."

Of the few staff who would prefer education provided by whoever is most qualified, it was commented that "we need extensive info, by whatever agency that has the most up-to-date information." One staff member stated that "CSC is a very specialized environment. Consequently, there is a need for information from CSC. However, it is important that we understand the situation outside CSC in order that we can provide accurate information to inmates."

Information Needed

Seventy-one percent of the respondents reported that information or education on "everything" (general update on HIV/AIDS) is needed. When asked to prioritize their needs, the highest percentage of staff (73%) said that information on how to communicate with HIV-infected inmates is needed. Sixty-five percent of staff indicated a need for information or education on universal precautions, and on the resources and services available for HIV-infected people. There was less interest in issues such as treatments available (42%) or safe needle/drug use (38%).

EDUCATION ON DRUGS

Information about Drug Use

A little over half of the respondents (57%) said that information about drug use (for example, pamphlets or brochures) is given to staff in their institution. Of those who reported that such

information is **not** given to staff in their institution, 75% said that information should be given to each staff member.

When asked to specify the reasons why information on drug use should be given to each staff member, staff often said that "drugs are part of prison culture and reality" and are "widespread in institutions and are one factor in HIV/AIDS." It is thought that "a lot of staff do not know the effect of drugs and that they need to know the reasons" underlying drug use and be kept up-to-date on it. Some staff indicated that information was needed that would allow them to better "identify and deal with drug users."

Educational Programs about Drug Use

About half of the respondents (51%) said that educational programs about drug use are given to staff in their institution. Where such programs are not available, most staff (89%) said that they should be made available. Generally, it was commented that "staff should be made aware and then kept updated about the growing drug problems in the institution."

Drug Education Program Attendance

Slightly more than half of the respondents (53%) said that attendance in educational programs about drug use should be mandatory, for the same reasons as for educational programs on HIV/AIDS. It was felt that "those who require the information do not otherwise attend. Those who are already knowledgeable are the ones who show up when education is voluntary." Another interpretation of the question involved the need for drug use counselling for staff members themselves. Some staff members commented that "often the people most concerned by the problem do not otherwise attend for fear of being identified."

However, nearly half of the staff (46%) indicated that participation in such programs should be voluntary. It was thought that "if you force people, they go in with a negative attitude."

Providers of Drug Education

Responses to the question about who should provide such education were very similar to those given under the section on education about HIV/AIDS. Nearly half of the respondents (47%) indicated that CSC or Health Canada personnel should provide educational programs. It was suggested that these government organizations would "understand the prison subculture better." It is also thought that "it is the responsibility of CSC" to provide this education.

About the same number of staff (47%) reported that educational programs should either be delivered by outside agencies or be complemented by them. Staff members feel that "outside agencies have a better knowledge about the drugs that are used and about how they are introduced into the institution." Some staff members "have found it valuable when HIV-positive individuals have come to speak to staff and inmates" and feel that "this could be applied to drug users as well."

PROTECTIVE MEASURES FOR STAFF

Overall, nearly 70% of the respondents indicated that, in their view, the protective measures available to staff are sufficient to protect them from contracting HIV infection in the workplace. Almost all health-care staff (90%) indicated that the protective measures available to them are sufficient, whereas only half of the correctional officers (54%) thought that this was the case.

A variety of additional measures were suggested by those who felt that there was a need for them. Most importantly, it seems that many staff are concerned because "protective clothing should be more readily available." Specifically, in some cases "gloves and protective suits are not readily accessible." Another example of equipment that has not been made available to staff everywhere is "mouth-to-mouth equipment that allows for the safe resuscitation of inmates and staff." Not only should this equipment be provided, but "staff need to be trained about how to use this equipment in everyday situations."

In addition to universal precautions, some staff have suggested that "inmates could be placed in segregation if they are a danger to self or population or staff. Testing should be compulsory, and staff should be made aware of inmates with communicable diseases for their and inmates' own protection." As well, "inmates who are drug users should not get "replacement" needles for syringes – this increases risks of discarded needles (left in drawers)."

"NEED TO KNOW"

Knowledge of Prisoners with HIV/AIDS

Staff were asked whether, to their knowledge, there are any prisoners with HIV infection or AIDS in their institution. Of the 77% of staff who responded yes, 3.9 inmates on average were known to be HIV-positive. In one institution, a staff member knew of as many as 40 HIV-positive inmates. Surprisingly, 20% fewer health-care staff than correctional officers stated that they knew of HIV positive prisoners in their institution.

Knowledge of Staff with HIV/AIDS

Staff were asked whether, to their knowledge, there are any staff with HIV infection or AIDS in their institution. Fourteen staff members (3%) responded yes.

Need for Staff to Know Prisoners' HIV status

Many staff members (82%) feel that they "need to know" the HIV status of prisoners. A greater number of correctional officers (86%) than health-care staff (58%) think that they "need to know" prisoners' HIV status.

A large number of staff members (84%) provided reasons for staff needing to know the HIV status of the inmates in their institution. Some staff still believe that this will allow them to better protect themselves and that they could take extra precautions with known HIV-infected inmates. One staff member commented that "if staff are made aware of inmates with AIDS they may begin to feel more comfortable with them and AIDS."

Other staff members are concerned with the "inmate's own welfare." Staff feel that they "should know who requires specialized counsellors," and that this information "allows the system to evaluate program needs." A specific concern arose regarding sexually active inmates. "If an inmate is sexually active in the institution, it is important that – if the activity is discovered – staff are aware that the implications for the inmate and his partner are greater than just a break of regulations."

Some staff indicated that only those who in the course of their duties "come into physical contact with inmates need to know," while others claimed "all staff should know."

Other staff (18%) did not think that they needed to know the inmate's HIV status. These staff "treat everyone as though they are HIV positive," and apply precautions universally. One staff member pointed out that, while "staff do not need to know, they would find out in any case." Another staff member stated "that you shouldn't be concerned about the inmates whom you know have HIV. You should be more concerned about the ones who don't know they have it yet, and use universal precautions."

Need for Staff to Know Fellow Staff's HIV Status

About one-third of the staff (35%) reported that they needed to know the HIV status of fellow staff members. Again, a greater number of correctional officers (about 20% more) than health-care staff felt that this was necessary information.

Those who felt that they needed to know most often said that this was necessary to allow them "to take extra precautionary measures." One staff member "believed that staff and inmate safety and health issues deserve the same treatment with regard to confidentiality."

Many staff, however, made a distinction between a staff member's and an inmate's medical information, claiming that while a staff member's

HIV status is confidential information and there is no reason to disclose it, an inmate's HIV status is information in CSC's possession and needs to be known by staff. It was felt that "staff's HIV status is their personal matter." Another staff member stated that "revealing staff's HIV status without their consent would be an infringement of rights. You also expect staff to inform other staff if they think it necessary." A rather startling comment was made by one staff member, who felt that "a fellow staff's HIV status does not concern us; however, for respect for his colleagues, an HIV-infected staff should ask to be dismissed."

Need for Prisoner to Know Staff's HIV Status

Very few staff members (17%) felt that prisoners "need to know" the HIV status of staff. Staff suggested that "everyone should be warned so that they can take protective measures." Some staff felt that "if the infected staff member were a health-care professional, the inmate should be informed."

The majority of respondents (83%) expressed the view that inmates did not need to know staff's HIV status. Staff are concerned that "inmates may use the information to their advantage. Inmates should know nothing about staff." One staff member felt that "prisoners are not usually in a position where they would be put at risk by staff members." Another staff member suggested that "inmates have too many rights already."

CONDOM AVAILABILITY

Problems Due to Condom Availability

Most staff (82%) stated that making condoms available had not created any problems in their institution. However, a few concerns were discussed. Some staff were concerned that condoms could be used to hide contraband, and that making them available would be seen as encouraging homosexual activity. Others were concerned that condoms are too expensive, and that "inmates should be made responsible; they should pay for condoms."

Ways of Making Condoms Available

Presently, staff report that the ways condoms are made available varies between institutions. Condoms are available in washrooms, shower stalls, the library, only in health-care services, or in some cases are freely availabile on the ranges. Thirty-one percent of staff suggested that ways other than those currently used in their particular institution should also be used to make condoms available.

Availability of Condoms When Entering and Exiting Prison

Slightly under half of the respondents (41%) felt that condoms should be given to every prisoner at entry into prison (e.g., in first-aid or health-promotion kits). About the same number of staff (43%) stated that condoms should be given to every prisoner on leaving the prison in so-called "prison exit kits."

NEEDLE CLEANING/NEEDLE EXCHANGE PROGRAMS

Instructing Prisoners to Properly Clean Injection Equipment

A little over half of the staff (57%) replied that prisoners should be instructed on how to properly clean injection equipment (needles and syringes, tattoo needles, etc). Interestingly, most (87%) health-care staff were in favour of instructing inmates, whereas only less than half (45%) of correctional officers were in favour.

These respondents generally acknowledged that injection drug use does occur in federal institutions although it is a forbidden activity, and that CSC has a responsibility to reduce the harms deriving from this. Some staff felt that this issue "is no different from the condom issue. It is a moral decision based upon the sanctity of life," and that "they [inmates] are going to use needles." Therefore, "it is better to educate them how to use them properly and hopefully reduce the spread of

infection." As well, "it is information that they can use when they are released." One staff member concerned for the safety of staff commented that "there doesn't seem to be a way to ensure that there will be no use [of injection equipment], so we should at least make it safer for our staff who have to do searches."

Staff who said that prisoners should not be instructed how to clean injection equipment felt strongly that "drug use is illegal inside and outside the institutions", and that "it would be condoning the use of drugs." Some staff commented that instruction in the cleaning of injection equipment would actually "encourage use of drugs" and that CSC would be seen as "endorsing substance abuse."

Tattooing Equipment Made Available

Generally, staff were not in favour (74%) of making tattooing equipment available to prisoners on an official basis to reduce the risks of infection. Slightly more than half of the health-care staff (56%) and 77% of correctional officers did not approve.

Staff opposed making tattooing equipment available to inmates on an official basis because "tattooing equipment is contraband and should remain so." Staff realize "that needle use exists," but state that they "cannot and should not promote it." Other staff commented that this would be "a dangerous practice," "encourage use," and it "would look to offenders like CSC approves tattooing." Another concern raised was the "added cost to the system" that this would entail.

Staff proposed a variety of ways to make tattooing equipment available and argued that inmates who decide to be tattooed, regardless of the fact that it is prohibited, should at least be able to "reduce the risk of infection." Prisoners "will make their own equipment anyway and spread disease," so "why not let it develop into a legitimate trade." It was suggested that, for each institution, CSC could "assign someone who knows the practices of safe tattooing and have that person and equipment monitored by staff." It was also suggested that CSC could "hire an inmate to do tattooing for pay." Another recommendation was to have the "inmate committees take this responsibility; perhaps special tattoo sessions could be set up, where inmates bear the cost and are provided with the means necessary to stop the spread of infection."

Bleach Made Available to Prisoners

Although a little over half of the respondents (56%) reported that they did not agree that bleach should be made available to prisoners, there was a large split in the opinions of health-care staff and correctional officers. Only 23% of health-care staff disagreed with this suggestion, whereas 64% of correctional officers were in disagreement.

Respondents who were of the opinion that bleach should not be available to inmates, stated that they are concerned that making bleach available "encourages illegal drug use" and encourages "men to be tattooed." Other staff are afraid that bleach "could be used as a weapon," and therefore see it as "too much of a security risk." "Bleach when combined with other cleaning substances can form a dangerous gas. There is a risk to staff from this." As well, "small amounts can be accumulated to reach lethal amounts without staff's knowledge." A few staff were concerned for the well-being of potentially suicidal prisoners who "might drink it." As a solution to avoiding the use of bleach, one staff member suggested having "a needle exchange program (confidential) via health care services inside penitentiaries" and/or "having professional tattoo artists visit institutions to sell their services to those wanting tattoos."

Staff who thought that bleach should be made available to prisoners thought that it should be available only in "small bottles already diluted to a safe strength," and for "immediate use" only. "Using bleach should be authorized, but storing bleach and accumulating it should remain an institutional offence," as some staff are concerned with "security risks." A few staff felt that "small quantities should be made available on the ranges," whereas others thought it "should only be available through the health care facility." One

staff member commented that bleach "is already available in minimum security institutions."

Needle Exchange Program Made Available to Prisoners

Overall, staff were not in favour (82%) of making a needle exchange program available to prisoners in which prisoners could trade in a used needle for a new, clean needle. Again, there was a notable difference in the opinions of health-care staff and correctional officers. A high percentage of correctional officers (85%) were not in favour, whereas a little over two-thirds (69%) of the health-care staff disagreed with this suggestion.

Respondents opposed making a needle exchange program available to prisoners because it "seems to condone intravenous drug use." They are concerned with the "possibility of a growing drug culture," and feel that "maybe if needles weren't available there would be less drugs." Some staff feel that other methods would be more appropriate, for example, "if bleach is made available, they can clean the needles they have." Others suggested that "they need more help in overcoming their addiction." Another concern raised by staff was "the cost" involved in distributing clean needles, and some staff are asking "why should the taxpayer pay for it?"

Staff in favour of a needle exchange program felt that "it would be better if they used a good clean needle than a make-shift or a dirty one. If they have a needle (syringe) to exchange, this would mean that they are already using one. The issue of staff safety is already there: the inmate has a needle now, but it's dirty, old and possibly infected by more than one individual." Suggestions for means of distributing needles varied between staff members. One staff member suggested that they should be distributed "in each institution – openly – formally – with hazard boxes for disposal of used needles," and a "witnessed exchange of needles" with a "rigorous count" by a "senior registered nurse or correctional supervisors." Others felt that needles should be exchanged through "health care or a substance abuse counsellor." Many staff suggested that the "users should have to take part in an educational program as part of the needle exchange program." One staff member suggested that: "1. They should have to attend a class for educational purposes; 2. Health care only should run it, setting a time or times for the exchanges, daily, weekly, etc.; 3. By a nurse who has been trained to answer questions when dispensing, not just any nurse."

SELF-HELP GROUPS

Existence of Self-Help Groups for HIV/AIDS Prisoners

The majority of staff (71%) responding to the survey stated that there were no self-help groups for prisoners with HIV infection or who have AIDS in their institution. A few staff (12%) did not know whether there was such a program in their institution. Generally, staff were in favour (73%) of setting up such self-help groups in institutions.

Setting Up Self-Help Groups

Staff in favour of setting up self-help groups felt that "a group should be set up just like on the outside." Staff opposing the setting up of these groups felt that there were "not enough reasons to form a group" and that they "don't foresee this happening until a large number of the prison population is sick and needs the support." One staff member stated that "from talking with offenders, I think any self-help group set up would not be utilized and it would cause problems among the rest of the offenders who do not have HIV/AIDS."

HEALTH SERVICES

Problems with Access to Health Services

The majority of staff (87%) did not think that there were any problems with prisoners' access to health services for HIV/AIDS and/or drug use. Most staff commented that health care is easily accessible and that inmates usually get what they

ask for. A few staff felt that "too much is available to them," and that "they are better served than the general population outside prisons."

However, a few staff felt that there were problems with accessing health services for HIV/AIDS and drug use. One concern raised was that "prisoners with HIV/AIDS are usually fearful and require a greater access to these services." Another staff member stated that "health concerns of inmates are not addressed quickly enough due to staff numbers reduction."

OTHER ISSUES

Twenty-eight percent of respondents thought that there were additional issues of concern relating to HIV/AIDS and/or drug use in prisons. Some staff feel that they "are not kept informed as to whether either of these issues is becoming a problem within the institution" and are disappointed that "management have a tendency to keep this information to themselves." It was also emphasized that staff should "be taught the importance of universal precautions instead of focusing on the need to identify those with HIV," which leads to a false sense of security. A few staff are concerned with the "lack of education for staff" on these issues. One staff member is "astounded by the amount of overdoses and drug use allowed within the institutions. Inmates are given all these rights that now make it even more difficult for staff to charge an inmate for offences while incarcerated."

CONCLUSION

In many ways, the results of the staff questionnaire support ECAP's conclusions and recommendations. Importantly, they support ECAP's view 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" (Recommendation 7). Most staff expressed a need for educational programs on HIV/AIDS and on drug use, and it is the hope of the Committee that CSC will act quickly on its recommendation to provide staff with educational sessions on a regular basis (Recommendation 7(2)). The results of the staff questionnaire will provide CSC with some guidance as to what the most pressing needs of staff with regard to education are.

Another important issue is that of protective measures for staff. While nearly 70% of all respondents feel that the protective measures available to them are sufficient to protect them from contracting HIV infection in the workplace, only a slight majority of correctional officers believe that enough is being done to protect them. The majority of correctional officers also expressed the view that they "need to know" prisoners' HIV status. ECAP acknowledges the importance of protecting staff and recommends a variety of measures to increase the protection already afforded them against exposure to and transmission of HIV and other infectious agents. However, ECAP does not recommend that the HIV status of known infected inmates be disclosed to staff, because it firmly believes that this would not enhance staff safety, but rather would endanger staff by giving them a false sense of security. In any educational programs, it will be extremely important to explain to staff the importance of applying precautions universally and to instruct them how to do so.

Results of the questionnaire show that making condoms available in federal institutions has been well accepted by staff and that, in general, it has not created any problems. They further show that a majority of staff believes that inmates should be instructed how to properly clean injection equipment, and that nearly half also think that bleach should be made available to inmates. This demonstrates that many staff support measures to reduce the harms from HIV/AIDS and from drug use such as those recommended by ECAP, and see them as necessary not only for the protection of prisoners, but also for their own. Many staff also acknowledge that drug use is a reality in many prisons and that CSC has a responsibility to try to prevent not only the use of drugs, but also the harms deriving from it.

Results of the Staff Questionnaire

One other measure proposed by ECAP is, however, rejected by most staff: making clean tattooing equipment available to prisoners on an official basis to reduce the risks of infection. Making sterile injection equipment available in the institutions is also rejected by most staff. The Committee is concerned about this opposition because it believes that any measures undertaken to protect inmates and staff should be acceptable to all parties concerned. It hopes that its work, and in particular the sections in its *Final Report* that discuss the reasons why ECAP recommends that tattooing equipment be made available to inmates, and that research be undertaken that will identify measures that will further reduce the risk of HIV transmission in prisons, will convey to staff the importance of these measures. As emphasized by ECAP in its Report, making such measures available or undertaking such research will have to be accompanied by planning, communication and education that will make them acceptable to staff, inmates, and the public.

	Percent Stating Yes
Education on HIV/AIDS	
1. Is information about HIV/AIDS (for example, pamphlets or brochures) given to staff in your institution?	79
If no, should it be given to each staff member?	85
2. Are educational programs about HIV/AIDS (for example, lectures, video presentations) available to staff in your institution?	67
If no, should such programs be made available?	96
Should attendance in such programs be:	
• Voluntary	35
• Mandatory	65
Who should provide this education?	
• CSC or Health Canada	47
• Outside health or community organizations or individuals	28
• Both of the above	20
• Whoever is most qualified	6
Is more information needed for any of the following?	
• "Everything" (general update about HIV/AIDS)	71
• Transmission and prevention	63
• Universal precautions (infection-control procedures and practices)	65
• Counselling and employee assistance programs	49
• Symptoms	56
• Treatment/cure	42
• Safe needle/drug use	38
• HIV testing	52
• How to communicate with HIV-infected inmates	73
• Women and HIV/AIDS	41
• What resources/services are available for HIV-infected people?	65

Summary of Results

	Percent Stating Yes
Education on Drugs	
1. Is information about drug use (for example, pamphlets or brochures) given to staff in your institution?	57
If no, should it be given to each staff member?	75
2. Are educational programs about drug use (for example, lectures, video presentations) available to staff in your institution?	51
If no, should such programs be made available?	89
Should attendance in such programs be:	
• Voluntary	46
• Mandatory	53
Who should provide this education?	
• CSC or Health Canada personnel	47
• Outside health or community organizations or individuals	24
• Both	23
• Whoever is most qualified	6
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?	68
"Need to Know"	
1. To your knowledge, are there any prisoners with HIV infection or AIDS in your institution?	77
2. To your knowledge, are there any staff with HIV infection or AIDS in your institution?	3
3. Do you think that staff "need to know" prisoners' HIV status?	82
4. Do you feel that staff "need to know" fellow staff's HIV status?	35
5. Do you feel that prisoners "need to know" staff's HIV status?	17

	Percent Stating Yes
Condom Availability	
1. Has availability of condoms created any problems in your institution?	14
2. Are there other ways that should be used to make condoms available?	31
3. Should condoms be given to every prisoner at entry into prison (e.g., in first-aid or health-promotion kits)?	41
4. Should condoms be made available to every prisoner leaving the prison in so-called "prison exit kits"?	43
Needle Cleaning/Needle Exchange Programs	
1. Should prisoners be instructed how to properly clean injection equipment (needles and syringes; tattoo needles, etc.)?	57
2. Should clean tattooing equipment be made available to prisoners on an official basis to reduce the risks of infection?	25
3. Should bleach be made available to prisoners?	42
4. Should a needle exchange program be available to prisoners, that is, a program in which prisoners could trade in a used needle for a new, clean needle?	17
Self-Help Groups	
1. Are there self-help groups of prisoners with HIV infection or who have AIDS in your institution?	17
If no, should self-help groups be set up?	73
Health Services	
1. In your opinion, are there any problems with prisoners' access to health services for HIV/AIDS and/or drug use?	7
Other Issues	
1. 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?	28

McGill

Centre for Medicine,
Ethics and Law
3690 Peel Street
Montreal, Quebec, Canada H3A 1W9

Centre de médecine, d'éthique
et de droit de l'Université McGill
3690, rue Peel
Montréal (Québec) Canada H3A 1W9

Tel.: (514) 398-7400
Fax: (514) 398-4668
Telex: 05268510

The Expert Committee on AIDS and Prisons ("ECAP") was created by the Solicitor General of Canada on 15 June 1992. The Committee's goal is to assist the federal government in three major tasks:

1. promoting the health of inmates;
2. protecting staff;
3. preventing transmission of HIV and other infectious diseases in federal correctional facilities.

In order to achieve these goals, ECAP wants to obtain as much information as possible on these issues. ECAP has visited several prisons in British Columbia, Ontario and Quebec. It has met with Inmate Committees and with health care and other staff. In addition, letters have been sent to groups and individuals across the country and internationally asking for input and advice about the issues raised by HIV/AIDS and drug use in prisons. A questionnaire has been sent to Inmate Committees in every federal penitentiary to obtain input from prisoners on such questions as the availability of condoms, education about HIV/AIDS and drug use, confidentiality and HIV antibody testing, as well as questions regarding bleach and clean needles or syringes.

It is also essential to obtain input from prison staff. Therefore, ECAP is now writing to prison staff in order to obtain information on the concerns of staff with regard to their safety, and on concerns of prison authorities with regard to the maintenance of safety and order in the prison environment. We are asking you to complete the enclosed questionnaire and to return it to the address below before 31 March 1993. We are interested in learning about the personal concerns or opinions of staff regarding HIV/AIDS and drug use in prisons, and about measures which might ensure a safe working environment. Staff are invited to include their suggestions, recommendations or comments regarding HIV/AIDS and drug use in prisons on the questionnaire. Any information provided to ECAP will be considered confidential.

We enclose copies of the first two issues of ECAP NEWS, the newsletter of the Committee. We will send you future issues of this newsletter to keep you informed on our activities.

You can write us to obtain further information about our work, if you have any questions or if there are relevant matters which you feel the Committee should address.

Thank you very much in advance for your input into this important project.

Sincerely,

Ralf Jürgens, LL.M., Dr.iur.
ECAP Project Co-ordinator

ECAP Project Co-ordinator
McGill Centre for Medicine, Ethics and Law
new address: 3690 Peel Street
Montreal, Quebec H3A 1W9
TEL: (514) 398-6980 FAX: (514) 398-4668

Education on HIV/AIDS

1. **Is information about HIV/AIDS (for example, pamphlets or brochures) given to staff in your institution?**

   O yes
   O no

   If no, should it be given to each staff member?

   O yes
   O 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?

   O yes
   O no

   If no, should such programs be made available?

   O yes
   O no

   Please specify the reasons for your answer.

   Should attendance in such programs be

   – voluntary ..... O
   – mandatory ..... O

   Please specify the reasons for your answer.

   Who should provide this education?

   – CSC or Health and Welfare Canada personnel ..... O
   – outside health or community organizations or individuals ..... O

Please specify the reasons for your answer.

Is more information or education needed for any of the following?

- "everything" (general update about HIV/AIDS) ..... O
- transmission and prevention ..... O
- universal precautions (infection control procedures and practices) ..... O
- counselling and employee assistance programmes ..... O
- symptoms ..... O
- treatment/cure ..... O
- safe needle/drug use ..... O
- HIV testing ..... O
- how to communicate with HIV infected inmates ..... O
- women and HIV/AIDS ..... O
- what resources/services are available for HIV infected people ..... O

Education on Drugs

1. Is information about drug use (for example, pamphlets or brochures) given to staff in your institution?

   O yes
   O no

   If no, should it be given to each staff member?

   O yes
   O 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?

   O yes
   O no

If no, should such programs be made available?

O yes
O no

Please specify the reasons for your answer.

Should attendance in such programs be

- voluntary ..... O
- mandatory ..... O

Please specify the reasons for your answer.

Who should provide such education?

- CSC or Health and Welfare Canada personnel ..... O
- outside health or community organizations or individuals ..... O

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?

   O yes
   O no

   If no, what additional measures would you suggest should be adopted? Please specify.

Copy of the Staff Questionnaire

"Need to Know"

1. To your knowledge, are there any prisoners with HIV infection or AIDS in your institution?
   - O yes
   - O no

   If yes, how many?

2. To your knowledge, are there any staff with HIV infection or AIDS in your institution?
   - O yes
   - O no

   If yes, how many?

3. Do you think that staff "need to know" prisoners' HIV status?
   - O yes
   - O 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?
   - O yes
   - O no

   Please specify the reasons for your answer.

3. Do you feel that prisoners "need to know" staff's HIV status?
   O yes
   O 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?
   O yes
   O 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?
   O yes
   O 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)?
   - O yes
   - O no
4. Should condoms be made available to every prisoner leaving the prison in so-called "prison exit kits"?
   - O yes
   - O no

Needle Cleaning/Needle Exchange Programs

1. Should prisoners be instructed how to properly clean injection equipment (needles and syringes; tattoo needles, etc.)?
   - O yes
   - O 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?
   - O yes
   - O no

   Please specify the reasons for your answer.

2. Should bleach be made available to prisoners?
   - O yes
   - O 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, ?

O yes

O 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?

O yes

O no

If no, should self-help groups be set up?

O yes

O 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?

O yes

O 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?

O yes

O none, at this time

If yes, what are they, and how might they be addressed?

Copy of the Staff Questionnaire

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 6

RESULTS OF THE INMATE QUESTIONNAIRE*

BACKGROUND

Introduction

There has so far been only one study of knowledge, attitudes and behaviour of inmates in Canadian prisons.[1] The study, which was undertaken by Toepell in two provincial prisons in the Toronto region, examined prisoners' attitudes toward HIV-infected inmates, toward correctional staff and community groups, and toward HIV testing. Further, it explored identified high-risk behaviours prior to incarceration, including sexual behaviour either with or without condom use, injection drug use with and without sharing of needles, and tattooing. The study revealed that surveyed inmates had a high level of awareness concerning HIV/AIDS, but also that there were gaps in their knowledge, primarily related to myths and misconceptions. Many prisoners expressed strong "AIDS-phobic and homophobic attitudes."[2] They felt threatened if fellow inmates infected with HIV were in their units or ranges, and suggested separate living arrangements in prison for infected prisoners. 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 were injection drug users tended to share their equipment, mostly with their sexual partners, and commonly cleaned and shared equipment. Prisoners with tattoos were generally unaware of the risks involved when sharing tattoo guns, needles and inks. 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."[3]

Among the over 90 submissions the Committee received, one recommended that ECAP be dissolved and recast as PCAP (the Prisoners' Committee on AIDS and Prisons). In this submission, it is argued that reform by "experts" does not work, and that "when interventions are planned and executed by those who cage prisoners, the actual purpose of the reform

* ECAP's Project Coordinator, Dr. Ralf Jürgens, wishes to acknowledge Maria Hooey's assistance in the preparation of Appendix 6.

1. Toepell, AR. Prisoners and AIDS – Knowledge, Attitude and Behaviour. John Howard Society of Metropolitan Toronto, 1992.
2. Ibid. at iii.
3. Ibid. at iv.

becomes control not amelioration of suffering." ECAP took the concerns expressed in this letter very seriously. From the beginnning, the Committee made a great effort to hear from prisoners about their concerns and about how they would like to see the issues surrounding HIV/AIDS and drug use in prisons addressed. Therefore, during its prison visits, the Committee spent as much time as possible with the inmate committees to discuss their views and suggestions. Furthermore, individual prisoners were urged to write to the Committee and to express their personal concerns, opinions or suggestions regarding HIV/AIDS and drug use in prisons and questionnaires were sent to inmate committees in every federal penitentiary to obtain more input from prisoners into ECAP's work.

Rationale for the Study: Goals and Objectives

The goals and objectives for undertaking this study were similar to those of the study of staff's needs and opinions. ECAP undertook this study to obtain more input from prisoners. The Committee felt that prisoners should have an additional opportunity to raise any concerns they might have with regard to many of the issues raised in ECAP's report. A further objective was to raise awareness about the issues involved and about ECAP's work in general. Because the Committee believes that education will be an important component of any effort to prevent HIV transmission in prisons, it included in the questionnaire a variety of questions on the perceived educational needs of inmates. Responses to these questions will, it is hoped, assist CSC in the development of future educational programs for inmates. Finally, ECAP wanted to gain knowledge about acceptance of some of the measures that the Committee was considering should be undertaken in prisons to prevent HIV infection, and wanted to verify some of the information it had obtained during interviews with individual prison committees in prisons in British Columbia, Ontario and Quebec.

METHODOLOGY

Instrument

The instrument chosen was a questionnaire very similar to that given to institutional staff. It was developed by ECAP's Project Coordinator to address the specific goals of the study. The questionnaire was reviewed by ECAP's members and observers and some CSC staff, and is presented at the end of this appendix.

Design and Data Collection

A questionnaire was sent to inmate committees in federal correctional institutions to obtain information about inmates' opinions and concerns regarding the issues raised by HIV/AIDS and by drug use in prisons. In particular, inmate committees were asked about: (1) their educational needs with regard to HIV/AIDS and drug use; (2) whether condoms should be made more easily accessible; (3) whether inmates should be instructed how to properly clean injection equipment; (4) whether bleach or sterile needles should be made available to inmates; (5) whether there is concern that prisoners will not seek testing because they fear that their test results will not remain confidential; and (6) whether anonymous testing should be available for prisoners. Questionnaires were sent to federal correctional institutions, including community correctional centres, in October and December 1992 and in January 1993. They were addressed to the inmate committee of the institution, which was asked to consult on the issues addressed in the questionnaire, and to complete and return it to ECAP's Project Coordinator. The Committee also urged the inmate committees to inform prisoners in their institution about its activities, so that individual prisoners could also contact the Committee with suggestions, recommendations or comments regarding HIV/AIDS and drug use in prisons. The deadline for responding to the questionnaire, originally 15 December 1992, was extended twice, first to 15 January and then to April 1993. In order to keep inmate committees

informed about its work, ECAP included copies of ECAP NEWS, the Committee's newsletter, with its requests for information.

PARTICIPANTS

Inmate Committees

Although the questionnaire was sent out three times, only 21 inmate committees (about 40%) responded: three from the Atlantic Region of CSC, four from the Quebec Region, six from the Ontario Region, four from the Prairie Region, and four from the Pacific Region.

Inmates

Thirteen individual inmates (six from the Pacific Region, five from the Ontario Region and two from the Quebec Region) also filled out copies of the questionnaire.

Due to the small sample size, the survey does not claim to be representative of all inmates' opinions and needs, but should provide an overview of many of the issues relating to HIV/AIDS that concern inmates across Canada.

RESULTS

Introduction

The results of the questionnaires received from inmate committees follow. Results of the small sample of questionnaires received from individual inmates are included only if they are of particular interest. Results are presented according to the following categories:

1. Education on HIV/AIDS
2. Education on Drugs
3. Condom Availability
4. Needle Cleaning/Needle Exchange Programs
5. Testing and Confidentiality
6. Self-Help Groups
7. Other Issues

For each category, this section briefly presents the responses for each question and, where applicable, contains selected, slightly edited responses provided by inmate committees or individual inmates when asked to specify the reasons for their responses. A table summarizing the results of the questionnaire has been included at the end of this appendix.

EDUCATION ON HIV/AIDS

Information about HIV/AIDS

Most inmate committees (71%) reported that information about HIV/AIDS (for example, pamphlets or brochures) is given to inmates in their institution. All the committees for institutions who presently do not receive information about HIV/AIDS felt that prisoners in their institutions should be provided with such information.

Educational Programs about HIV/AIDS

Slightly less than half of the inmate committees (44%) stated that educational programs about HIV/AIDS (for example, lectures, video presentations) are given to inmates in their institution, indicating that "live education" for inmates is less frequent than handing out of educational brochures. All inmate committees who reported that "live" educational programs are not provided to inmates in their institution said that such programs should be made available.

HIV/AIDS Educational Program Attendance

Most inmates committees (85%) stated that attendance in educational programs should be voluntary.

Providers of HIV/AIDS Education

About two-thirds of the inmate committees (65%) felt that outside health or community organizations should provide educational programs on HIV/AIDS

to prisoners. About 15% of the inmate committees suggested that educational programs be a group effort, combining the knowledge of correctional officers, prison medical staff, fellow inmates, and outside health or community organizations. Another 10% agreed that education should be a group effort, with the exception of correctional workers. One inmate committee was interested in being educated by fellow inmates working with outside health or community organizations, and another committee suggested that programs should be offered by prison medical staff only. None of the committees wanted to be educated by correctional workers alone, nor were they interested in having programs run by fellow inmates alone.

Information Needed

Seventy-five percent of inmate committees reported that information or education on "everything" (general update on HIV/AIDS) is needed. When asked to prioritize the needs of inmates, the highest percentage of inmate committees (79%) said that information on how to communicate with HIV-infected inmates is needed. Seventy-one percent of committees indicated a need for information on transmission and prevention, on HIV testing and on the resources and services available for HIV-infected people. Inmates also expressed an interest in obtaining information on safe needle/drug use (69%), the symptoms of HIV (64%), women and HIV/AIDS (64%), and treatments (57%).

EDUCATION ON DRUGS

Information about Drug Use

A little over half of the inmate committees (55%) said that information about drug use (for example, pamphlets or brochures) is given to inmates in their institution. Almost all the committees (90%) who reported that information about drug use is not given to staff in their institution said that such information should be provided.

Education Programs about Drug Use

Sixty-eight percent of the inmate committees said that educational programs about drug use (for example, lectures, video presentations) are given to inmates in their institution, indicating that "live education" on drug, in contrast to "live education" on HIV/AIDS, is more frequent than the handing out of educational brochures. All inmate committees who reported that "live" educational programs are not provided to inmates said that such programs should be made available.

Drug Education Program Attendance

Almost all the committees (89%) felt that attendance in educational programs about drug use should be voluntary.

Providers of Drug Education

Most inmate committees (87%) were interested in being educated about drugs by outside health or community organizations. One committee suggested that both outside health or community organizations and fellow inmates should provide the education, and another suggested that educational programs with a combination of all groups should provide education on drug use. None of the committees were interested in educational programs provided by one group working alone, such as correctional workers or prison medical staff or fellow inmates.

CONDOM AVAILABILITY

Ways of Making Condoms Available

Condoms are made available in a variety of different ways in federal institutions. Many institutions provide condoms "at the nursing station, or at the hospital's clinic upon request." One inmate expressed some concern about this, as "inmates have to go to health care and request them, usually from a female nurse. For this reason, many people do not go to ask for condoms. Also, there are usually other inmates present." Condoms are depending on the

institution, made available "on the living ranges," "in dispensers in the shower room," "on shelves in the laundry areas," and in other "discreet, open locations." In some cases, "condoms are given freely to the inmate committee representative in each living unit. Distribution from that point varies." The number of condoms distributed greatly varies between institutions. In some cases, inmates are given one per request, whereas other institutions supply unlimited amounts. One inmate committee emphasized the importance of freely supplying condoms. They suggested that "condoms should definately not be sold. Once there is a cost involved, fewer inmates will avail themselves of the opportunity."

Other Ways of Making Condoms Available

Almost half of the inmate committees (47%) suggested other ways of making condoms available. Some suggestions were to make condoms available "in the gym," "the outside yard," "the canteen," and "random placement throughout the institution." One inmate committee suggested that condoms "should be available in dispensers or issued to every inmate. That way there would be no intimidation."

Availablility of Condoms When Entering and Exiting Prison

About half of the inmate committees (52%) responded that condoms should be given to every prisoner at entry into prison (e.g., in first-aid or health-promotion kits), and 76% said that they should be made available to every prisoner leaving the prison, in so-called "prison exit kits."

NEEDLE CLEANING/NEEDLE EXCHANGE PROGRAMS

Instructing Prisoners to Properly Clean Injection Equipment

Most of the inmate committees (80%) were in favour of instructing inmates how to properly clean injection equipment (needles and syringes, tattoo needles, etc.). Even more inmate committees (86%) thought that bleach should be made available to prisoners. One inmate committee stated that bleach should be made available, but only in controlled settings, e.g., "a specific inmate being allowed to sanitize needles." A few inmate committees opposed making bleach available "because in this prison it will only encourage men to be tattooed," or "because it could be used as a weapon." One committee questioned "why not have a confidential needle exchange program, carried out by health care, in prisons? Why not have professional tattoo artists visit institutions to sell their services to those who want tattoos?"

Needle Exchange Program Made Available to Prisoners

Inmate committees (74%) were also in favour of setting up needle exchange programs for prisoners. Inmates committees suggested a few methods of exchanging needles. Some inmate committees were in favour of having "outside health organizations coming in and doing the exchanges," and suggested that they "should be located in a private area of the institution where no CSC staff can monitor who uses it." Other committees suggested that "the clinic should be made available for a needle exchange program so that the clinic staff can ensure that health and safety requirements are met. This method would be a most suitable way of attaining anonymity in this type of setting." As well, some inmate committees suggested that an exchange could be set up "by inmate committees in the inmate committee office. Used needles would be returned by the inmate committee to health care staff for safe disposal." "No questions or names" would be asked. Another committee suggested that the exchange of needles could be accomplished very easily by allowing an inmate (approved by other inmates) access to the living units for this purpose. One inmate in favour of needle exchange programs added that these "programs should also discourage people from injecting drugs."

Of the few inmate committees who were not in favour of making a needle exchange program available to prisoners, it was suggested that such a program "would be promoting illegal drug use." "If it is illegal on the street, why promote it in a confined society." Others felt that "shooting dope and tattooing are illegal activities. Prisoners would never draw "heat" on themselves that way – the needle exchange would not work," especially "with correctional officers being able to watch it." One committee was concerned that a needle exchange "does not give inmates any hope for change and with the excellent substance abuse programs they provide here, one can easily give up the habit." One individual inmate did "not agree with hard drugs being condoned," and suggested "that alternatives like methadone should be provided." Another inmate informed ECAP that he has "already heard inmates who do not currently use intravenous drugs say that they are looking forward to a needle program so that they can get into this advanced form of drug use. Do we want to make it easier? Do we want to increase drug use? Are we then going to supply drugs too, to make sure that it is of the highest quality? There is no end to this."

TESTING AND CONFIDENTIALITY

In general, inmate committees (75%) were concerned that prisoners would not seek testing because they fear that test results would not remain confidential in their institution. Consequently, most inmate committees (80%) favoured providing inmates with access to testing by someone not connected with the prison system (for example, an outside doctor or agency), and almost as many committees (75%) were in favour of anonymous testing.

Inmate committees were in favour of a system where test "results remain only in health care and are not disclosed to any other person." It was felt that "other than medical staff, no other personnel should be able to obtain medical information," and that it was necessary to "treat a positive diagnosis as strictly a medical issue, not a security concern." In the event that security is informed, it was suggested that "security should be made aware of how to handle the information responsibly and professionally because sometimes it is to the inmate's advantage that someone knows." Some inmates feel that "totally anonymous testing by outside agencies is the only way to ensure greater confidentiality." One inmate suggested that confidentiaility wouldn't be such a concern if we can "educate all citizens about the reality of HIV," as "it is a problem that cuts across social and cultural boundaries" and "affects all persons in some way."

SELF-HELP GROUPS

Few inmate committees (15%) reported that there are self-help groups of prisoners with HIV infection or AIDS in their institution, but most committees (73%) were in favour of setting them up.

OTHER ISSUES

Some inmate committees and individual inmates took advantage of the opportunity given to them and added a list of further issues relating to HIV/AIDS or to drug use that were of concern to them, or made longer comments on the space provided for that purpose. A few inmates were interested in receiving "more information about hepatitis B" and "tuberculosis." Another inmate commented on the importance of education:

> It is so sad to see that in this day and age some people believe you can actually get the virus by kissing, sharing a cigarette, using a public payphone, etc. By making education mandatory in schools and in the workplace, we would put a lot of people's unfounded fears to rest and teach people to be more understanding and caring about a disease that is becoming increasingly widespread and is affecting each and every one of us.

Many inmates and inmate committees were concerned about the drug programs and the issues relating to drug use in the instiutions. For example, one inmate commented that "there is concern that the issue of needles in prisons will continue to be treated as a criminal issue, not as a medical issue. This will result in more prisoners

being at risk of contracting and/or transmitting the virus." Another inmate committee stressed the need for a change in the present drug programs:

> Prisoners in the Pacific Region are appr. 90% drug users, and most of them have no interest in changing their behaviour in this regard. For those who do substance abuse programs, they are a waste of time – dispensing of outdated or factually false information. Most of the programs are taught by CSC personnel who have no personal experience with drug use. The programs are a bust, and the only reason why many people participate in them is that they would not otherwise get paroled or be transferred.

CONCLUSION

In many ways, the results of the inmate questionnaire are similar to those of the staff questionnaire. In particular, this is true of the need for education about HIV/AIDS and about drug use that was expressed in the responses to both questionnaires. However, while many staff indicated that educational programs could or should be provided by CSC or Health Canada personnel, a vast majority of inmates indicated that such programs should be provided by outside groups. This reaffirms ECAP's position that education for prisoners should at least be complemented by input from outside groups, because inmates are more likely to trust outside groups and will feel more comfortable addressing difficult issues such as sexuality and drug use with them.

Not surprisingly, inmate committees were more favourable than staff toward some of the measures that could be undertaken to reduce the spread of HIV in prisons. In particular, a majority of committees not only supported instructing inmates about how to properly clean injection equipment and making bleach available to them, but also setting up needle exchanges in prison. They made several proposals about how this could be done.

An issue that ECAP addressed at great length in its report is that of testing and confidentiality of test results. The questionnaire confirmed what the Committee had consistently heard in its many conversations with inmates: inmates fear that the results of an HIV test will not remain confidential. Two of the measures proposed by ECAP to address inmates' concern, namely to make testing by outside agencies and anonymous testing available to inmates, were widely supported by inmate committees in this survey. To allow more inmates to be tested without fear that their result will be disclosed, it will be important to act quickly on ECAP's recommendations.

Summary of Results

	Percent Stating Yes
Education on HIV/AIDS	
1. Is information about HIV/AIDS (for example, pamphlets or brochures) routinely provided to inmates in your institution?	71
If no, should it be given to each prisoner?	100
2. Are educational programs about HIV/AIDS (for example, lectures, video presentations) available to inmates in your institution?	44
If no, should such programs be made available?	100
Should attendance in such programs be	
• voluntary	85
• mandatory	15
Who should provide such education?	
• correctional workers	0
• prison medical staff	5
• fellow inmates	0
• outside health or community organizations	65
• all of the above	15
• prison medical staff, fellow inmates and outside health or community organizations	10
• fellow inmates and outside health or community organizations	5
Is more information or education needed for any of the following?	
• "everything" (general update about HIV/AIDS)	75
• transmission and prevention	71
• symptoms	64
• treatment/cure	57
• safe needle/drug use	69
• HIV testing	71
• how to communicate with HIV-infected people	79
• women and HIV/AIDS	64
• what resources/services are available for HIV-infected people	71

	Percent Stating Yes
Education on Drugs	
1. Is information about drug use (for example, pamphlets or brochures) routinely provided to inmates in your institution?	55
If no, should it be given to each prisoner?	90
2. Are educational programs about drug use (for example, lectures, video presentations) available to inmates in your institution?	68
If no, should such programs be made available?	100
Should attendance in such programs be	
• voluntary	89
• mandatory	11
Who should provide such education?	
• correctional workers	0
• prison medical staff	0
• fellow inmates	0
• outside health or community organizations	87
• all of the above	7
• fellow inmates and outside health or community organizations	7
Condom Availability	
1. Should condoms also be made available by other mechanisms or channels?	47
2. Should condoms be given in a "condom kit" to every prisoner at entry into prison?	52
3. Should condoms be made available to every prisoner leaving the prison in so-called "prison exit kits"?	76
Needle Cleaning/Needle Exchange Programs	
1. Should prisoners be instructed how to properly clean injection equipment (needles and syringes; tattoo needles, etc.)?	80
2. Should bleach be made available to prisoners?	86
3. Should a needle exchange program, where prisoners could trade in a used needle against a new, clean needle, be available to prisoners?	74

Summary of Results

	Percent Stating Yes
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?	75
2. Should prisoners have access to testing by someone not connected with the prison system (for example, an outside doctor or agency)?	80
3. 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)?	75
Self-Help Groups	
1. Are there self-help groups of people with HIV infection or who have AIDS in your institution?	15
If **no**, should self-help groups be set up?	73
Other Issues	
1. Are there other issues relating to HIV/AIDS and/or drug use in prisons that are of concern?	32

McGill

Centre for Medicine,
Ethics and Law
3690 Peel Street
Montreal, Quebec, Canada H3A 1W9

Centre de médecine, d'éthique
et de droit de l'Université McGill
3690, rue Peel
Montréal (Québec) Canada H3A 1W9

Tel.: (514) 398-7400
Fax: (514) 398-4668
Telex: 05268510

The attached questionnaire was sent to your Committee and to the Inmate Committees in every federal penitentiary in October and December 1992. We kindly asked you to consult on the issues addressed in the questionnaire, to complete the questionnaire and to return it to the address below.

In addition, we are also interested in learning of the concerns and opinions of individual prisoners regarding HIV/AIDS and drug use in prisons. We therefore urged you to inform prisoners in your institution about our activities, so that they could contact the Expert Committee on AIDS and Prisons (ECAP) with suggestions, recommendations or comments regarding HIV/AIDS and drug use in prisons.

During the last months, we have received many responses to our request. However, we have not heard from you or any prisoner in your institution. Once more, we would like to encourage you and prisoners in your institution to inform us of your opinions concerning the availability of condoms, education about HIV/AIDS and drug use, confidentiality and HIV antibody testing, as well as questions regarding bleach and clean needles or syringes.

We feel strongly that your input is very important. In order to give you more time to respond to our request, we have extended the deadline for submissions to **15 April 1993**.

To keep you informed of our activities, we enclose a copy of the third issue of *ECAP NEWS*.

You can write us to obtain further information about our work if you have any questions or if there are relevant matters that you feel the Committee should address.

Many thanks in advance, and best regards,

R. Jürgens

Ralf Jürgens
ECAP Project Coordinator

ECAP Project Coordinator
McGill Centre for Medicine, Ethics and Law
new address: 3690 Peel Street
Montreal, Quebec H3A 1W9
Tel: (514) 398-6980 Fax: (514) 398-4668

Copy of the Inmate Questionnaire

ECAP-Questionnaire

Education on HIV/AIDS

1. Is information about HIV/AIDS (for example, pamphlets or brochures) routinely provided to inmates in your institution?

   O yes
   O no

   If no, should it be given to each prisoner?

   O yes
   O no

2. Are educational programs about HIV/AIDS (for example, lectures, video presentations) available to inmates in your institution?

   O yes
   O no

   If no, should such programs be made available?

   O yes
   O no

   Should attendance in such programs be

   - voluntary ..... O
   - mandatory ..... O

   Who should provide such education?

   - correctional workers ..... O
   - prison medical staff ..... O
   - fellow inmates ..... O
   - outside health or community organizations ..... O

   Is more information or education needed for any of the following?

   - "everything" (general update about HIV/AIDS) ..... O
   - transmission and prevention ..... O
   - symptoms ..... O
   - treatment/cure ..... O
   - safe needle/drug use ..... O
   - HIV testing ..... O
   - how to communicate with HIV-infected people ..... O
   - women and HIV/AIDS ..... O
   - what resources/services are available for HIV-infected people ..... O

Education on Drugs

1. Is information about drug use (for example, pamphlets or brochures) routinely provided to inmates in your institution?

   O yes
   O no

   If no, should it be given to each prisoner?

   O yes
   O no

2. Are educational programs about drug use (for example, lectures, video presentations) available to inmates in your institution?

   O yes
   O no

   If no, should such programs be made available?

   O yes
   O no

   Should attendance in such programs be

   – voluntary ..... O
   – mandatory ..... O

   Who should provide such education?

   – correctional workers ..... O
   – prison medical staff ..... O
   – fellow inmates ..... O
   – outside health or community organizations ..... O

Condom Availability

1. How are condoms made available in your institution?

2. Should condoms also be made available by other mechanisms or channels?

   O yes
   O 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?
   - O yes
   - O no
4. Should condoms be made available to every prisoner leaving the prison in so-called "prison exit kits"?
   - O yes
   - O no

Needle Cleaning/Needle Exchange Programs

1. Should prisoners be instructed how to properly clean injection equipment (needles and syringes; tattoo needles, etc.)?
   - O yes
   - O no
2. Should bleach be made available to prisoners?
   - O yes
   - O 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?
   - O yes
   - O 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?

   O yes

   O no

   Should prisoners have access to testing by someone not connected with the prison system (for example, an outside doctor or agency)?

   O yes

   O 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)?

   O yes

   O 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?

O yes

O no

If **yes**, how are they set up? Please describe their activities.

If **no**, should self-help groups be set up?

O yes

O no

Other Issues

Are there other issues relating to HIV/AIDS and/or drug use in prisons that are of concern?

O yes

O none, at this time

If yes, what are they, and how might they be addressed?

APPENDIX 7

DISCLOSURE OF OFFENDER MEDICAL INFORMATION: A LEGAL AND ETHICAL ANALYSIS*

> [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]

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 paper addresses some of the issues raised in federal correctional institutions by the generation and communication of personal medical information pertaining to 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

* This paper was prepared by R. Jürgens and N. Gilmore, McGill Centre for Medicine, Ethics and Law. The authors wish to acknowledge the contribution of Prof. M.A. Somerville in preparing the 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.

Canada and the disclosure of offender medical information.[3]

ANALYSIS OF THE LEGAL, ETHICAL, AND POLICY BACKGROUND

The Duty of Confidentiality

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 law[6] 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 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

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 peformed 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.

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.

> 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, 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 the 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.

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, and 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]

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]

11. *Hay*, supra, note 10 at 757-758.
12. *McInerney*, supra, note 8 at 153.
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 pysician 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.
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.

PRISON POLICY

The general principle according to which medical information is confidential also applies in correctional institutions. Inmates have the same rights, including those of autonomy, inviolability, and confidentiality, as any other Canadian, except where these rights are necessarily 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:

> 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 diagnoses 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]

Exceptions to the Duty of Confidentiality

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 that permit or even require a breach of confidentiality.

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.

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 that 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 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-seropositive 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

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.

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 *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.

public safety."[31] Courts in some states 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]

ETHICAL OBLIGATIONS

The ethical obligation to maintain confidential the information 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 "[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

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); *Skillings v. Allen,* 143 Minn. 323, 173 N.W. 663 (1919) (scarlet fever); *Edwards,* 69 N.H. 599, 45 A.480 (infectious sore); *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 case law, see Belitzky and Solomon, supra, note 19 at 204-207.

36. (1987), 137 *Can. Med. Ass. J.* 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.

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).

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]

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 on 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]

> [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

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.

43. The Privacy Commissioner of Canada, supra, note 2 at 40.

44. Ibid. at 40.

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]

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]

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] (1) the harm(s) to be avoided must be serious and probable, and would not be avoidable without disclosure; (2) 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; (3) 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; (4) 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.

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.

45. National Advisory Committee on AIDS. *HIV and Human Rights in Canada*, 1992 at 17.

46. Somerville, supra, note 1 at 211.

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.

50. Gilmore and Somerville, supra, note 5 at 6.

"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 that 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.

The Objective of Disclosure

There are two situations in which claims for disclosure of offender medical information may arise: (1) disclosure preceding exposure to HIV in order to prevent HIV transmission; and (2) disclosure following exposure to HIV. These situations are discussed separately.

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.

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 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.

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.

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 will occur. The risk or probability of HIV transmission varies greatly. It depends upon the

type of exposure (skin or mucosal contact, or innoculation 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.

(1) 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.

(2) 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 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 over-estimated 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]

(3) 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.

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.

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.

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 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: (1) 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 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. (2) 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

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.

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 could 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 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 choose not 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]

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.

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 at 248.

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-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

63. Heilpern H., Egger, S. AIDS in Australian Prisons – Issues and Policy Options. Canberra: Department of Community Services and Health, 1989 at 21.
64. Memorandum from M.H. Zazulak: note *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.

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. 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 counterproductive. In contrast, interventions that 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 substantially reduce 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 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 that can prevent or reduce sexual assault from occuring 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 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

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.

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.

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.

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]

CONCLUSION

From the foregoing, it should be clear that in most situations disclosure of offender medical

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.

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.

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: (1) the information would seldom, if ever, provide useful protective information; (2) for their own interest, staff need to apply precautions universally and assume that everyone in the institution is or may be infectious; (3) 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, benefits, potential or actual, 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: (1) First, the restricted mobility of prisoners can augment the risks and harms that may result from being known to be HIV infected.[73] (2) 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. (3) Third, some of the benefits or services that 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 that they might not otherwise have obtained.[75]

Specific Concerns Relating to the Disclosure of Personal Medical Information

There are specific concerns that 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.

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

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.

74. Tomašević 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.

whatever marginal benefits might be gained by the disclosure.

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.

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.

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.

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.

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 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.

76. Gilmore and Somerville, supra, note 21 at 16-19.

When a family visit is postponed or cancelled, the reason for this should not be disclosed to staff or to fellow inmates.

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.

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.

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.

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.[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

77. Memorandum from M.H. Zazulak: note *supra,* at 5.

78. Gouvernement du Québec, Bureau du coroner. Rapport d'investigation, Claude Paquin, Coroner investigateur, Montréal le 24 novembre 1992.

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)).

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 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.

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 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. To educate staff and inmates about precautions that 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 that 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.

80. Somerville and Gilmore, supra, note 21 at XXII.

APPENDIX 8

"HIV/AIDS in Prisons": Selected Presentations Given at the Sessions on "HIV/AIDS in Prisons" at the 6th and 7th Annual British Columbia AIDS Conferences

6TH ANNUAL BRITISH COLUMBIA AIDS CONFERENCE

A special session on "HIV/AIDS in Prisons," organized by ECAP's 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, Inmate, Mission Institution, *An HIV Positive Prisoner's View*;
- Rodger Brock, Warden, Mission Institution, *A Warden's Perspective*;
- John Turvey, Downtown Eastside Youth Activities Society, *The Role of Community Groups*;
- Ray Sill, Allied 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, Health Care Planning, 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*.

The texts of the presentations given by Michael Linhart and by Diane Riley follow.

An HIV Positive Prisoner's View

Michael Linhart, Prisoner, Mission Institution

I have been asked to speak to you and give a prisoner's view of what it is like to be HIV-positive and incarcerated in a federal prison. My knowledge is limited to my personal experiences and conversations I have had with other prisoners who have been tested, considered being tested, or are considering being tested. These things in no way make me an expert on what it is like to be HIV-positive in prison, and I should not be taken as speaking for the needs of all infected prisoners. The things I say are only an attempt to try and help you understand the very different environment in which a prisoner with HIV finds himself.

As late as 1989, HIV-positive prisoners in federal institutions in Ontario and Alberta were being isolated from the general population. These prisoners were subjected to inhumane treatment. I had heard rumours of this treatment while awaiting trial. When I requested an HIV test while on remand, I learned firsthand that prisoners were isolated when being tested. A newspaper article told me infected prisoners on remand remained isolated. After watching an episode of W5 [a news-documentary television program], I learned the rumours about the treatment of HIV-positive prisoners, were largely true. These things caused me to reject the idea of being tested while in Ontario, although I suspected I had been infected.

Among the questions and fears I had were:

(1) Would I be isolated and subjected to the same kind of inhumane treatment I had seen on W5?

(2) With a positive diagnosis would I be able to transfer to other institutions?

(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 HIV?

(9) What will the Correctional Service do in the future to ensure that my needs will be met?

I have spoken with other prisoners who have been in different institutions across the country. For prisoners who have thought of these issues, such questions seem to be pretty much consistent among prisoners who think they have engaged in high risk activities. Most of us cannot help but wonder why the Correctional Service of Canada does not properly inform prisoners of the treatment they will receive should they test positive. Had I known I would not be isolated I would almost certainly have been tested sooner. Because of the horror stories I had seen on W5, and rumours I had heard, I waited for three and a half years to be tested.

No prisoner expects to be given guarantees on how other prisoners will react. Prisoners react differently in every region, and at different security levels. What they need to hear is that testing positive is not cause for being denied a transfer, that they will not be segregated and, most importantly, that they have nothing to fear from contact with infected prisoners unless both parties are engaged in one of the three high-risk activities. Within Canadian prisons tattooing, needle sharing and unprotected anal sex (both consensual and non-consensual) rank as the methods of frequent transmission. Not all prisons

have the same ranking for the frequency of high-risk behaviour. In Eastern Canada tattooing is more common than needle sharing. Whatever the order, there is no denying the fact that prisoners are engaging in high-risk behaviours.

There can be times when the medical needs of an infected prisoner cannot be met due to the lack of proximity of an institution to necessary medical facilities. In this way, there is no difference between an HIV-infected inmate and an inmate with acute medical needs.

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 provide.

I freely admit there are and will always be prisoners who will try to "scam" stronger, more effective drugs from an institutional doctor. But this happens in virtually every city — not just in prisons. As a result of these various and inventive "scams," nursing staff in institutions can become very jaded toward prisoners as a whole. There are many examples I could cite where a valid concern has been dismissed as a trivial complaint or as an attempt by a prisoner to obtain one drug or another.

Several months ago I contracted a stomach flu that produced excessive diarrhea. After a couple of days of intense diarrhea, I became worried that there might be something wrong. I went to the health care centre and explained the problem. I was given a bottle of Kaopectate and told to go back to work. When the Kaopectate did nothing to stop the diarrhea, I became worried. Again, I went to health care, and the same nurse said that I had nothing to worry about. She made no effort to listen to my fears or to get more information. If she had taken the time to explain more about the parasite I feared, and to explain that a stomach flu was the probable cause of the diarrhea, a lot of time and anxiety could have been spared.

Although the medical profession has yet to acknowledge HIV as a field of speciality, there are an increasing number of doctors whose entire practice revolves around HIV-positive patients. As a result, these doctors have much more time for and interest in keeping abreast of the latest developments, and are better able to recognize symptomatic problems earlier. If I were living in the community I would be able to go to a doctor with this type of practice. A doctor whose patients are primarily HIV-positive is more knowledgeable than a general practitioner, who treats everything from ear infections to ingrown toenails. I have been provided with a virologist to monitor the virus and a haematologist to treat a Platelet condition related to the virus.

In my opinion, prisoners should be given a greater degree of consideration when they bring a medical complaint to the health-care staff. The few minutes it takes to listen to prisoners and respond would save time later on.

It would be unfair of me to talk about health-care staff without saying that there are many who do genuinely seem to care about the medical needs of prisoners. They have a difficult job, and must try to discern who is attempting to pull a "scam" and who has a valid medical concern. As a prisoner, I would offer this: Take the time to hear what the prisoner has to say, ask questions. Any "scam" I have ever heard, and I have heard and used a great many, will quickly become self-evident with a few carefully chosen questions.

My questions regarding confidentiality were quickly answered when I was escorted to my first doctor's appointment after receiving my diagnosis. The essential security requirement when escorting a prisoner on a pass is that the prisoner remain

within sight and sound. This is done in order to meet the Correctional Service of Canada's mandate to ensure the protection of society. There is no way a prisoner can speak freely to his doctor when there is one or more security staff in the room. I have been told that they are expected to keep what they heard in their confidence. However, I also know security staff are human and make mistakes. I also know some staff have told other staff and prisoners there was an "AIDS inmate" in the institution.

Recently there was a case of a case management officer talking to another prisoner about the prisoner's friend, who was HIV-positive. At the same time the infected prisoner heard from other prisoners that the case manager had informed other prisoners about who the rumoured HIV-positive prisoner was. The HIV-positive prisoner experienced a few days of grief worrying about how the rest of the population would react to the news. Were his fears of violence and social isolation about to become a reality? Fortunately, they were not!

In fact, as a result of this situation, the prisoner decided it was now time to stop hiding the "secret" and, to use a common phrase: "stand up and be counted." Since taking this step I have found a number of truly supportive people. There are three fellow prisoners who have been there whenever I felt the load had become too heavy to carry alone. They have exhibited a compassion, empathy and understanding that would amaze even the strongest critic of prisoners.

Not every prisoner has been receptive or kind. I have listened to some negative comments. I have learned they are simply part of what is to be expected. I would have heard many things even if I were living in the community. Most times, they are a result of fear, ignorance or a simple lack of consideration for other people's feelings. There has been no strong objection raised by any prisoner to being around HIV-positive prisoners. To be frank, Mr. Brock [former Warden of Mission Institution] would not tolerate it. So, the answer to the question, "How other prisoners will react to my being HIV positive?" has been largely favourable, to a degree that I would never have believed. It has been nice to know that, in Mission at least, my fears were largely unfounded.

There probably always will be more that can be done to dispel the ignorance and fear surrounding HIV-positive prisoners. It is a slow process, and it will take time, patience and perseverance. Prisoners are highly resistant to change, but no man can hold out forever. Recently, the administration gave their approval to a group run by and for prisoners; it will work with the institution in creating an even greater understanding of HIV/AIDS issues.

The question of available support services for infected prisoners is a complex issue. At present, there is nothing locally for people living with HIV/AIDS. It is my hope that this will change in the near future. However, I realize it will take both interest and effort for this to happen and it may be that, at the present time there is a decisive lack of one or both of these elements. With the rate at which the infection is being spread, this will undoubtedly change.

In the Vancouver area there are no less than seventeen support groups or therapies available to persons living with HIV/AIDS. In Mission Institution there is only the newly founded group, meetings with Xavier [Sanchez Horno], my peer counsellor, and friends without whom I would be lost, conversations with those precious three friends who have really been there for me, my terrific work supervisor, health care staff, my AA/NA group, Pathfinders, and a few wonderfully caring staff such as Sandy, who is one of my escorts today. What is sadly lacking is the opportunity to sit and share with other infected and affected persons the frustrations, feelings, trials, tribulations and successes we all experience as we learn to live with HIV and AIDS. Although I am unable to make use of the support services within the community, I am still fortunate. In Kent, Matsqui, Mountain and Ferndale Institutions there is nothing available to HIV-infected prisoners. In addition, from everything I have learned, the general attitude of prisoners to HIV-positive prisoners is decidedly negative.

It is my hope that some of you attending this conference will want to become involved with one or more of the prisons. If you wish to make contact with any of these institutions to offer your assistance, you can do so by contacting the chaplain for that institution. ...

Two of my original nine questions remain to be answered. One is: "What will the Correctional Service do to meet my needs in the future?" I am not qualified to answer this question. However, I can tell you what I would like to see happen:

(1) HIV-positive prisoners should be considered a special needs group. Special funding should be provided to each institution to be used in meeting the needs of this group.

(2) Infected prisoners must be given a greater input into their treatment and disease management, including a greater involvement in choosing the doctor they see. HIV-positive prisoners should be provided with doctors who have become familiar with many early warning signs of symptomatic infections.

(3) Communities and the Correctional Service of Canada must find a way to bridge the gap between them, and work together in advocating responsible behaviour, educating prisoners, staff and members of the community and in providing support to infected prisoners.

(4) Prisoners must be given the right to manage their disease so long as security concerns can be met. Meeting security concerns must remain a key component, to ensure that the protection of society remains the priority. This means allowing prisoners access to alternative treatments if that is what the prisoner feels is best for them. ...

(5) The health-care managers and deputy commissioners in each region should meet with infected and affected prisoners and with representatives from community agencies and support services to discuss needs, support and future programs.

(6) Case mangement officers should be provided with special training on dealing with infected prisoners. It is important for case managers to understand that this is a disease with both a physical and psychological effect.

(7) Health-care workers in every institution should take full advantage of the resource and information services available in agencies such as AIDS Vancouver and the Persons with AIDS Society. While these agencies are not "medical" centres, there is much that can be taken from these agencies that would be useful in dealing with HIV-infected prisoners. A case in point: for the past year there has been a standing offer for health-care staff from one institution to visit the offices of both the Persons with AIDS Society and AIDS Vancouver. To date, there has been no serious attempt to make this visit a reality.

(8) There is a need for institutional staff to work with community agencies and infected prisoners to promote greater support and understanding of HIV/AIDS-related issues among prisoners. Infected and affected prisoners should be encouraged to take a more active role in advocating responsible behaviour, and especially in providing education to prisoners and their families.

(9) There is increasing evidence that diet control and proper nutrition is a beneficial method of managing the virus. Institutional physicians should become willing to provide prisoners with special diets. The proper diet is simple, and does not represent any major increase in the cost of feeding the prisoner. I requested a diet low in fat and high in complex carbohydrates, proteins, raw vegetables and fresh fruits and received it without too much difficulty. It has helped to make a difference in my helper/suppressor cell counts. But Mission is the exception rather than the norm. In other institutions this would not be as easy to accomplish.

At Mission Institution, an HIV/AIDS Support Group has been founded. It is my hope that other institutions will begin the development of similar groups in the near future. The objectiives of this

group are: (1) to advocate responsible behaviour by prisoners and their families; (2) to begin to work with the institution in providing greater awareness of HIV/AIDS issues within the prison; (3) to assist the institution in meeting its mandate to educate prisoners about HIV/AIDS issues; (4) to develop a book that will contain simple, easy to read and understand information about HIV/AIDS issues; (5) to develop a list of resource agencies, community contacts and support services available within the community; (6) to earn the respect and trust of prisoners and staff alike, and be able to function as a liaison between the two; (7) this Group is based on the assumption that prisoners are more receptive to new ideas presented by other prisoners.

Now only one of my original questions remains unanswered: "What will happen to me if the virus becomes life-threatening?" I wish I could answer that question for myself, let alone for all of you. My greatest single fear is dying in prison. I am doing everything in my power to prevent the disease from getting a hold. In three months, through a weight training program and a special diet, I have brought my helper/suppressor cell count from 46 to 55. Through greater attention to my health and body, I have gained 35 pounds in the past seven months, an accomplishment I am proud of. I believe I can continue to maintain and even improve on these things. What will happen, will happen. I hope and pray I will meet it with strength and courage.

I refuse to spend a great deal of time thinking about what may happen. The only moment I can be certain I will have is this one. I can and will look to the next moment. Since I learned that I was HIV-positive, I have begun to grow. I have come to appreciate the value of living, something I never understood before. Most importantly, I have learned that life is for the living, and I, like all of you, am living — many of us with HIV and AIDS.

Drug Use in Prisons

Diane Riley, Senior Policy Analyst, Canadian Centre on Substance Abuse, and Department of Behavioural Science, University of Toronto

AIDS AND DRUG USE

In many parts of the world, including North America, injection drug users (IDUs) and their sexual partners are now the group in which there is the highest rate of increase of infection with HIV. In the United States, 35% of all HIV infection is now IDU related. Injection drug users are also the primary means by which AIDS spreads to the heterosexual population in most countries. In North America, the majority of women with HIV infection have acquired it through their own injecting behaviour or that of their partner, and almost all cases of newborn infection are IDU related (see also Riley, 1991, and in press). Drug use in general is associated with the spread of AIDS, in that there is a correlation between AIDS and sex-for-drugs activity as well as between drug use (including alcohol use) and unsafe sexual practices.

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. Homosexual behaviour in prison often involves persons who are of a heterosexual orientation outside prison and thereby provides a "bridge" between IDUs and the heterosexual population as well as the homosexual population. As a result infections such as HIV and hepatitis can be transmitted between and amongst the different populations.

DRUG USE AND CRIME

The link between drug use and crime is complex and highly politicized. Although the nature of the causes and the direction of causality are not known, it is true to say that substance abuse is associated with a criminal lifestyle that includes

such characteristics as aimlessness, self-absorption and an inability to relate to other people. The very nature of the criminal lifestyle and the risk-taking inherent in it suggests that alcohol and other drugs would be an important factor as both an accompaniment or facilitator of the crime and as a way of coping with the consequences of the lifestyle. There is also a relationship between drug use and crime, in that some users commit crime in order to pay for their drugs (see, e.g., Fazey, 1991).

A study conducted by the Correctional Service of Canada (CSC) in 1989/90 found that more than 10% of 371 prisoners admitted using drugs every day in the six months prior to incarceration and 17% had regular drinking binges. Sixty-four percent of offenders said that they had consumed alcohol or other drugs on the day of their crime (Robinson et al., 1991).

Figures from France, Holland, Switzerland, Italy and Spain indicate that, during the three months prior to entry, 20 to 30% of prisoners had injected drugs at least once a week (Harding, 1990). This fact alone explains why prisoners are at risk for being HIV-positive on entry to European prisons. Prisons are the single largest response to the drug problem in most European countries. More resources are used in moving drug users through the criminal justice system in Europe than on any other form of management, medical or social (Harding, 1990).

As a consequence of drug prohibition in the United States, the prison population has increased to one and a half million inmates in the last fifteen years. In addition, in 1990 2.5 million people were maintained in correctional control under probation or parole. While the majority of drug users are white, the majority of people arrested for drug use are black. While African Americans represent only 12% of the US population, they account for nearly 40% of the nation's prisoners. Twenty-five percent of all African-American men between the ages of 20 and 30 are either in prison, on probation, or under parole — more than are in American colleges. About half of these incarcerations are drug-related offences and another 20 to 30% involve drug users. In the United States, imprisonment has been the primary response to the drug problem, as reflected in the following statement by William Bennett, former drug czar: "We need ... a sustained commitment to the drug war. We must build more prisons. There must be more jails." (1989) Deinstitutionalization of psychiatric patients in the United States has caused additional problems for the criminal justice system: today there are ten times as many mentally disturbed and/or substance abusing persons in prisons and jails than there are in mental hospitals (Pepper and Massaro, 1992).

Canada has the dubious honour of having the highest number of drug arrests per capita of any nation other than the United States. With respect to drug legislation and enforcement it has recently been described as having "a bite worse than its bark" (MacCoun et al., 1992). There are currently 1200 inmates serving time for drug-related offences in Canadian federal prisons. By far the majority of drug offences are seen in the provincial systems. Between 1985 and 1990, there were 16,541 sentenced admissions to provincial prisons in Canada for drug-related offences (Correctional Services Canada, 1990). Lest we feel smug in comparing ourselves with the United States, we should remember that there are more drug users in Canadian prisons than there are in treatment programs.

While drug use declined in Canada in the period 1986-1989, there was an increase in the overall drug-related crime rate, with a significant number of those charged being given a prison sentence (Erickson, 1992). In 1990, 64% of the 60,000 drug offenses in Canada were for cannabis-related offences; the majority were for simple possession only (Williams et al., 1992). With respect to cocaine, total convictions increased from 2,800 to 6,900 between 1985 and 1989. Furthermore, those imprisoned for cocaine possession rose from 17% to 29% of cases. Increased resources have been put into local drug squads. For example, in Toronto 97 new officers were added in 1989. This resulted in a doubling of drug seizures, a 31% increase in all drug charges and a 53% rise in trafficking charges. The increased trafficking

charges are, however, deceptive, since the increases are only for small amounts of drug, especially cannabis. Charges for all other trafficking in cannabis and other drugs have, in fact, declined (Erickson, 1992). The overall result of this increased enforcement activity has been an overloading of courts and cells. In Ontario as a whole, the number sentenced to provincial correctional facilities for drug offences rose from 1,800 in 1986-87 to 3,150 in 1989-90. The proportion of all Ontario incarcerations accounted for by drug offences increased from 4% to 7% (Erickson, 1992).

At the federal level, the proportion of inmates charged for drug-related offences rose from 9% to 14% between 1986 and 1990 (Erickson, 1992). Although there have been steady declines in drug use in the population as a whole in Canada, the number of drug-related charges made by the RCMP has remained stable. There have been large increases in some categories of charges, such as that of small-level marijuana trafficking (RCMP, 1990).

It is important to note that much drug-related crime is property crime, and that it and violent crime are often more a function of prohibition than of the drugs themselves. Yet, despite the fact that Canada's Drug Strategy is labelled one of harm reduction, its primary mode of action is criminalization. As Pat Erickson recently observed: "the fact is that adolescents and young adults are still arrested in large numbers (mainly for cannabis), go to court, get criminal records, and are often imprisoned " (1992, at 257).

Methadone and other forms of treatment can cut down on the amount spent on illegal drugs and so reduce crimes committed to obtain drugs (Fazey, 1991; Newcombe, 1990). Treatment can also reduce other criminal behaviour associated with alcohol and drug use (e.g., Andrews et al., 1990). The result is a saving not only in terms of economic loss due to theft but also in terms of legal and prison costs. Such reduction in criminal behaviour, however, occurs only as long as the user stays in treatment and only as long as treatment is effective. Effectiveness of treatment and whether or not the user stays in treatment depend on the type of treatment they receive. Flexible treatment programs, where multiple options exist for each person, appear to be the most effective in keeping users away from illegal drugs and the most successful at retaining clients (Fazey, 1991; Newcombe, 1990).

DRUGS IN PRISON

There is extensive drug use and drug dealing in prisons. This should come as no surprise for several reasons: (1) Worldwide, the main response to drug use and drug dealing is criminalization and imprisonment. The only countries that do not have significant drug problems in their prisons have the death penalty for both drug use and trafficking. (2) Drug use and abuse are ways of dealing with boredom, anxiety and despair; just how many prisons are there that are able to promote stimulation, relaxation and hope in their inmates by natural means? Drug use as a means of altering consciousness is a universal phenomenon that has been documented since the beginnings of recorded history. To imagine that there would not be drug use in prisons would be to ignore facts about human nature as well as about the effects of drugs. (3) Drug dealing provides high incomes, requires no equipment or training, and drugs can be easily passed on without detection. In a climate of prohibition, drug costs are high and guards and other staff can be offered high levels of pay for their assistance. The result is an economy that is almost perfect for the prison environment, especially since many of the participants have been involved in dealing before entering the institution.

In Canada, many of the inmates of federal and provincial prisons as well as those on parole use drugs as a 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 percent of all federal inmates were classified as having a serious substance-abuse problem (Correctional Services Canada, 1990). In prison,

offenders may be involved in an active drug trade that defies all barriers and sets up conflicts involving debts and coercion. 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).

Inmates who enter the institution with no history of drug use often become drug users in prison. The extent of injection drug use in prison 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 (Millson, 1991).

In considering ways in which to reduce the number of drugs in prisons, it is important to recognize that if attempts are made to search visitors for drugs, this will encourage the entry of highly concentrated forms of drug into prisons, thereby increasing harm. Increased security to limit drug smuggling will increase tension and mistrust due to regular body searches, restrictions on parcels, books and other materials sent from outside, and strict limitations on any direct contact with visitors (Harding, 1990). Drug testing is also likely to increase tension and mistrust.

AIDS PREVENTION IN PRISONS: THE CURRENT SITUATION

AIDS prevention measures in the federal and provincial systems in Canada at the moment are inadequate. These measures include the following: (1) Bleach may be available on cell floors where inmates wash clothes; it is not made available for the purpose of cleaning needles. (2) Clean syringes are not available in prisons. One concern in this regard is that the provision of syringes would "send the wrong message" regarding drug use. Another concern is that the syringes will be used as a weapon. These and other concerns clearly have to be addressed if syringe exchanges are to be workable in the prison environment. (3) Condom distribution to prisoners in federal institutions has recently been approved but this is not yet the case in all provincial systems. There has been concern that condoms can be used for a number of illegal activities, including secreting drugs and making homebrew.

DRUG TREATMENT IN PRISONS: THE CURRENT SITUATION

Canada's Drug Strategy recommends the establishment of both pre-release and aftercare programs for inmates of both federal and provincial institutions. A CSC task force on substance abuse recently finished a two-year assignment to design a national substance-abuse program strategy for the next five years (1991). Studies included research on drug offenders, existing treatment programs and the need for community aftercare services. The review of more than 170 substance-abuse programs currently underway showed a need for revision and upgrading of treatment. CSC is now in the process of setting up programs based on these recommendations in each of its five national regions. Offenders are usually highly motivated to enter treatment programs. One reason for this is the positive effect that treatment participation has on chances for parole. It is expected that half of the federal inmate population will be affected by CSC treatment programs.

The main problem with respect to treatment of substance abuse in offenders is that after an inmate serves time he or she often meets up with old friends, is exposed to old cues, and the crime/substance abuse cycle starts again. The ex-inmate also runs the risk of unknowingly spreading HIV. It is for these reasons that the role of community services both within and outside prison is so important in ensuring the cost-effectiveness of drug abuse and AIDS programs.

THE POLICY OF HARM REDUCTION

Harm reduction is a relatively new social policy with respect to drugs that has gained popularity in

recent years, especially in Great Britain, the Netherlands and Australia. 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. This policy can be contrasted with the dominant policy in North America at the present time, that of abstentionism, which has as its first priority a decrease in the prevalence of drug use (Newcombe, 1992). According to a harm-reduction approach, a strategy 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 abstinence is not the only acceptable or 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 characterized by pragmatism. One example of a hierarchy of harm-reduction goals is as follows: (1) the cessation of sharing of injection equipment; (2) a move from injectable to oral drug use; (3) a reduction in the quantity of drugs consumed; (4) abstinence.

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.

The harm-reduction approach has been working very successfully in Merseyside, England, for several years. In addition to syringe exchange schemes, drug prescribing and helping services for drug users, police in Merseyside have started a program named Responsible Demand Enforcement. The Head of the Merseyside Police Drug Squad, Derek O'Connell, has stated their policy in the following way:

> [W]e do live in the real world and, despite our efforts and those of other agencies, we have to accept that there will be those who will slip through our combined net and continue to ingest heroin from the illegal market. Years ago it may have been argued that as an enforcement agency we could put the squeeze on this group by making it hard to get hold of both the drug and the syringes. The advent of HIV has changed all that. As police officers, part of our oath is to protect life. In the drugs field that policy must include saving life as well as enforcing the law. Clearly, we must reach injectors and get them the help that they require, but in the meantime we must try and keep them healthy, for we are their police as well... People can be cured of drug addiction, but at the moment they cannot be cured of AIDS (O'Connell, 1990).

One of the most important features of the Merseyside Police strategy has been its emphasis on using resources to deal with drug traffickers, while operating a discretionary cautioning policy toward drug users. Cautioning, which has now been adopted to some extent by all police authorities in Great Britain, has been recommended by the Attorney General of the UK as an appropriate option for some classes of offence such as drug possession. Cautioning involves taking an arrested drug offender to a police station, confiscating the drug, recording the incident, and formally warning the offender that any further unlawful possession of drugs will result in prosecution in court. The offender must also meet certain conditions, such as not having a previous drug conviction, not having an extensive criminal record, and cooperating with the police in their enquiries. The offender is also given information about treatment services in the area, including syringe exchanges (this has now been extended to all prisoners). There is no prosecution for possession of residual drug in a syringe; if the police find dirty syringes in someone's possession, the person is given a receipt which they can then take to obtain clean needles. The first time an offender is cautioned they are not given a criminal record. On the second and third occasions they are sent to court, where they are fined for

possession of small quantities and sentenced for possession of large amounts. If an addict becomes registered through getting in touch with service agencies, then he or she is legally entitled to carry drugs for personal use. Merseyside Police were one of the first forces to implement a cautioning policy for possession of marijuana, and they were the first force to extend cautioning to any drug, including heroin and amphetamine. It is believed that the overall effect is to steer users away from crime and possible imprisonment, and, when appropriate, into health services for problem drug users. This is supported by the finding that 85% of those cautioned for drug offences by Merseyside Police in 1989 did not reoffend (before introduction of the policy the majority did reoffend). This program is part of a larger strategy aimed at reducing drug-related harm and to date has proven very effective in minimizing the spread of HIV in drug users and reducing drug-related crime (for more details on this program, see Riley, 1991, and in press).

The most practical and inexpensive way of evaluating many harm-reduction interventions is to focus on risks rather than consequences because the riskiness of drug-taking behaviour is usually easier to assess by observational, interview and questionnaire methods (Newcombe, 1992). For instance, it is easier to ask drug users about sharing of equipment than it is to establish how many are infected with HIV. One way of reducing drug-related harm is to limit the risks posed by sharing of drug-injection equipment through establishment of syringe exchange schemes.

RISK REDUCTION: SYRINGE EXCHANGE SCHEMES

Syringe exchange schemes began in Amsterdam during the mid-1980s in response to the spread of hepatitis from and amongst injection drug users. Syringe, or needle, exchanges are stationary or mobile sites where new syringes can be exchanged for old ones (not all require strict exchange), where bleach and other cleaning materials and condoms can be obtained, where counselling is given and where contact with treatment services can be made. One of the primary initial concerns about syringe exchanges, and one of the reasons they are still resisted in many places today, was that they would simply promote drug injection and not help to curb the spread of AIDS.

This fear is misplaced for two main reasons. First, syringe exchanges clearly reduce drug-related harm: drug users have been found to exchange equipment with high frequency, especially at accessible community sites, and the rates of spread of HIV have been kept low in areas where exchanges were introduced early in the epidemic, such as Merseyside. In areas where exchanges have been introduced when HIV rates were already quite high, such as Montreal, it is hoped that they will prevent the rapid explosion in HIV positivity that has been seen in other cities without exchanges. For example, in Edinburgh, where syringe distribution was prohibited for a significant period, the rate of infection rose from 5 to 50% in two years. In New York City, where the only syringe exchange was closed down soon after opening, more than 60% of injection drug users are positive for the AIDS virus. In those cities with accessible, community-run exchanges that are well-supported by the police, HIV rates have remained remarkably low. For example, in Merseyside the rate of HIV spread in drug users has remained close to zero, and in Vancouver, Canada, the rate of HIV in IDUs has remained stable at three percent for two years.

The second reason that the fear over promotion of drug use is misplaced is well expressed by the World Health Organization: since AIDS poses a greater threat to health than does drug use, every effort must be made to reduce the spread of HIV even though this may mean changing our priorities with respect to drug use.

One of the chief obstacles in setting up a syringe exchange is lack of public education on injection drug use and AIDS. Once the public is aware that syringe exchanges help to significantly reduce the spread of AIDS, they are much more supportive of them (although not necessarily in their own backyards). In North America, the "drug war" mentality has built additional serious barriers: any

seeming support for drug users has been construed by some as support for drug use. This is more of a problem in the United States than in Canada, but nonetheless it is such that, even in Toronto in 1991, some city councillors opposed syringe exchanges on the grounds that they would be seen as promoting drug use.

Quite apart from the practicalities of approvals and police support, there are the legal barriers to syringe exchanges. In most cases in Canada, however, these barriers are more perceived than real. The illegality of syringes as "paraphernalia" is still raised as a reason not to allow syringe exchanges, even though syringes are exempt from paraphernalia charges under the criminal code and relevant statutes. The law is opaque on this matter, however, and in order to ensure support from law enforcement and other officials it needs to be clarified. Where there may be grounds for genuine concern is around the possession of residual drugs in used syringes, since this has been used as grounds for arrest. Rewriting of the relevant legislation to explicitly allow for syringe exchanges would help to clear this obscurity and thereby make it easier for communities and institutions all over Canada to open sites without fear of some hidden meaning of the law.

IDENTIFYING THE HARMS

It is clear that in order to be truly effective, any attempt to reduce drug-related harm in prisons needs to be part of a thorough-going harm-reduction approach to drugs in society as a whole. This approach must include evaluation of the effects of drug use, trafficking and prohibition itself. It also demands recognition of the fact that some drugs (e.g. marijuana) are less harmful in the prison setting than others (e.g., alcohol, cocaine) because they provoke less aggressiveness. In this regard, drug testing may encourage inmates to use drugs that are less detectable in a urine sample, such as PCPs, which provoke more violence than more readily detectable drugs, such as marijuana.

In addressing the problems associated with drugs in prisons we first have to realistically (as opposed to morally) assess what the problems are. The main problems appear to be: (1) infection from sharing of contaminated needles; (2) other health problems related to drug use; (3) violence resulting from conflict between competing users and between trading groups; (4) aggressiveness/ hostility towards other prisoners and/or staff aggravated by drugs such as alcohol and cocaine.

The following section offers some recommendations for dealing with these and other problems associated with drugs and the criminal justice system.

RECOMMENDATIONS REGARDING THE REDUCTION OF DRUG-RELATED HARM IN PRISONS

Reduce the Number of Drug Offenders in Prison

(1) Fewer persons should be jailed for possession of small amounts of drugs for personal use, especially cannabis. For example, this might involve the introduction of fines and a cautioning system rather than imprisonment for drug offences such as possession of marijuana and other drugs for personal use. The resources and effort could then be directed at large-scale traffickers rather than at users. This would also substantially decrease the number of drug users being given a criminal record.

(2) Drug offenders should be generally referred to community help and treatment services rather than sending them through the courts.

(3) First-time offenders for drug possession should be cautioned, not charged.

(4) Provision of more options for repeat offenders, including community-based multifactorial programs (including job training and housing) rather than imprisonment.

Promote Prevention and Treatment Programmes for Inmates and Ex-Inmates

(5) Cross-training of criminal justice, mental health and substance abuse professionals should be provided in all provinces.

(6) There should be provision of accurate, appropriate and truthful drug and AIDS education for all staff (including workers in aftercare programs) and inmates, including those with disabilities, from different ethnic and linguistic backgrounds, with poor language skills, and of different races and sexual orientations. Drug education programs and HIV/AIDS support, education, and treatment programs should be run by community-based organizations brought into the prisons, and peer education programs should be encouraged: "Health education must be based on trust; the prison environment undermines trust" (Harding, 1990 at 203). In addition, because of the high levels of stress-related problems, depression and suicide in prisons, they may not be good places for drug users to learn that they are HIV-positive — without the support of friends and family, this is a very heavy load indeed (Harding, 1990). Community groups and networks such as PASAN in Ontario should be funded so that they can provide a wide range of services to ex-inmates and thereby help to break the substance abuse/crime/prison cycle. Most people who enter prison stay for less than six months; education and prevention should thus prepare the inmate for release, and this is especially true in the case of young drug users (see Harding, 1990).

(7) There should be ready access to condoms, dental dams and other safer sex materials.

(8) Tattoo equipment and supplies should be classified as "hobby-craft" and better safety precautions should be established.

(9) Bleach kits should be made available to inmates and ex-inmates on a confidential basis. Any concerns that bleach tablets can be used to tamper with urine samples for drug testing should be allayed at the outset by directing the use of liquid solutions with a minimum of one percent bleach solution in institutions.

(10) Provision of confidential syringe exchange programs for inmates and ex-inmates, preceded by a public relations campaign to overcome any resistance by staff or the public. The provision of needles and syringes in prisons on the same basis as in the general community raises serious problems to do with discipline and general policy for prison authorities. A community-style syringe exchange also raises problems of confidentiality for inmates. Other solutions have to be worked out for both regular prisons and "open" prisons that still allow for the supply of clean needles and syringes to those in need of them. The development of syringes that could not be used as weapons also has to be considered a priority.

(11) Methadone maintenance and methadone detoxification programs should be made available to all inmates and ex-inmates who need them. The reduction of the risk of heroin abuse through methadone maintenance in prisons is currently being evaluated in New York's prison system. Such an approach raises extremely difficult ethical and practical issues concerning the selection of clients and follow-up treatment (see Harding, 1990). As part of a broader-based harm-reduction approach, methadone should be made much more widely available to opiate users throughout Canada than currently is the case.

(12) Recognition of the fact that some modes of drug administration are less harmful than others (e.g., provide encouragement for injecting drug users to move to non-injecting modes of drug use).

(13) Reconsideration of the use of drug testing in prisons since it may, in fact, increase drug-related harm.

(14) Special treatment programs should be developed for inmates and ex-inmates with dual or multiple disorders.

(15) Provision of a wide range of sports and other activities that can serve as alternative ways of

relieving stress and boredom as well as providing natural highs and altered states of consciousness.

The above recommendations also apply to young offenders, psychiatric inmates and refugees and immigrants awaiting hearings or deportation.

CONCLUSIONS

The World Health Organization recommendations on the control of AIDS in prisons state that health care within prisons should be equivalent to health care in the community. For those of us who have started to feel that we have begun to make headway in introducing harm reduction as an acceptable policy in our countries, the situation in prisons should make us realize how much has still to be done. Reducing drug-related harm in society means reducing such harm in prisons too, and in that regard we have so far clearly failed. As Timothy Harding writes:

> [T]he responses to the drug taker in the prison environment ... reveal society's ambivalence towards the problems of drug users and remind us that there is a real risk that efforts to combat the AIDS epidemic by applying well-established public health principles and respecting fundamental ethical values concerning personal autonomy, relief of suffering and promotion of health can be undermined and replaced by other, sinister reactions based on fear and rejection. Experience has shown us that the drug taker is especially at risk of non-respect of basic human rights — and nowhere more than in prisons (1990 at 197).

In attempting to put a thoroughgoing harm-reduction program in place we need to recognize that harm comes not just from drug misuse but also from the measures employed to control drug use. What we need most of all at this point in time is an open and frank debate about how we can reduce drug-related harm in all its forms, and this includes restructuring the criminal justice system, rethinking drug strategy and reassessing our social policies. We need to expand community-based programs to combat excessive imprisonment: this means we must develop new approaches to drug issues and social policy that involve many agencies working together to reduce drug-related harm to the individual, the community and society as a whole.

REFERENCES

Andrews, D., Zinger, I., Hoge, R., Bonta, J., Gendreau, P. and Cullen, F. (1990) Does correctional treatment work? A clinically-relevant and psychologically-informed meta-analysis. **Criminology, 28.**

Appleford, B. (1989) **Family violence review: Prevention and treatment of abusive behaviour**. Ottawa: Correctional Service Canada.

Correctional Service Canada. (1988) **Study to determine the incidence of psychiatric and behavioural disturbance among federally incarcerated offenders: Appendices A through H.** Ottawa: Correctional Service Canada.

Correctional Service Canada: Research and Statistics Branch (1990) **Forum on Corrections Research, 2** (4), Ottawa: Correctional Service Canada.

Correctional Service Canada. (1991) **Task force report on the reduction of substance abuse: Annual report**. Ottawa: Ministry of Supply and Services.

Erickson, P. (1992) Political pharmacology: Thinking about drugs. **Daedalus**, Summer.

Fazey, C. (1992) An empirical study of the relationship between heroin addiction, crime and medical treatment, In P. O'Hare, R. Newcombe, A. Matthews, E.Buning, and E.Drucker, **The Reduction of Drug-Related Harm**, New York: Routledge.

Harding, T. (1990) HIV infection and AIDS in the prison environment: A test case for the respect of human rights, In J. Strang & G. Stimson (Eds.) **AIDS and Drug Misuse. The Challenge for**

Policy and Practice in the 1990s, Routledge: New York.

MacCoun, R., Reuter, P. and Kahan, J. (1992) What harms do harm reduction strategies reduce? A cross-national study of heroin addiction. Paper presented at the Third International Conference on the Reduction of Drug Related Harm, Melbourne, March.

Matlock, R. Mulligan, M., and Glasson, J. (1990) AIDS and prisons: A seminar report. Department of Public Health Medicine and Oxford Regional Health Authority, U.K.

Millson, P. (1991) Evaluation of a programme to prevent HIV transmission in injection drug users in Toronto, Toronto Board of Health.

Newcombe, R. (1990) Preventing the spread of HIV infection from and among injecting drug users in the U.K. **The International Journal of Drug Policy, 1**, 20-27.

Newcombe, R. (1992) The reduction of drug-related harm: A conceptual framework for theory, practice and research. In P. O'Hare, R. Newcombe, A. Matthews, E.Buning, and E.Drucker, **The Reduction of Drug-Related Harm**, New York: Routledge.

O'Connell, D. (1990) The role of the police in Merseyside. Plenary paper presented at the First International Conference of Drug Related Harm, Liverpool, April.

Prisoners with AIDS/HIV Support Action Network (PASAN) (1992) HIV/AIDS in prison systems: A comprehensive strategy. A brief to the Minister of Correctional Services and the Minister of Health, Ontario.

Pepper, B. and Massaro, J. (1992) Transinstitutionalization: Substance abuse and mental illness in the criminal justice system, **Tie Lines**, 9 (2), 1-5.

RCMP, (1990) **National Drug Intelligence Estimate,** Ottawa: Ministry of Supply and Services.

Riley, D. (1991) Drug use, AIDS, and human rights: The policy and practice of harm reduction. Ottawa: CCSA.

Riley, D. AIDS, drug use and public health: A harm reduction approach, **Sante Culture Health**, in press.

Robinson, D., Porporino, F., & Millson, B. (1991) **Patterns of alcohol and drug use among federal offenders as assessed by the computerized lifestyle screening instrument: Research report no. 1.** Ottawa: Correctional Service Canada.

Williams, B., Chang, K. & van Truong, M. (1992) **Annual Sourcebook: Canadian Profile.** Toronto: Addiction Research Foundation.

7TH BRITISH COLUMBIA AIDS CONFERENCE

Another session on HIV/AIDS in prisons, again organized by ECAP's Project Coordinator, was held in Vancouver at the 7th Annual British Columbia AIDS Conference, called *HIV in Canada Today*, on 25 October 1993. The speakers at the session and titles of their talks were:

- Ralf Jürgens, ECAP Project Coordinator, and Donald Yeomans, ECAP Member, *HIV/AIDS and Prisons: New Developments in Canada and Abroad*;
- Diane Rothon, Director, Health Services, B.C. Corrections, *Results from the HIV Prevalence Study of Inmates in B.C. Prisons*;

- Liviana Calzavara, Assistant Professor, Department of Preventive Medicine and Biostatistics, Faculty of Medicine, University of Toronto, *Results from an Anonymous Unlinked HIV Seroprevalence Study of Inmates in Ontario*;
- Fred Hitchcock, Regional Coordinator, Disordered Offender Project, B.C. Ministry of Attorney General, Corrections Branch, *Guidelines for Improved Working Relationships between Hospital and Corrections Staff*;
- Jim Cairns, B.C. Ministry of Solicitor General, Corrections Branch, *B.C.'s Experience with Bleach in Prisons*;
- Michael Linhart, Inmate, Mission Institution, *An HIV Positive Prisoner's View: One Year Later* (video presentation);
- Andréa Riesch Toepell, Consultant, *Educating Prisoners about HIV/AIDS: Purpose, Politics and Practice*;
- Christiane Richard, Physician and ECAP Member, *Making Clean Needles Available to Prisoners?*
- Bert Kampuis, *Community Groups, HIV/AIDS and Prisons.*

Texts of some of these presentations follow.

Results from the HIV Prevalence Study of Inmates in B.C. Prisons*

Diane Rothon, Director, Health Services, B.C. Corrections

ABSTRACT

Objective: To ascertain the prevalence of HIV-1 infection in provincial adult correctional centres in British Columbia and correlate rates with age, gender, ethnic status and history of injection drug use.

Design: Unlinked voluntary prospective saliva HIV-1 antibody testing.

Setting: All adult provincial correctional centres in British Columbia that received new prisoners during the study period.

Participants: All adult inmates admitted to provincial correctional centres in British Columbia between 1 October 1992 and 31 December 1992.

Main Outcome Measures: Rate of HIV-1 positive saliva specimens. Independent variables include age, gender, Native status and injection drug use.

Results: Ninety-one point three percent (91.3%) of all inmates admitted (2,719) during the study period agreed to be tested. Results are expressed as a percent of individuals admitted, not just percent of those tested. The overall rate of HIV-1 positivity was 1.0%. By age, the highest rate occurred in the 20-29 year age group (2.3%). By gender, women had an HIV-1 prevalence rate of 3.1%

* This research was funded in large part by the Ministry of Attorney General of British Columbia, Corrections Branch. Contributions were also gratefully received from Health and Welfare Canada, Medical Services Branch and the Ministry of Health of British Columbia, Division of STD Control.

The outstanding efforts of nurses in B.C. correctional centres in the collection of this valuable data are acknowledged; also, Stephen Howell, Analyst, B.C. Corrections, for demographic data; Lorraine Harvey for expert manuscript typing.

compared with 0.9% in men. Native individuals had a 0.8% rate compared with 1.1% in non-Natives. Native and non-Native men showed identical HIV-1 prevalence rates of 0.9% but non-Native women had a rate of 4.6%. Native women were too few in number and had too high a rate of refusal of HIV testing (7/54) to generate reliable data. None of those Native women tested (47/54) were HIV-1 positive. Injection drug users had over four times (2.1%) the HIV-1 prevalence rate of non-using inmates (0.5%) and were twice as likely to refuse testing.

Conclusions: Unlinked voluntary HIV-1 antibody testing using saliva collection can achieve high rates of subject compliance for testing. Rates among prisoners suggest serious public health consequences. Preventative measures should be aimed especially at younger inmates, female inmates and injection drug users.

INTRODUCTION

From a public health perspective, prisons are essentially environments where certain conditions exist and behaviours occur that impact on disease transmission, both within the immediate prison context and the community in general. Needle sharing and sexual activity, though prohibited in prison, nevertheless take place covertly to an unknown degree among individuals who often already have a history of similar high risk behaviours prior to incarceration.

HIV-1 prevalence rates for an entire provincial adult correctional system have not previously been known. The aims of such a project are manyfold and include: obtaining a notion of the magnitude of the problem of HIV-1 disease in B.C. Corrections inmates; supporting the need for a comprehensive education program on infectious diseases for inmates; supporting the availability of condoms and bleach in our correctional facilities; anticipating health education and health-care resource requirements for the future; targeting certain critical groups or types of inmates based on demographic correlates such as gender, age or geographic location, as regards health-care budgeting and prevention programs; obtaining a baseline for future research on the impact of our various programs and initiatives; comparing our prevalence with the general population in Canada and other correctional jurisdictions in North America and abroad, where available.

METHODS

In early 1992, B.C. Corrections Branch management gave assent for a research project to study the prevalence of HIV infection among B.C. correctional inmates. Final approval for the project came only after rigorous scrutiny of the research protocol by Branch administration. The protocol first received ethical and legal approval from the Legal Services Branch of the Ministry of the Attorney General and was also reviewed and approved by the B.C. Civil Liberties Association.

Data collection and testing proceeded over the three-month period of October, November and December, 1992. During the three-month data collection period, all adult individuals admitted to a B.C. correctional facility were asked to participate in our HIV prevalence study.

The testing procedure and reason for the study were explained to each inmate. Testing was in all cases voluntary. Specimens, once obtained, were unlinked from the subject. A four-digit code was assigned to each specimen but this could not be traced to the identity of the donor. Only demographic and risk-factor data could be associated with each specimen. All inmates underwent the usual intake evaluation, which includes a medical history and physical examination. Additionally, all inmates, including those who refused testing, had personal and demographic data recorded, including: age group, gender, intake centre, history of injection drug use and ethnic origin (Native or non-Native only). Also, each was asked whether he or she knew if they were HIV-positive. Each subject was only entered into the study once even if readmission occurred during the three-month study period.

Testing proceeded by means of saliva collection onto a piece of absorbent paper, which was then placed in the appropriate collecting tube (OMNI-SAL Sterile Collection Device) and sent to the Provincial Laboratory at the B.C. Centre for Disease Control. Specimens were tested by means of the Recombigen HIV-1 EIA enzyme immunoassay kit (Cambridge Biotech; Cambridge, Massachusetts). Several studies have been done to test the reliability of saliva HIV antibody testing. Agreement between HIV antibody testing on matched saliva and serum specimens has been found to be 100%. Sensitivity and specificity of the Cambridge Recombigen kit were both found to be 100%.[1] Confirmatory tests were done by radioimmunoprecipitation. Results are calculated over all persons who were offered the test (the study population), not just those who were tested.

RESULTS

In all, 2,719 adult inmates were interviewed for this study, of whom 2,482 (91.3%) were tested for HIV-1.

Of the 2,719 study population, 163 (6%) were women and 2,556 (94%) were men. Of the 2,719 study population, 622 individuals (22.9%) were Native Indian and 2,097 were non-Native (77.1%). There were 237 inmates (8.7%) who refused testing for HIV-1 and there was a rather interesting difference in the rate of refusal to be tested between Native men and women and between Native and non-Native subjects.

Overall, 13 of 163 women (8.0%) and 224 of 2,556 men (8.8%) refused to be tested; however, 7 out of 54 Native women (13.0%) refused, while only 43 out of 568 Native men (7.6%) refused. The lowest refusal rate, 5.5%, occurred among non-Native women (See Table 1).

It would appear that Native women refused to participate in this study more often per capita than other groups. The reasons for this are not clear.

We may speculate regarding factors such as greater mistrust of the system, less cooperativeness and possibly some solidarity in these attitudes among Native women in jail.

Participants were also asked about their history of injection drug use (IDU). Overall, the rate of injection drug use by history in our study population was 854 out of 2,719, or 31.4%. Inmates who acknowledged a history of IDU were more likely to refuse testing for HIV-1, an alarming finding. Among injection drug users the refusal rate was 12.9% compared to a 6.8% refusal rate among inmates denying IDU. In other words, those with the highest risk of being HIV-1 positive refused testing almost twice as often as those with less risk.

To be sure that our study population was representative of our total inmate population, various demographic data were compared. This comparison is illustrated in Tables 2-4 and demonstrates a marked consistency between the two populations with respect to age distribution, ethnic origin and gender ratios.

As was previously stated, all rates are expressed as a percentage of individuals admitted during the study period (the study population), not just as a percentage of those tested.

The overall rate of HIV-1 positivity was 28 of 2,719, or 1.0%. This overall rate was broken down by age, gender, ethnic status and history of injection drug use.

According to age breakdown, the highest prevalence (2.3%) was found in the 20 to 29 years age range. Table 5 shows the distribution by age groups.

Comparison of HIV-1 positive rates by ethnic status yielded 5 positives (0.8%) in 622 individuals of Native origin compared with 23 positives (1.1%) of 2,097 non-Native subjects.

1. Major C; Read S; Coates R; Francis A; McLaughlin B; Shepard F; Fanning M; Calzavara L; MacFadden D; Johnson JK; Evaluation of Saliva as an alternative to Blood for HIV Seroprevalence Testing, Int. Conf AIDS. 1990 Jun 20-23; 6(3):241.

Significant gender differences were also found. Women showed an overall prevalence rate of 5 out of 163 (3.1%) compared with 23 out of 2,556 (0.9%) for men ($p = 0.00035$).

However, a breakdown by both gender and ethnic groupings demonstrates an even more extreme gender difference between non-Native men and women. Table 6 summarizes the above information, and shows a staggering 4.6% HIV-1 positive rate among non-Native women compared with 0.9% in non-Native men.

Subjects were also asked whether they had ever injected drugs. In all, 854 (31.4%) of 2,719 subjects reported a history of ever having used injection drugs (IDU). The rate of HIV-1 positive specimens among IDUs was found to be 18 out of 854, or 2.1%, compared with 10 out of 1,865 or 0.5% among those denying that risk factor.

This means that the relative risk of an injection drug user of being HIV-1 positive is 4.2 times that of a non-user. If we also remember, as was previously reported, that IDUs were almost twice as likely to refuse testing in our study, then our HIV-1 prevalence rates for IDU may be substantially higher than they appear.

All female inmates (5/5) who tested positive for HIV-1 had a history of injection drug use, while only 57% (13/23) of the men reported that risk.

Finally, subjects were asked if they knew whether they were HIV-positive. We wanted to know whether those individuals who ultimately tested positive for HIV-1 in the study knew they were positive. As we have seen, we could not trace results back to individuals and therefore we could not tell them. What we found was quite unexpected, namely that there was no way of predicting whether an individual was in fact HIV-1 positive merely by what he or she claimed to be. There were as many participants who said they were positive who turned out to be HIV-1 negative (19) as there were participants who said they were negative or did not know and who turned out to be HIV-1 positive (17). There were only 11 people who said they were HIV-1 positive and also tested positive.

DISCUSSION

A province-wide HIV-1 Prevalence Study was undertaken in adult B.C. correctional facilities in October 1992. An initiative of this scope was a first in Provincial Corrections in Canada. Despite the inclusion of over 2,700 participants in this study, the numbers for female inmates are still relatively small and conclusions must be tentative regarding that segment of the inmate population.

Volunteer bias was minimized by attaining a 91.3% participation rate and by showing rates of HIV-1 positives as a percentage of total intake population over the three-month study period, not just as a percent of those tested for HIV-1. This gives the most conservative estimate possible for this population. Actual rates are likely higher.

Overall, the rate of HIV-1 positive individuals in B.C. correctional facilities was 1.0%. This compares with an estimated rate of 0.1% in the general population of British Columbia. Women in jail demonstrated a much higher HIV-1 rate of 3.1% overall, with an alarming rate of 4.6% in non-Native women. Rates for Native women are inconclusive because of their small numbers and their higher rate of refusal to be tested for the study.

Native women refused to be tested in this study more often per capita than other groups (13% refusal rate). The reasons for this are not clear. We may speculate regarding factors such as greater mistrust of the system, less cooperativeness, and possibly some solidarity in these attitudes among Native women in prison.

Age proved to be a correlating variable, with a rate of 2.3% HIV-1 positive in the 20-29-year age group overall. Injection drug use proved highly correlated with HIV-1 positive status, with the HIV-1 positive rate being 2.1% among injection drug users compared with 0.5% in non-IDUs. This means that the relative risk in an injection drug user of being HIV-1 positive is 4.2 times that of a

non-user. If we also remember, as was previously reported, that IDUs were almost twice as likely to refuse testing in our study as non-IDUs, then the actual HIV-1 prevalence rates for incarcerated IDUs may be substantially higher than they appear in our study.

It was interesting to note that while all the women (5/5) who tested positive for HIV-1 had a history of injection drug use, only 57% (13/23) of the men reported that risk. This suggests the action of other risk factors, presumably high-risk sexual activity, for the men in the study.

Elsewhere in provincial Corrections, rates for HIV-1 have been reported. A study done among incarcerated men in Quebec shows rates of 4.7% and 2.0% respectively in two provincial correctional institutions, but results are expressed as a percentage of the number tested since January 1990 and are difficult to compare with the present study.[2] Also, it is not known whether the two centres in question are representative of the entire provincial inmate population. A similar study of incarcerated women volunteering to be tested in one medium-security prison in Quebec reported an HIV-1 prevalence rate of 19/248 women, or 7.7%.[3] Again, as in the study of male inmates, results are expressed as a percentage of inmates volunteering for testing but it is significant that, just as in the present study in B.C., women have a higher HIV-1 prevalence rate than men. This fact is borne out by studies in a variety of correctional jurisdictions in the U.S. and Europe. An HIV-1 prevalence study of inmates in provincial prisons was also undertaken in Ontario.

Finally, we found that of the 28 individuals who tested positive for HIV-1 only 11 knew they were positive. Seventeen of the 28 either said they were negative or did not know. Interestingly, there were 19 individuals who said they were positive and who turned out to be HIV-1 negative. This was quite unexpected and suggests that we should never label an individual based merely on what HIV status he or she claims to have. Also, it would appear that only a minority of incarcerated HIV-1 positive individuals (11/28, 39.3%) know they are HIV-positive. The most worrisome conclusion may be that those individuals who do not know they are positive are less likely to take precautions to prevent infecting others in prison or in the community.

The implications of the present study are many. Unlinked voluntary HIV-1 antibody testing using saliva collection can achieve high rates of subject compliance for testing. The use of saliva avoids the risk and inconvenience inherent in the drawing, handling and disposal of blood. The higher rate of HIV-1 prevalence among subjects aged 20 to 29 supports the need for education and preventive measures to begin as early as possible, presumably in schools, with material that is understandable and appealing to young people.

The higher rate in women, also confirmed by other studies, suggests ominous public health implications, both for the women involved in high-risk behaviours and for the children they bear. The finding of injection drug use history in 100% of HIV-1 positive women in our study, and 57% of the men, suggests an urgent need for access to sterile injection equipment, among other preventive measures. The need for a comprehensive educational program on infectious diseases for inmates is certainly supported, as is the availability of condoms and bleach in our correctional facilities.

2. Hankins, C; Gendron S; Handley M; Rouah, F; O'Shaughnessy M; HIV-1 Infection Among Incarcerated Men — Quebec, *Canada Diseases Weekly Report* 1991; 17:233-235.

3. Hankins, C; Gendron S; Richard C; O'Shaughnessy M; HIV-1 Infection in a Medium Security Prison for Women — Quebec, *Canada Diseases Weekly Report* 1989; 15:168-70.

Table 1: Refusal Rates Stratified by Gender and Ethnic Status among 2,719 Inmates Admitted to B.C. Corrections Facilities between 1 October 1992 and 31 December 1992

	Overall	Native	Non-Native
Total Study Pop.	237/2,719 (8.7%)	50/622 (8.0%)	187/2,097 (8.9%)
Women	13/163 (8.0%)	7/54 **(13.0%)**	6/109 **(5.5%)**
Men	224/2,556 (8.8%)	43/568 (7.6%)	181/1,988 (9.1%)

Table 2: Comparison by Age Distribution in Adult Centres

Age Groups	General Inmate Population	Study Population
<20	7.2%	8.2%
20 - 29	43.8%	46.2%
30 - 39	30.3%	29.9%
40 - 49	12.7%	11.7%
≥50	6.0%	4.1%

Table 3: Comparison by Ethnic Distribution in Adult Centres

Ethnic Background	General Inmate Population	Study Population
Native	17.7%	22.9%
Non-Native	82.3%	77.1%

Table 4: Comparison by Gender Distribution in Adult Centres

Gender	General Inmate Population	Study Population
Female	5.0%	6.0%
Male	95.0%	94.0%

Table 5: HIV-1 Prevalence Rates Stratified by Age Distribution among 2,719 Inmates Admitted to B.C. Corrections Facilities between October 1, 1992 and December 31, 1992

Age Range	Totals	HIV-1 +	Rate HIV-1 +
<20	222	1	0.5%
20 - 29	1,256	15	**2.3%**
30 - 39	812	9	1.1%
40 - 49	317	3	1.0%
≥50	112	0	0.0%
TOTAL	2,719	28	1.0%

Table 6: HIV-1 Prevalence Rates Stratified by Gender and Ethnic Status among 2,719 Inmates Admitted to B.C. Corrections Facilities between October 1, 1992 and December 31, 1992

	Overall			Native			Non-Native		
	Total # Inmates	Number HIV-1 +	Rate	Total # Inmates	Number HIV-1 +	Rate	Total # Inmates	Number HIV-1 +	Rate
Women	163	5	**3.1%**	54	0	0.0%	109	5	**4.6%**
Men	2,556	23	0.9%	568	5	0.9%	1,988	18	0.9%
Total	2,719	28	1.0%	622	5	0.8%	2,097	23	1.1%

Preliminary Results from an Anonymous Unlinked HIV Seroprevalence Study of Inmates in Ontario*

Liviana Calzavara, Assistant Professor, Department of Preventive Medicine and Biostatistics, Faculty of Medicine, University of Toronto

INTRODUCTION

Current literature indicates that, worldwide, incarcerated populations have higher rates of HIV than the general population.[1] A large proportion of those incarcerated are injection drug users (IDUs) and sex-trade workers, and are drawn from the most sexually active age group (35 and younger).

Information on the rates of HIV-prevalence among Canada's prison population is extremely limited. Prior to the start of this study, the only available information was based on a self- selected sample of adult prisoners in three Montreal-area provincial correctional facilities.[2] The study reported HIV prevalence rates of 7.2% among females and 3.6% among males.

Since the inception of the Ontario study, two other volunteer-based studies have been undertaken. The British Columbia Corrections Branch has conducted a study using saliva to screen for HIV antibody (see above). A study was also conducted at Joyceville Penitentiary using blood specimens obtained from male inmates.[3]

The study of *HIV Prevalence in Ontario Jails and Detention Centres* is the first large scale Canadian study of the prison population to use a design that ensures anonymity and reduces the volunteer bias inherent in the designs used by the other three Canadian studies.

OBJECTIVES

1. To determine the prevalence of HIV infection in the inmate populations by using a design that would reduce volunteer bias.
2. To identify any differences in rates of HIV infection among:
   - adult males and females
   - young offender males and females
   - those with a history of injection drug use
   - five regions in Ontario.
3. To obtain baseline infection rates which can be used to monitor change.

METHODS

A modified anonymous unlinked design was developed in consultation with the Ministry of Correctional Services and community groups representing prisoners. Urine specimens, routinely collected from those admitted to Ontario jails and detention centres, were used to screen for HIV-1 infection. Descriptive data on gender, age, and history of injection drug use were also obtained. No names or other identifiers were obtained. The public was informed of the study through a media release. Inmates were informed through a multilingual poster and a limited verbal statement at the time of collection.

* The HIV Prevalence in Ontario Jails and Detention Centres study was funded by the Laboratory Centre for Disease Control, Health Protection Branch, Health and Welfare Canada. Special thanks to Dr. Paul Humphries, the Ontario Ministry of Corrections, the over 200 nurses who assisted in the data collection, and to the anonymous contributors of urine specimens.

1. Harding, T., R., et al. HIV/AIDS and Prisons: A Survey Covering 54 Prison Systems in 45 Countries. WHO Global Programme on AIDS, University Institute of Legal Medicine, Geneva, May 1990.

2. Hankins, C. et al. "Risk Factors for Human Immunodeficiency Virus Infection Among Incarcerated Women". *Clinical and Investigative Medicine* 1990; 13 (Suppl. B59): Abstract 371; Hankins, C. et al. "HIV-1 Infection Among Incarcerated Men — Quebec". *Canada Diseases Weekly Report* 1991; 17:233-234.

3. Results are reported in *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons.*

The data were collected over a three-month period (February - May 1993) for adult males and over a six-month period (February - August 1993) for adult females and young offenders. All 42 jails and detention centres in the province of Ontario participated in the study.

Urine specimens were screened by the Ontario Ministry of Health Central Laboratory using a modified Cambridge Biotech Corporation Recombigen HIV-1 kit modified to enhance sensitivity (sensitivity=98.8%, specificity=98.4%). Repeatedly reactive and grey-zone specimens were confirmed using Western blot. In addition, all reactive, grey-zone and randomly selected negative specimens were parallel-tested using the Murex/Wellcome GACELISA system.

RESULTS

Preliminary study results indicate that:

- Data were collected on 10,530 adult males, 1,518 adult females, 1,480 young offender males, and 92 young offender females.
- A total of 12,551 urine specimens were collected from the 14,284 individuals admitted during the collection period. Specimens were not obtained from approximately 12% of the total admissions (9.5% failed to provide a routine specimen, 1.1% refused to have their urine used for research purposes, and reason for no specimen was not recorded for 1.5%).
- The proportion of individuals with a known history of injection drug use was 20% among adult females, 13% among adult males, 2% among young offender females, and 3% among young offender males.
- The prevalence of HIV among those entering Ontario jails and detention centres is higher than rates in other segments of the population.
- The rate of infection for adult females is higher than that of males.
- Differences in rates between males and females are explained in part by the higher proportion of females who are injection drug users.
- Rates of HIV infection among injection drug users are 6 to 8 times higher than among non-injection users.

Table 1. Overall Rate By Subgroup

SUBGROUP	Adult Females	Adult Males
Overall Rate	1.23%	0.99%
95% Confidence Interval	0.63 - 1.83	0.89 - 1.09
Number of Specimens Tested	1,302	9,201

Table 2. Rates By Known History Of Injection Drug Use

SUBGROUP	IDU	Non-IDU
Adult Females		
Rate	4.20%	0.49%
CI	1.77 - 6.63	0.06 - 0.91
n	262	1,024
Adult Males		
Rate	3.63%	0.59%
CI	2.57 - 4.70	0.43 - 0.75
n	1,184	7,640

B.C.'S EXPERIENCE WITH BLEACH IN PRISONS

Jim Cairns, B.C. Ministry of Solicitor General, Corrections Branch

After considering the subject for two years, in July 1992 the B.C. Corrections Branch issued a policy directing that bleach was to be made available to inmates. Based upon information available at the time, a dilution of 10-1 was employed. Subsequent information revealed that this dilution had a very short shelf-life (three days) and was thus ineffective as a cleansing agent. The dilution was then increased to a strength of 1-1. More recent information has challenged the effectiveness of that dilution.

Prior to implementing the availability of bleach for inmate use, the Branch had to address a number of issues, including the potential for security breaches resulting from misuse of the bleach, the potential for damage to septic fields in rural locations due to large quantities of bleach entering the system, and the possibility that such a policy would be seen as tacit approval of needle use by inmates. There have been no incidents of misuse presenting security breaches, no known damage to septic fields, or any evidence to indicate an increase in needle use.

The key to infection-control policy is not the distribution of condoms or the availability of bleach, it is education — education for both staff and inmates, education that is available upon intake and throughout the term of incarceration.

An HIV Positive Prisoner's View: One Year Later

Michael Linhart, Inmate, Mission Institution

As most of you are aware, I am an HIV-infected inmate serving a life sentence, currently in Mission Institution. When I was invited to speak at the Conference this year, it was my hope that the Parole Board would again grant me an escorted pass to speak in person. Although this was not to be, through the wonders of modern video technology I can still participate and give voice to issues concerning HIV in prisons.

In addressing the 6th Annual B.C. AIDS Conference last year, I spoke of the need for improvements in addressing the issue of HIV in prisons. During the past year there have been a few developments that show a more proactive approach toward fighting HIV.

Staff training for new recruits now includes a more in-depth segment on HIV/AIDS. Yet some staff have stated that they have not received any new information or training. During an interview for transfer to another institution, I spoke openly about being HIV-infected. One of the interviewers stated that he "didn't know anything about the disease and didn't want to." This shows a clear need to improve the training of staff who have been working in the institutions for some time.

A recent joint funding venture by the provincial and federal governments has produced two positions for infectious-disease educators. Although I have only sketchy details on the duties that come with these positions, there can be no doubt that such positions hold the potential for making a positive impact on the issue, from both staff and inmate perspectives.

One significant development in the fight to promote education and awareness over the past year came from the Allied Indian Metis Society (AIMS). They have created a position of AIDS educator/facilitator to provide much-needed education to Aboriginal offenders. Kevin Blaney was hired for this position, and has begun teaching AIDS 101 to interested inmates without regard for cultural or ethnic background.

Peer counselling has been developed and promoted in at least two institutions in the Pacific Region of CSC. As a result of these peer counselling programs, inmates have avenues to seek answers to questions they may be otherwise

reluctant to ask. These questions have ranged from information on bleaching needles and on testing to specific questions relating to the disease process.

The wardens of both Matsqui and Mission Institutions have on many occasions made provisions for me to travel to Matsqui to meet with their HIV-group as well as to give one-on-one counselling. This has been a most rewarding experience and one I am truly grateful for.

On several occasions peer counsellors have also worked with staff. There is little doubt that if inmate peer counsellors are properly trained, they have the potential to become valuable resources in our prisons. It is also conceivable that in the future, paid inmate peer counsellor positions will be created.

Both Matsqui and Mission Institutions have peer support groups set up by inmates. Mountain Institution has also expressed an interest in developing a similar group. These groups have begun to take the initiative and address the issue of HIV/AIDS in prison through events such as Matsqui's "Family Awareness Seminar" and Mission's "Family HIV Awareness Dinner and Bingo." Some of you may think a bingo is a strange thing to hold in relation to AIDS; however, sometimes unusual measures are required to obtain results from resistant groups of people. In this case the lure of the bingo prizes brought people in and they listened to what was said. If just one person in attendance truly heard and acted on their new knowledge, then the end justified the means.

Andréa Riesch Toepell has written a book designed for inmates living with HIV for CSC. I was asked to provide comments on the contents and concept of the book. I can sum them up by saying that this is one of the most important developments I have seen in the past year. The book covers a variety of subjects and provides answers to questions any infected person, whether in prison or not, is bound to have. I wish I had been able to read a book like this much sooner. As it was, even after living with HIV for two years I found the information useful.

The greatest single step toward dealing with the issue of HIV in prison comes in the form of the Working Paper of the Expert Committee on AIDS and Prisons. When I received my copy to comment on, I was amazed at the level of understanding contained within the pages of the document. Admittedly, many prison administrators would not agree with me, as is their right. ECAP has, in my opinion, looked at the situation with open eyes and made good, solid recommendations that, if implemented, can significantly reduce the transmission of HIV in Canadian prisons. It is my fervent hope that the Solicitor General and the Commissioner of CSC will look openly at the recommendations contained in the report. More importantly, it is to be hoped that this report will not have the same fate that similarly conceived reports on, for example, Aboriginal issues have had. There have been over forty commissions and reports on Aboriginal issues and, according to reliable, informed sources, there has been little action taken on the basis of these reports. This should never have been allowed to happen and certainly cannot be allowed to happen with the ECAP Final Report. Everyday lives are affected by this disease and the time for action is now!

Having discussed the positive initiatives of the past year, it is time to look at the areas that still need to be addressed.

In this region during the past year, two inmates have died of AIDS-related complications. In both cases the inmates were transferred from one institutional setting to another (prison to hospital). In ECAP's Working Paper I found mention of a May 1991 Parole Board guideline covering the conditional release of inmates with HIV/AIDS. These guidelines are brief and vague. However, they do provide the Parole Board with the authority to release inmates with AIDS provided that the protection of society is given paramount importance. This I both understand and agree with: it is not my intention to suggest that an inmate be released simply because he has AIDS.

ECAP recommends that inmates with HIV/AIDS be considered for early release while they still enjoy some quality of life, and acknowledges that the protection of society must remain the first and most important consideration when determining the suitability of an inmate for early release. It is my hope that the Parole Board will begin to look more closely at using the guidelines established and the recommendations contained in the ECAP Report.

It is a known, although seldom acknowledged fact, that intravenous drugs are used in Canadian prisons. The Correctional Service takes steps to prevent their entry, but they continue to be available. It has been suggested that if I spoke about there being drugs in prison, the public would begin to call for the visiting programs to be terminated. This action would penalize all inmates for the actions of a few, and would also be in direct conflict with the Mission Statement, which "recognizes the importance of family."

The issue of needle exchange programs in prisons is one that raises considerable debate on both sides of the issue. Prison administrators do not want to see the establishment of needle exchange programs, as this could easily be viewed as condoning drug use. Those with an opposing view see needle exchange programs as a way of effectively reducing transmission of infectious diseases. While these issues are being debated, lives are being affected. Often the lives at risk are not only those of the prisoners, but their wives, girlfriends and, in the case of pregnancy, the unborn child.

Anyone with any experience in the prison system will tell you that inmates are a most resistant group of people who seldom take direction or follow rules or guidelines. There are drug programs; however, they often do not help inmates look for the reason(s) behind their substance use. Until these barriers can be overcome, it is necessary for the Correctional Service to provide every effective means for inmates to both educate and protect themselves from diseases such as HIV.

There is no reason that the Correctional Service cannot continue to enforce the penalties for drug use, and work toward eliminating drugs from prisons, while still providing inmates with the means to protect themselves. It may be true that many inmates would not use a needle exchange program, but I feel confident that a majority of IV drug users would in fact use such a service. I am not just advocating that inmates be provided with free needles. There must be an accompanying counselling session, in order to re-enforce alternatives to drug use. Every inmate exchanging needles should also be reminded of the penalties for using and being caught with drugs.

There is a bottom line when looking at the issue of HIV in prison. That line becomes apparent when looking at the cost involved in failing to develop and implement effective education and prevention programs. The Correctional Service can either spend tax dollars on these programs now or spend considerably more on health care in the near future. Medications and treatment for HIV-infected people is expensive, and costs continue to escalate as the disease becomes more prevalent. Each inmate who becomes infected increases the demand on health-care budgets. These rising costs will eventually be transferred to the taxpayer, adding stress to an already strained economy.

Community agencies continue to provide only minimal service to infected inmates. There is a definite need for these agencies to set up regular visits to the institutions. Opening up to someone about having HIV/AIDS can take time and requires a great degree of trust. This can only be accomplished through a program of regular visits and interaction. Admittedly, prisons are not very pleasant places to visit, but they are generally safe places, and there are people in prison that need to be reached. If you have lived a secret such as having HIV, as I have, then you remember the terrible burden you carried. Peer support counsellors and support groups will help, but there will always be those who will not respond even to their peers. When specific issues have been brought to the attention of these agencies, their response has been slow at best

and often what is done is only the bare minimum required. The members of the HIV groups in Matsqui and Mission Institutions submitted a proposal for an AIDS educator/counsellor to one organization. In the letter included with the submission, it was requested that the proposal be reviewed and, if it was acceptable, that the agency seek funding for the project. It was to be a pilot project similar to that of the AIMS project, but with a greater emphasis on counselling. To date, there has been no response to our request, and when we have asked for comments have received no clear answers. It would seem that this proposal is either caught up in the bureaucracy of the agency or has been forgotten.

Testing and confidentiality continue to be key issues when discussing HIV with many inmates. There is still the sense that any information regarding drug use during the pre- or post-testing interview will be relayed to security staff. In addition, many inmates including myself are under the impression that having our medical information kept strictly confidential is not feasible. When security staff know that inmates are HIV-infected they discuss it among themselves. There are still staff members who feel they have a "right to know." This reinforces the claim that far more staff training is needed. It would seem that the only clear method of resolving fears relating to confidentiality would be to look seriously at having anonymous testing conducted by outside agencies. If testing were conducted by outside contract, inmates would feel that they could answer questions about how they may have contracted HIV with a greater degree of confidence that the information would not be relayed to security staff.

Prison health care itself is an important issue for inmates, whether HIV-infected or not. As I know from personal experience, administrative policies continue to dictate "optimal" medical care. Obtaining medication to help offset the insomnia caused by ddI proved to be a difficult task. I didn't want the drugs, I just wanted to sleep! Had I been in any setting other than prison, I strongly doubt I would have encountered so much difficulty. In every institution in this country there are complaints regarding the health-care system – this is not something new. Often these are dismissed as being just another inmate complaining because he didn't get what he wanted. It is somewhat strange, however, that if hundreds of inmates are complaining, the fault is always with the inmate. While it is impossible for every inmate to feel they are being treated correctly, there must be a way in which this issue can be resolved. Institutional physicians are seen as another part of the "system," and are therefore considered to be untrustworthy. It is the opinion of many inmates that doctors could be contracted on a short-term basis. In this way doctors would not become jaded by inmates constantly trying to "scam" medications. I think that this would also reduce the amount of verbal abuse that doctors are subjected to.

Some inmates who have been so bold as to complain to Members of Parliament have been told such things as that they could find themselves in the same institution two years from now receiving no more than basic medical care. When this type of comment is made by a health-care professional there is cause for great concern. If such comments were brought to the attention of the administration of a correctional facility, there can be little doubt that the story would be changed and no wrong found.

During my address to the Conference last year I spoke of a book to be published by the HIV group in Mission Institution. While I am pointing out the shortcomings of everyone else, it is important for me to point out my own as well. The book is still not finished and I really have no good excuse. I am certain that I could have spent more time and effort to complete it. There are also many other things that we as prisoners could be doing to help stop the spread of HIV. Many inmates fear becoming involved because they might be labelled as activists. Personally, I don't feel that being labelled an activist is necessarily a negative thing: For me it means being willing to do what I can to prevent others from making the mistake I made.

It is not my intention to leave the impression that the Correctional Service is doing nothing to deal

with the issue of HIV in the prison system. What I am really saying is that the current initiatives are too little and too slow, given the magnitude of the problem. It is not enough to say that there are pamphlets and videos available for inmates. We must continue to search for ways to not only lead the horses to water, but to get them to drink as well.

Although I am perhaps the least learned speaker at this Conference, I can honestly tell you that there is a very real and significant potential for HIV to become rampant in our institutions. I do not need research, figures or projections to see it. I am not sitting behind a desk, I am living at the heart of the problem. I listen as inmates who have been in the community talk about sex, and when I ask if they protected themselves and their partners, all too frequently I hear them say no. I see the needle-sharing with my own eyes. I also see these inmates going to conjugal visits and know these same inmates are not protecting themselves or their spouses.

I have been told that educating inmates about diseases such as HIV is a mandate of the CSC, but I do not believe that inmates are excused from doing their part. If we are to effectively address the issue of HIV in prison, everyone concerned needs to be actively working toward that same goal. Inmates must educate themselves, advocate responsible behaviour those around them and work to make each other more aware.

The Correctional Service and community-based organizations should be working together with inmates in trying to work out an effective method of addressing both inmate and staff concerns. Even with an issue as controversial as HIV in prison there has to be compromise, but a solution does not have to compromise one group more than another. It is my belief that if the wardens, chiefs of health care and deputy commissioners, together with representatives from inmate populations, Citizens' Advisory Committee members, community agencies and the Parole Board were to sit down together, they would be able to formulate a plan of attack that would be effective in increasing awareness and decreasing the number of inmates who will be infected. Getting such a diverse group of people together represents a difficult challenge, but it can be done. Everyone involved simply has to want to do it. Although there are many decisions that can only be made by the Commissioner, the deputy commissioners in each region are not without influence. The recommendations from a meeting such as I suggest could be taken by the deputy commissioners to the Commissioner, who could weigh them against the recommendations contained in the ECAP Report. Policies and directives could then be amended or created that would go a long way in reducing the spread of HIV in prisons.

As an infected inmate serving a life sentence, I have come to terms with the fact I may well die from AIDS while in prison. What I have a hard time coming to terms with is knowing that many inmates still feel that they won't contract HIV. There are means available to help inmates protect themselves, but the lives of inmates are caught up in the bureaucracy of a system that seems unwilling to look at the issue from both the medical and criminal perspectives. As long as this continues, the cost in prison health care will continue to soar, more people will become infected and more lives will be lost.

In comparison to the rest of the world's prison populations, Canadian prisoners have it good. HIV-infected prisoners are not segregated or grossly mistreated. Although we do not receive what we consider to be effective medical care, what we do receive is better than what the citizens of many other countries receive. This does not and should not mean that the Canadian correctional systems should feel content in their efforts. More effort is needed and the time for it is now, before we are faced with an infection rate similar to that in other countries.

In our communities and in our prisons, nobody else ever has to contract this disease. Those who are truly committed to changing things within the prisons and communities need only work together, and through that cooperation there can be found a middle ground that strikes a balance between the

criminal, medical and social issues surrounding HIV/AIDS in prisons.

There is a possibility that one day in the near future I will be allowed to return to a society I previously took so much from. My hope is that when that day comes I will have contributed to the betterment of that society. My commitment will only end with the end of my life. At that time, I hope that somewhere in the course of my efforts I will have had a positive and productive influence in helping to reduce the spread of HIV in prisons. This is the goal I have committed the past year working toward. It is also one that I have every intention of continuing to work toward – and, I believe, one that can be realized. It is my assumption that many of you listening today share at least a small measure of this commitment. If this is so, I urge you to become more involved.

The Correctional Service recognizes the potential for human growth and development, and that the offender has the potential to live as a law-abiding citizen. Whatever is thought of criminals, they are human beings with feelings, and there are people who love them. Everyone owes it to themselves and to society to do what they can to help reduce the spread of HIV/AIDS, regardless of who is at risk. Without adopting this approach, more lives will be infected with and affected by this disease.

In conclusion, I would like to thank Drs. Ralf Jürgens and Norbert Gilmore for providing the opportunity for me to take part in the Conference again this year. I would also like to acknowledge those who have supported and strengthened me over the past year. It is not necessary to list all of them: they know who they are. In particular I want to thank Xavier [Sanchez Horno] for always being behind me even when we didn't see eye to eye. To those members of the Organizing Committee who moved to make this video presentation possible, my sincerest appreciation. Lastly, I have to thank all of you for having shown enough interest to sit and listen.

EDUCATING PRISONERS ABOUT HIV/AIDS: PURPOSE, POLITICS AND PRACTICE

Andréa Riesch Toepell, Consultant, Toronto

I have been asked to describe my experiences in developing educational materials for the prison population. I have come across several barriers in the process. After explaining why inmates need HIV/AIDS education, I will describe the politics involved in developing such materials and, finally, the effort to produce and disseminate these materials in the prison system.

Depending on how HIV/AIDS affects our lives and what our interest in HIV/AIDS is, we are all aware of the political realities of the virus and the disease. Decisions specifically related to AIDS education are continually based on current political realities and political pressures. Examples of these include: the selecting of community groups to fund the development of educational materials; which messages specific to safer behaviours should be endorsed or how they are to be written; etc.

Add to these politics the obstacles of working with an invisible yet highly monitored and regulated population in our community, the prison population. Examples of obstacles include: how do we best gain access to this population?; how do we best provide education, given the limitations concerning an institution's security rules and policies?; what restrictions might be encountered regarding the content of educational materials?; etc.

Previous research I have undertaken demonstrates the need for providing educational materials to inmates:

(1) prisoners have a superficial understanding of HIV/AIDS;

(2) their primary source of information is the media, which mostly provides biased or skewed information and misinformation;

(3) they do not seek HIV/AIDS education and information when outside prison;

(4) the materials available to them outside prison are not necessarily appropriate to inmates, in that they are usually written at a high literacy level and do not use clear language;

(5) any materials produced for the inmate population must provide basic HIV/AIDS education; the teaching of safer behaviours and attitudes; and be written at a low literacy level, using clear language, with many illustrations.

The research supporting these statement includes two studies I have completed: an AIDS education needs assessment[1] and a knowledge-attitude-behaviour study[2] specific to HIV/AIDS. To date, these studies remain Canada's only such studies with the prison population concerning this topic. I will not further describe the findings of these studies, but suffice it to say that inmates are in need of accurate and unbiased HIV/AIDS education, and that they strongly support HIV/AIDS education programming in the prison setting. Details and results of the findings of these studies are described in two reports and are available from the Canadian Public Health Association.

Provincial institutions vary greatly in their efforts to provide education and prevention tools, while federal institutions share a more consistent policy (i.e., allowing external AIDS educators access to institutions; condom, dental dam and lubricant distribution; and support for HIV/AIDS peer education development). Nevertheless, many of the educational initiatives stem from the community outside the institutions, and these initiatives are often met with resistance.

In the prison setting we can't simply enter the institution with educational materials and expect to disseminate them freely. Not only are publicly available materials carefully screened, but such materials are often not appropriate for the prison population. Materials specifically developed for the prison population should be comprehensive, written at a low literacy level using clear language, supplemented with many illustrations, discuss risk behaviours in prisons (such as tattooing, injection drug use, and sex), and be presented in a non-condescending manner.

Interestingly, however, the unique features of such materials that make them most accessible to the prison population are generally the same features that can ultimately prevent the materials from being distributed, as they give rise to political apprehension. An excellent example of how politics prevented the distribution of materials especially prepared for the prison population is the book entitled *Get the Facts: Surviving in Prison and in the Community.*

I developed and wrote this book for the John Howard Society of Metropolitan Toronto, in response to the AIDS education needs assessment study I completed. The conclusions and recommendations from this study point to the need for a book such as *Get the Facts.*

Perhaps some of you are familiar with this book, and perhaps some of you are also aware that the original book (the yellow-covered copy) was rewritten because of politics stemming from two provincial ministries in Ontario (Health and Corrections). The book was approved by both ministries prior to printing. The rewritten version is this book, looking identical to the original book, only with a blue cover.

What features of this book could have caused such a controversy that it had to be rewritten? Concern was raised with regard to:

1. Toepell, A.R. *Prisoners and AIDS: An AIDS Education Needs Assessment.* John Howard Society of Metropolitan Toronto, 1992.

2. Toepell, A.R. *Prisoners and AIDS: Knowledge, Attitude and Behaviour.* John Howard Society of Metropolitan Toronto, 1992.

(1) possible implications of acknowledging sexual activity and drug use in prison (fearing the implication that government bodies condone such behaviours);

(2) conflict over the educational needs of prisoners (ministry versus the community);

(3) ownership of safer sex and safer needle use messages (community versus government messages);

(4) censorship concerning language and terminology used;

(5) censorship concerning illustrations and content of illustrations;

(6) prison staff's reactions to educational initiatives;

(7) prisoners' reactions to educational initiatives.

Although I am using *Get the Facts* as an example, I have experienced these same barriers and concerns with other materials I have developed for the prison population. But I will use *Get the Facts* as an example when discussing obstacles and processes of overcoming them because this book has a before-and-after history. To describe these concerns in further detail:

(1) Possible implications for acknowledging tattooing, sexual activity and drug use in prison

The concern was that, because I addressed these behaviours, I brought attention to them and to the fact that the Ontario Ministry of Correctional Service does not provide prisoners with the tools to make these behaviours safer in prison. Also, it was feared that the public and/or correctional officers would assume that government bodies condone such behaviours behind bars. Further, I was highlighting a contradiction: although sexual activity, drug use and tattooing are felonies inside prison (and if caught, prisoners can be charged), these behaviours exist in the prison setting.

(2) Conflict over the educational needs of prisoners

Although much research had been conducted and documented regarding the educational needs of prisoners, and extensive focus testing was completed prior to publishing *Get the Facts*, the voice of the prisoners was largely ignored by government bodies and some community members. What was of far greater concern was the *image* projected by government bodies for, firstly, funding such a publication and, secondly, for distributing it.

(3) Ownership of safer sex and safer needle use messages

It is very interesting to note that messages provided by AIDS community groups in your area are not necessarily the same ones shared by the Department of Public Health in your area or even the Ministry of Health in your province or territory. It has been my experience with *Get the Facts* that, after printing, the funding body (City of Toronto) was very particular about the messages provided, and has caused exceptional conflict with the rewriting of the book. This was because the City's perspective is one of harm elimination, while the book provided a harm reduction approach. The City preferred that unsafe behaviours not be discussed in the book, because safer behaviours using proper tools could not be promoted (condoms and bleach are not generally available in Ontario provincial prisons). However, I felt it unreasonable **not** to discuss these behaviours, as they are realities of prison life. Of course, a disclaimer printed on the inside front cover (something to the effect that "views expressed in this book are not necessarily those shared by the funding agency") would have alleviated much grief concerning the discussion of safer sex and safer needle use in prison. Unfortunately, this was not acceptable to the funding agency. Also problematic was determining "who" or "what body" was the final authority on safer messages and who or what owned the message itself.

(4) Censorship concerning language and terminology used

The original version of *Get the Facts* used some street terminology and explicit language in the

safer sex section. When I was carrying out the needs assessment study, 65% of the inmates pointed to a pamphlet that uses such language when they were asked to select pamphlets that interested them (from a collection of materials brought in for the study). Again, during the focus testing prior to printing the book, such language was endorsed and strongly encouraged by the prison population. Also, the use of this language was approved by both ministries prior to printing.

However, just after the book was printed, the political climate in Toronto changed drastically, especially with regard to the use of explicit sexual terms in HIV/AIDS-related educational materials. The Toronto Board of Health, the Department of Health and the City of Toronto felt it necessary to tone down the language used, although the prison population clearly made it known that the language was accessible and appropriate. The concern was with the potential image of these groups and not whether the use of such terminology enhanced understanding of the information provided.

Also at this time, materials produced by other Toronto social service agencies were being scrutinized for use of language and safer sex messages.

(5) Censorship concerning illustrations and content of these illustrations

Although the illustrations were considered appropriate by the prison population, and they were approved prior to the original printing of the book, attitudes changed considerably as the climate changed in Toronto and among officials at the Ministry of Correctional Services. It was strongly requested that the illustrations depicting sex in prison (two inmates hugging) and drug use in prison (two inmates sharing a needle as a third looks over his shoulder watching for anyone unexpectedly coming by) be removed, and the criticism was made that too many illustrated penises accompanied the text in the section describing condom use (and would I consider removing one, preferably two of them). Again, the concern was the Ministry's image rather than accessibility of information, and how staff and/or the public would react to such illustrations. Also reflected were homophobic attitudes and a denial that such behaviours happen behind provincial bars.

(6) Staff's reactions to educational materials for inmates

When the original version of the book became available, health-care staff were approached to distribute it to all inmates being seen by them (inmates at provincial centres are seen by health care within 48 hours of admission). The health-care staff objected to the explicit (toned-down) language, stating that the book promoted the use of such language, which is in contradiction with prison policy. A prisoner can be charged with "misconduct" for uttering such words. Despite my meeting with the nurses, discussing the research on which the book was based, the nurses were not willing to distribute the book to inmates, although they thought it was a useful and informative publication. Because the language was taken out of context, the entire book was rejected.

Several months after the book was rewritten, it was distributed at the Toronto Jail as a pilot project. The correctional officers revolted against this rewritten, toned-down version of *Get the Facts*, although it is not a book written for them. They felt that the street language used is not necessary and that it encourages the use of such language; that the tone of the book is insulting to prisoners; that the illustrations are pornographic; and that it is degrading to women. Even after an exhausting meeting, the officers picketed the jail, protested the book's distribution, drew a lot of media attention to the book being at the jail, and took up the issue of the book with their union.

(7) Prisoners' reaction to educational initiatives

After the book had been in circulation at the Toronto Jail for five months, I completed a formal

evaluation[3] of the book's success or failure. I conducted private one-on-one interviews lasting 20 minutes. The 74 prisoners interviewed raved about *Get the Facts*, and strongly suggested that all inmates across the province be given it. Very few suggestions for changes were made, but they included adding more illustrations and providing information specific to women and young offenders. The use of explicit language and the content of the illustrations were not offensive to or considered inappropriate by the prisoners.

So then, how can we as AIDS educators best provide educational materials that we know are most appropriate for prisoners because we have sought the views of this population? What is the process involved? Through careful negotiation, many of the issues concerning HIV/AIDS education for inmates can be resolved. Sometimes compromises have to be made (such as removing topic-sensitive illustrations, replacing street language with terms more acceptable to the general public), and at other times initiatives are flatly rejected (such as having an outside AIDS educator come into the prison setting to provide education, or give a condom demonstration or syringe-cleaning demonstration). However, much of the success of these initiatives and negotiation processes are dependent on the institution involved, the officials or medical staff at the institution, or the government body with whom discussions and/or negotiations are necessary.

The process involved in negotiating a means for educating prisoners includes the following aspects: (1) many officials learn and are made aware for the first time through these efforts of the issues concerning educating inmates; (2) many people will need to be re-educated on HIV/AIDS issues, and their attitudes changed or challenged; (3) a large dose of maturity and understanding for the concerns of others is necessary; (4) enough time should be allowed for officials or negotiating members to get use to and prepare for the initiatives, language, messages being proposed (since many people are concerned about media attention, staff's reactions, etc.); (5) it is necessary to be prepared to get down to brass tacks, such as word counts of street terms used (of all the words found in the materials, the percentage of words considered offensive), to negotiate for illustrations and content based on research (assessments, surveys, consultation with prisoners) backing the recommendations being made; (6) knowing what the bottom line is and just how far one can deviate from prisoners' educational needs without compromising the efficacy of the materials or the program is vital.

Through collaboration with external agencies and AIDS educators, appropriate programming for prisoners can be developed. Costs for such efforts can be reduced or shared between ministries via partnership building.

Successful educational initiatives have given many inmates an opportunity to learn about HIV prevention and AIDS, which they would otherwise not seek when released from prison. Although it often feels like you are taking one step forward, two steps back, and the frustration is mounting, all programming initiatives are appreciated and respected by the inmates, and future efforts are always strongly encouraged.

3. Toepell, A.R. (1993) "Evaluation of *Get the Facts* with inmates at the Toronto Jail," report to the John Howard Society of Metropolitan Toronto.

APPENDIX 9

LIST OF SUBMISSIONS TO ECAP AND OF RESPONSES TO THE WORKING PAPER

LIST OF SUBMISSIONS

In August 1992, ECAP sent letters to selected national and international bodies, groups and individuals, requesting information about issues raised by HIV/AIDS and by drug use in prisons and asking them to make submissions to the Committee. Among those to whom letters were sent are:

- provincial and territorial ministries of health;
- provincial and territorial ministries responsible for the provision of young offenders and adult 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 issues;
- selected correspondents from the international HIV/AIDS in Prisons Information Exchange Network managed by the University Institute of Legal Medicine, Geneva.

ECAP received 91 submissions and has addressed many of the issues raised in these submissions in its Working Paper and Final Report. The following is a list of those who sent submissions to the Committee.

Ministries of Health

Cheverie, Hon. W.D.
Minister of Health and Social Services,
Department of Health and Social Services,
Province of Prince Edward Island,
Charlottetown, Prince Edward Island

Cull, Hon. E.
Minister of Health and Minister Responsible for Seniors, Province of British Columbia,
Victoria, British Columbia

Hayden, Hon. J.
Minister of Health and Social Services, Yukon,
Whitehorse, Yukon

King, Hon, R.H.T.
Minister of Health and Community Services,
Province of New Brunswick,
Fredericton, New Brunswick

List of Submissions to ECAP and of Responses to the Working Paper

Laberge-Ferron, Ms. D.
Directrice générale, Centre québécois de coordination sur le sida, Gouvernement du Québec, Ministère de la Santé et des Services sociaux, Montréal, Québec

Larke, Dr. B.
Medical Director, Provincial AIDS Program, Alberta Health, Edmonton, Alberta

Orchard, Hon. D.W.
Minister of Health, Province of Manitoba, Winnipeg, Manitoba

Simard, Hon. L.
Minister of Health, Province of Saskatchewan, Regina, Saskatchewan

Strand, Dr. L.
Executive Director, Laboratory and Disease Control Services Branch, Saskatchewan Health, Regina, Alberta

Ministries Responsible for the Provision of Adult and Young Offenders Correctional Services

Cooper Mont, Ms. N.
Deputy Solicitor General, Province of Nova Scotia, Halifax, Nova Scotia

Connor, Mr. J.
Health Care Manager/AIDS Coordinator, Alberta Solicitor General, Correctional Services Division, Lethbridge Correctional Centre

Curley, Mr. A.J.
A/Provincial Administrator, Adult Facilities, Department of Justice and Attorney General, Community and Correctional Services, Province of Prince Edward Island, Charlottetown, Prince Edward Island

Currie, Mr. A.J.
Deputy Minister, Department of Justice and Attorney General, Province of Prince Edward Island, Charlottetown, Prince Edward Island

Demers, Mr. D.J.
Assistant Deputy Minister, Manitoba Justice, Corrections, Winnipeg, Manitoba

Dunbar, A.B.
Acting Deputy Minister, Northwest Territories Social Services, Yellowknife, Northwest Territories

Duperron, Mr. W.A.
Director, Corrections Service Division, Northwest Territories Justice, Yellowknife, Northwest Territories

Ford, Mr. P.
Project Officer, Operational Coordination Branch, Ministry of Community and Social Services, Province of Ontario, Toronto, Ontario

Gabelmann, Hon. C.
Attorney General, Province of British Columbia, Victoria, British Columbia

Joe, Hon. M.
Minister of Justice, Yukon, Whitehorse, Yukon

Mitchell, Hon. R.W.
Minister of Justice and Attorney General, Province of Saskatchewan, Regina, Saskatchewan

Simard, Mr. A
Responsable des Services à la clientèle, Gouvernement du Québec, Ministère de la Sécurité publique, Direction générale des Services correctionnels, Direction de la détention, Sainte-Foy, Québec

Smith, Hon. B.A.
Solicitor General, Province of New Brunswick, Fredericton, New Brunswick

Thornhill, Mr. R.J.
Office of the Minister, Department of Community Services, Province of Nova Scotia, Halifax, Nova Scotia

West, Hon. S.C.
Alberta Solicitor General, Edmonton, Alberta

List of Submissions to ECAP and of Responses to the Working Paper

Wilson, Mr. L.
Director of Institutional Operations, Saskatchewan Justice, Corrections, Regina, Saskatchewan

Human Rights Commissions

Bernard, Mr. C.
Acting Director, Policy Unit, Ontario Human Rights Commission, Toronto, Ontario

Burka, Ms. M.
Director, British Columbia Council of Human Rights, Victoria, British Columbia

Cullinan, Ms. J.E.
Director, Compliance Branch, New Brunswick Human Rights Commission, Fredericton, New Brunswick

De Kovachich, Mr. N.
Vice-President, Quebec Human Rights Commission, Montreal, Quebec

Hucker, Mr. J.
Secretary General, Canadian Human Rights Commission, Ottawa, Ontario

Jamont, Mr. K.C.
Executive Director, Saskatchewan Human Rights Commission, Saskatoon, Saskatchewan

May, Ms. D.
for D. Beauchamp, Human Rights Officer, The Manitoba Human Rights Commission, Winnipeg, Manitoba

Pachai, Dr. B.
Executive Director, Nova Scotia Human Rights Commission, Halifax, Nova Scotia

Vivian, Ms. G.
Executive Director, Newfoundland and Labrador Human Rights Commission, St. John's, Newfoundland

Wyatt, Mr. J.M.
Executive Director, Prince Edward Island Human Rights Commission

Drug Abuse Commissions

Baldwin, Ms. K.
Regional Manager, Department of Health, Government of Newfoundland and Labrador, St. John's, Newfoundland

Balram, Dr. B.C.
Director, Health Promotion and Disease Prevention, Health and Community Services, Fredericton, New Brunswick

Blumenthal, Mr. L.
Chief Executive Officer, Alberta Alcohol and Drug Abuse Commission, Edmonton, Alberta

Donovan, K.D.
Saskatchewan Alcohol and Drug Abuse Commission, Regina, Saskatchewan

Farrally, Ms. V.
Executive Director, Alcohol and Drug Programs, Ministry of Health and Ministry Responsible for Seniors, Victoria, British Columbia

Hrenchuk, Ms. C.
Addiction Prevention Consultant, Yukon Alcohol and Drug Services, Yukon Health and Social Services, Whitehorse, Yukon

Individuals and Groups in Canada with an Interest in the Issues

Barnett, Ms. J.
Prisoners with AIDS/HIV Action Network, Toronto, Ontario

Calzavara, Dr. L.M.
Assistant Professor, Department of Preventive Medicine and Biostatistics, Faculty of Medicine, University of Toronto, Toronto, Ontario

Davidson, Mr. H.
Editor, *Journal of Prisoners on Prisons*, Edmonton, Alberta

List of Submissions to ECAP and of Responses to the Working Paper

Diamond, Mr. D.
Inmate and Peer Health Counsellor,
Kingston Penitentiary, Kingston, Ontario

Garmaise, Mr. D.
National Programmes Director,
Canadian AIDS Society

Gibson, Mr. F.E.
Chairman, National Parole Board, Ottawa, Ontario

Glaremin, Mr. R.
Inmate and Member, Peer Support Group,
Collins Bay Institution, Kingston, Ontario

Godkin, Mr. B.
Inmate and President, "Prisoners of HIV/AIDS,"
Matsqui Institution, Abbotsford, British Columbia

Hankins, Dr. C.A.
Public Health Epidemiologist, Centre for AIDS Studies, Department of Community Health,
Montreal General Hospital, Montreal, Quebec

Hill, Ms. B.
Director of Policy Development, The John Howard Society of Ontario, Toronto, Ontario

Kulman, Ms. S.
Executive Director, The John Howard Society of Metropolitan Toronto, Toronto, Ontario

Linhart, Mr. M.
Inmate, Mission Institution, Mission,
British Columbia

MacLatchie, Mr. J.M.
Executive Director, The John Howard Society of Canada, Ottawa, Ontario

O'Donnell, Ms. E.A.
Chairperson, Social Issues Committee, The Elizabeth Fry Society of Calgary, Calgary, Alberta

Oscapella, Mr. E.L.
Barrister and Solicitor, Ottawa, Ontario

Pagliaro, Ms. A.M.
Associate Professor, University of Alberta,
Edmonton, Alberta

Serff, Ms. P.
Interim Executive Director, The John Howard Society of Kingston and District, Kingston, Ontario

Shore, Mr. R.
Prison Outreach Worker, Kingston AIDS Project,
Kingston, Ontario

Stepanko, Ms. C.
The Elizabeth Fry Society of Edmonton,
Edmonton, Alberta

Toepell, Dr. A.R.
AIDS Researcher, Toronto, Ontario

Zoutman, Dr. D.
Director, Department of Medical Microbiology and Infection Control, Kingston General Hospital,
Kingston, Ontario

Yetman, Ms. L.
Howard House Director (Acting), The John Howard Society of Newfoundland,
St. John's, Newfoundland

International Correspondents

Arnason, Dr. S.
Medical Officer, Icelandic Prisons,
Reykjavík, Iceland

Arpo, Dr. L.
Chief Medical Officer of the Prison Administration, Ministry of Justice, Prison Department,
Helsinki, Finland

Bernasconi, Ms. S.
Federal Office of Public Health,
Division of Health Promotion, AIDS Section,
Bern-Liebefeld, Switzerland

Bissuel, Dr. Y.
Service Médico-Psychologique Régional,
Lyon, France

List of Submissions to ECAP and of Responses to the Working Paper

Bolli, Dr. K.
Kantonale Strafanstalt, Regensdorf, Switzerland

Darbéda, Mr. P.
Ministère de la Justice, Direction de l'Administration Pénitentiaire, Paris, France

de Man, Dr. T.J.
Medical Inspector, Ministry of Justice, The Hague, The Netherlands

Dolan, Ms. K.
Researcher, Alcohol and Drug Services, St. Vincent's Hospital, Sydney, Australia

Dooley, Dr. E.
Director of Prison Medical Services, Dublin, Ireland

Göttinger, Dr. G.
Head of the Medical Services in Prison Administration, Ministry of Justice of the State of Lower Saxony, Hanover, Germany

Héritier-Augé, Ms. F.
President, Conseil National du SIDA, Paris, France

Koppenhöfer, Dr.
Bavarian Ministry of Justice, Munich, Germany

Lincoln, Ms. L.
Information Officer, AVERT AIDS Education and Research Trust, Horsham, England

Machon, Mr. S.
Information/Referral Coordinator, AIDS in Prison Project, The Correctional Association of New York, New York, New York

Martín, Dr. M.
Subdirectora General de Sanidad Penitenciaria, Ministry of Justice, Madrid, Spain

Martins, T. A.
Bureau of Documentation and Comparative Law, Lisbon, Portugal

Marx, Dr.
Ministry of Justice of Rheinland Pfalz, Mainz, Germany

Morelli, Dr. D.
Researcher, Scuola di Medicina e Scienze Umane, Centro Studi AIDS, Istituto Scientifico Ospedale S. Raffaele, Milan, Italy

Norberry, Ms. J.
Criminologist, Australian Institute of Criminology, Canberra, Australia

Palumbo, Mr. G.
Associazione Solidaritá AIDS, Milan, Italy

Pont, Dr. J.
Physician, 3. Medizinische Abteilung, Kaiser Franz Josef Spital, Vienna, Austria

Ralli, Dr. R.A.
Principal Medical Officer, Directorate of Health Care, HM Prison Service, London, England

Riedl, Ms. M.
Lawyer, Munich, Germany

Schäfer, Dr.
Ministry of Justice of Hessen, Wiesbaden, Germany

Starke
Ministry of Justice of Nordrhein-Westfalen, Düsseldorf, Germany

Thiele
Department of Justice, Freie und Hansestadt Hamburg, Germany

Vumbaca, Mr. G.
Manager, Prison AIDS Project, New South Wales Department of Corrective Services, Sydney, Australia

Walker, Ms. J.
AIDS Information Coordinator, The National Prison Project of the American Civil Liberties Union Foundation, Washington, District of Columbia

List of Submissions to ECAP and of Responses to the Working Paper

LIST OF RESPONSES TO ECAP'S WORKING PAPER

As part of its work, ECAP prepared *HIV/AIDS in Prisons: A Working Paper of the Expert Committee on AIDS and Prisons*. The Working Paper addressed many of the issues that HIV/AIDS and drug use raise in federal correctional institutions and contained conclusions of ECAP's deliberations and suggestions for action, but no recommendations. More than 1000 copies of the *Working Paper* were distributed in Canada and internationally to stimulate discussion and to give people interested in the issues raised by HIV/AIDS and by 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.

ECAP has received 50 responses to the *Working Paper*. Respondents have included inmates and several wardens and other staff of federal correctional institutions, and many individuals and groups working on issues raised by HIV/AIDS and by drug use in prisons, including the National Advisory Committee on AIDS (NAC-AIDS), the Canadian AIDS Society, the Prisoners with AIDS/HIV Support Action Network (PASAN), the Associate Director for HIV/AIDS at the U.S. Centers for Disease Control, the Medical Director of the U.S. Federal Bureau of Prisons, and the Deputy Director of the World Health Organization's Global Programme on AIDS.

The following is a list of those who have provided the Committee with comments, critiques, and suggestions about the issues addressed in the *Working Paper*.

Ministries of Health

MacKinnon, Ms. N.
Administrative Secretary, Ministry of Health, Winnipeg, Manitoba

Orchard, Hon. D.W.
Minister of Health, Manitoba Health, Winnipeg, Manitoba

Stratton, Dr. F.
Director, Disease Control & Epidemiology, Government of Newfoundland and Labrador, Department of Health, St. John's, Newfoundland

Yeates, Ms. G.
Associate Deputy Minister, Saskatchewan Health, Regina, Saskatchewan

Ministries Responsible for the Provision of Adult and Young Offenders Correctional Services

Simard, Mr. A.
Responsable des Services à la clientèle, Gouvernement du Québec, Ministère de la Sécurité publique, Direction générale des Services correctionnels, Direction de la détention, Sainte-Foy, Québec

Human Rights Commissions

Ludwick, Mr. R.
Human Rights Officer, The Manitoba Human Rights Commission, Winnipeg, Manitoba

Drug Abuse Commissions

Kearns, Mr. B.
Acting Chief Executive Officer, Alberta Alcohol and Drug Abuse Commission, Edmonton, Alberta

Individuals and Groups in Canada with an Interest in the Issues

Anderson, Ms. J.
Policy Volunteer, Canadian AIDS Society, Ottawa, Ontario

Barnett, Ms. J.
for the Prisoners with AIDS/HIV Support Action Network (PASAN), Toronto, Ontario

List of Submissions to ECAP and of Responses to the Working Paper

Betteridge, Mr. G.
Student, Faculty of Law, McGill University, Montreal, Quebec

Buckley-Couvrette, Mr. D.
Administrator, ACT-UP, Montreal, Quebec

Brock, Mr. R.B.
Warden, Matsqui Institution, Abbotsford, British Columbia

Calzavara, Dr. L.M.
Assistant Professor, Department of Preventive Medicine and Biostatistics, Faculty of Medicine, University of Toronto, Toronto, Ontario

Challis, Mr. J.
Inmate, Dorchester Penitentiary, Dorchester, New Brunswick

Chaput, Mr. R.
Deputy Warden, Donnacona Institution, Donnacona, Quebec

Cunningham, Dr. C.
Executive Director, Native Counselling Services of Alberta, Edmonton, Alberta

Currie, Ms. N.
Activist and Educator, Toronto, Ontario

de Burger, Mr. R.
Director, AIDS Program, Canadian Public Health Association, Ottawa, Ontario

Delisle, Mr. J.
Executive Director, Office of the Privacy Commissioner of Canada, Ottawa, Ontario

Deslauriers, Mr. M.
Warden, Regional Reception Centre, Ste-Anne-des-Plaines, Quebec

Dixon, D.J.
Chief, Health Care, Joyceville Institution, Kingston, Ontario

Fanning, Dr. A.
Director, Tuberculosis Services, Alberta Health, Edmonton, Alberta

Fitzgerald, Dr. J.M.
Chairman, Canadian Thoracic Society Tuberculosis Committee, Vancouver, British Columbia

Gillis, Mr. J.
Warden, Westmorland Institution, Dorchester, New Brunswick

Glaremin, Mr. R.
Prisoners' Peer Support Group, Collins Bay Institution, Kingston, Ontario

Hankins, Dr. C.
Public Health Epidemiologist, Centre for AIDS Studies, Department of Community Health, Montreal General Hospital, Montreal, Canada

Hart, Mr. W.C.
Chairman, Nova Scotia Advisory Commission on AIDS, Halifax, Nova Scotia

Hegeman, Ms. L.
Regina General Hospital, Regina, Saskatchewan

Hershfield, Dr. E.S.
Faculty of Medicine, Section of Respiratory Diseases, University of Manitoba, Winnipeg, Manitoba

Linhart, Mr. M.
Inmate, Mission Institution, on behalf of "Prisoners of HIV Group," Mission Institution, Mission, British Columbia

Linklater, Mr. J.
Warden, Edmonton Institution, Edmonton, Alberta

Lugosi, Mr. Z.
Inmate, Pittsburgh Institution, Kingston, Ontario

MacDonald, Hon. D.
Member of Parliament, Chair, Parliamentary Ad Hoc Committee on AIDS, Ottawa, Ontario

List of Submissions to ECAP and of Responses to the Working Paper

MacTavish, Mr. J.
Community Support Services Coordinator,
Kingston AIDS Project, Kingston, Ontario

McIsaac, Mr. E.
Executive Director, The Correctional Investigator
Canada, Ottawa, Ontario

O'Shaughnessy, Dr. M.V.
Chair, National Advisory Committee
on AIDS

O'Sullivan, Mr. J.
Warden, Saskatchewan Penitentiary,
Prince Albert, Saskatchewan

Riley, Dr. D.
Senior Analyst, Policy, Research and Information
Unit, Canadian Centre on Substance Abuse,
Toronto, Ontario

Sutherland, Ms. H.
Support Services Co-ordinator, Peterborough
AIDS Resource Network, Peterborough, Ontario

Taylor, Mr. B.
IDU Coordinator, KEEP SIX! Needle Exchange
Program, Kingston AIDS Project, Kingston, Ontario

Toepell, Dr. A.R.
Consultant, Toronto, Ontario

White, Ms. C.
Prison Outreach Coordinator,
Kingston AIDS Project, Kingston, Ontario

International Correspondents

Ainslie, Mr. D.
Department of Philosophy, University of
Pittsburgh, Pittsburgh, Pennsylvania

Blake, Dr. D.
Deputy Director, Global Programme on AIDS,
World Health Organization,
Geneva, Switzerland

Craven, Dr. D.E.
Director, Clinical AIDS Program, Boston City
Hospital, Boston, Massachusetts

Curran, Dr. J.W.
Assistant Surgeon General, Associate Director for
HIV/AIDS, Centers for Disease Control and
Prevention, Atlanta, Georgia

Dolan, Ms. K.
Research Officer, Alcohol and Drug Services,
St. Vincent's Hospital, Sydney, Australia

Kelly, Dr. J.M.
Assistant Professor, Buffalo State College,
Buffalo, New York

Moritsugu, Dr. K.P.
Assistant Surgeon General, Medical Director,
Federal Bureau of Prisons, U.S. Department of
Justice, Washington, D.C.

Schulman, Mr. D.I.
Supervising Attorney, AIDS/HIV Discrimination
Unit, Office of the City Attorney,
Los Angeles, California

DATE DUE

APR 3 1995		
96 OCT 18.		
96 DEC 11.		
08 JAN 03		
24. JAN 03		
22. APR 03		
13. MAY 03		
26. MAY 03		
15. DEC 11		