HIV/AIDS AND HEPATITIS C IN CORRECTIONAL FACILITIES: REDUCING THE RISKS

Carolyn Marshall
BA Hon, MPA

Marshall Consulting

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TABLE OF CONTENTS

Executive Summary iv
Summary of Recommendations vii
Acknowledgements xii

1. INTRODUCTION 1
   Nova Scotia’s Strategy on HIV/AIDS 1
   Background Work 2
   Focus Group with Offenders At-Risk 2
   Purpose and Structure of Report 2
   Report Caveats and Limitations 3

2. CORRECTIONAL FACILITIES IN THE ATLANTIC REGION 5
   Correctional Service of Canada 5
   Nova Scotia Department of Justice, Correctional Services 5

3. RATIONALE – WHY FOCUS ON OFFENDERS AS AN AT-RISK GROUP? 7
   Incarcerated Populations at Greater Risk 7
   Numbers Incarcerated 7
   HIV and HCV Prevalence Rate among Offenders in Canadian Prisons 7
   HIV and Associated Risk Behaviours in Correctional Institutions 8
   Unclean Needle Use 8
   Unsafe Sexual Practices 10
   Summary 11

4. METHODS 12
   Focus Group Criteria 12
   Recruitment 12
   Group Composition 12
   Group Location, Safety of Participants 13
   Purpose of the Workshop 13
   Objectives of the Focus Group 14
   Introduction/Confidentiality 14
   Sensitivity of the Subject Matter 14
   Other Forms of Input/Validation 15

5. FINDINGS 16
   5.1 Access to Methadone Maintenance Treatment 17
   5.2 Access to Clean Needles/Tattoo Equipment and Bleach 20
   5.3 Access to Safer Sex Tools 22
   5.4 Access to Health/Sexual Health Services/Confidentiality 22

HIV and Hepatitis C in Correctional Facilities: Reducing the Risks ii
Table I: Summary of Offender Issues of Concern by Topic and Applicability to Federal or Provincial Corrections Settings

6. ANALYSIS AND RECOMMENDATIONS

6.1 Current Policy Framework

- International Legal Framework
- Delivery of Health Services in Corrections in Canada
- Delivery of Health Services in Corrections in Nova Scotia

6.2 Analysis, Evidence Review and Recommendations

- Blood Borne Pathogens Prevention Services in Correctional Settings
- Prevention/Harm Reduction Education and Training
- Public Awareness of Harm Reduction
- Access to Methadone Maintenance Treatment (MMT)
- Access to Counseling, Testing, and Sexual Health Services
- Access to Safe Injection and Tattooing/Piercing Equipment and Bleach
- Access to Safer Sex Equipment
- Access to HIV/HCV Treatment
- Access to Sexual Education and HIV/HCV Prevention Programs
- Pre-release/Discharge Planning
- Engaging Stakeholder Support/Next Steps

6.3 Conclusion

Appendices

- Appendix A: Workshop Agenda
- Appendix B: Outline of Focus Group
- Appendix C: Focus Group Guide

Selected References
HIV/AIDS AND HEPATITIS C IN CORRECTIONAL FACILITIES: REDUCING THE RISKS

Executive Summary

In 2003, the Province of Nova Scotia and various HIV/AIDS stakeholders released its strategy to address HIV/AIDS, outlining a broad range of efforts to prevent/reduce the spread of the infection and improve access to care, treatment, and support for individuals affected by HIV/AIDS. The Nova Scotia Advisory Commission on AIDS has a leadership role in coordinating implementation of the strategy, along with government and community partners.

Prison populations are particularly vulnerable to HIV and Hepatitis C. Many Canadian offenders engage in high risk behaviours that contribute to transmission of HIV and other blood borne pathogens prior to, during, and after incarceration, exposing themselves and others to the virus. Risk behaviours include unsafe practices regarding injection drug use, tattooing, piercing, and sexual activity. Identifying opportunities to reduce risk and promote offender health and wellness is an objective of Nova Scotia’s Strategy on HIV/AIDS (Recommended Action #3.4).

The Commission began work to identify the needs and challenges that offenders with/at-risk of HIV/AIDS encounter in their transition to and from prison. In order to explore this further, a focus group was conducted with a group of individuals who had previously been incarcerated and who were receiving methadone maintenance treatment (MMT) from Direction 180. Direction 180 is a community-based MMT program in north end Halifax. The purpose was to “map their journey” through the correction systems to identify areas where intervention and support might be instrumental in reducing risk and supporting offender health. This group was chosen because a primary risk factor for transmission of HIV and Hepatitis C is injection drug use. The focus group was comprised of former injection/and or oral opioid drug users who had prior experience with the federal and/or provincial correctional systems, having had at least one prior conviction resulting in a sentence of incarceration. Most had experience with both systems.

The purpose of this report is to:
- identify views and experiences of this particular offender population as it pertains to risk factors and practices associated with HIV transmission in correctional facilities
- identify potential points of intervention, access to services and supports, or other opportunities to reduce the risk of transmission of HIV.

This report is intended to build on the first hand knowledge of former prisoners to suggest, from their perspective, effective policies, programs, and strategies to reduce the risk of HIV transmission among this high risk population. The report also builds on research conducted by others outlining “enabling policies” and “best and promising programs” from prison systems in Canada.
It begins by outlining the greater vulnerability of prison populations to infection (HIV and HCV infection rates among prisoner populations, risk behaviours practiced by inmates prior to and during incarceration). It describes the study methods and limitations, outlines the findings of the focus group conducted with offenders, provides an analysis of results, reviews the research evidence in support of particular interventions, and offers recommendations for moving forward. It identifies opportunities for action to effectively reduce the risk of transmission of HIV and Hepatitis C. The report speaks to both federal and provincial correctional systems, carefully distinguishing between them.

Areas explored include:
- Access to harm reduction services – MMT, clean needles and safe injection/tattoo equipment, bleach, safer sex tools (i.e. condoms, lubricant, dental dams)
- Access to health/sexual health counseling and services
- Access to testing and counseling for HIV and Hepatitis C
- Access to addictions, HIV and HCV prevention education and programming
- Access to drug free living units
- Pre-release planning/discharge
- Access to community supports

A table summarizing focus group comments by topic and its applicability to federal or provincial institutions appears in section 5. A summary of recommendations is listed on the following pages for ease of reference.

The report concludes that HIV and HCV infection are significant health issues facing inmate populations and are also significant public health issues as inmates originate from and return to communities. Because risk behaviours practiced by offenders before, during, and after release also pose risk for the community, effective targeted education, prevention, and harm reduction measures are critically important. Correctional health is closely intertwined both with public health and public safety from a crime prevention perspective. Incarceration provides a unique opportunity to change offender risk behaviours, reduce the risk of transmission of HIV and HCV, and provide access to methadone maintenance treatment for opioid dependence (and therefore reduced needle use).

All individuals have the right to access prevention, care, treatment and support while incarcerated. As a basic human right, offenders should be able to access services equivalent to those available in the community including methadone maintenance treatment; needle exchanges/safer tattoo equipment; safer sex equipment; HIV/HCV prevention/harm reduction education; testing, counseling and sexual health services in a confidential environment; HIV/HCV treatment; and support services prior to release. The evidence firmly supports the efficacy of such measures in meeting public health and public safety objectives. Sound public policy should be informed by and be based on solid research evidence.

This report is not intended to be a comprehensive overview of the situation as it applies to the delivery of risk reduction services to offenders in this province – the study scope and
resources were insufficient to conduct such a review. Rather, it is one, albeit critical, component – mapping the direct experiences of an at-risk population – in a series of efforts required to develop an integrated, coordinated response to reduce the risk of HIV transmission. It is intended to support further work as it applies to offender services and the prevention of the spread of infectious disease among prisoner and at-risk populations (review of policy and actual practice within the province – both in the health and corrections sphere, consultation with stakeholders to implement the recommendations and generate other solutions).

This report documents the experiences of individuals at risk of HIV and HCV in correctional settings and identifies opportunities to reduce risk with a number of prevention and harm reduction interventions – interventions which have been tried elsewhere and which the research evidence identifies as effective. The greatest priorities voiced by focus group participants are improved access to methadone maintenance treatment and improved discharge planning in provincial correctional centres. This is needed in order to reduce risks and better support individuals to transition in and out of the community. To not proceed to implement some of the most critical of these recommendations would be a tremendous missed opportunity.
HIV/AIDS AND HEPATITIS C IN CORRECTIONAL FACILITIES: REDUCING THE RISKS

Summary of Recommendations

1. Develop a Blood Borne Pathogens Prevention and Implementation Strategy for Provincial Corrections Facilities

It is recommended that the Province of Nova Scotia develop a strategy to guide development of services to reduce transmission of HIV/HCV and other blood borne pathogens within provincial correctional facilities, similar to and consistent with the overall Blood Borne Pathogens Standards for Prevention Services. This document should address the concerns raised in this report and outline how and what measures will be introduced to reduce the risk of transmission and support offenders to improve their health, consistent with the evidence base. It should address inmate access to

- methadone maintenance treatment
- clean needles/tattoo equipment
- safer sex tools
- HIV/HCV prevention education
- confidential health/sexual health counseling
- testing and counseling
- HIV/HCV treatment
- transition support to re-enter the community

Partners in development of such a strategy should include the Departments of Justice (Correctional Services), of Health, and of Health Promotion and Protection, Capital District Health Authority (Offender Health Services), the Correctional Service of Canada (CSC), the Nova Scotia Advisory Commission on AIDS, relevant community-based agencies, and other key stakeholders. This includes access to MMT and other health/sexual health, prevention and harm reduction services, as well as addiction prevention, treatment, and other support programs to support offender re-integration into the community. Links must also be made with the Department of Community Services to ensure offender access to income and employment support and housing where needed upon release. It is essential that partners work together to ensure collaboration, continuity of care, and sufficient resources.

Adequate resources must be provided to support implementation of such a strategy. This includes the provision of adequate funding support to ensure program capacity is sufficient to meet demand for service in the community once an offender is released.

An approach which supports the offender to access methadone treatment, to reduce their exposure to HIV/AIDS and Hepatitis C while in prison, and to successfully re-integrate into the community is critical, not only for the health of the offender, but for public health (reduced transmission) and safer communities (reduced crime).
2. **Provide Prevention/Harm Reduction Education and Training**

It is recommended, in order to support implementation of the proposed *blood borne pathogens prevention and implementation strategy for provincial corrections facilities* (as per recommendation 1), that information, education, and training about prevention/harm reduction approaches and their value in reducing the risk of transmission of HIV/AIDS, Hepatitis C and other blood borne pathogens, be provided to all those involved in the delivery of services to prison populations, especially populations with an addiction/drug users, HIV+ and HCV+ persons, and those at-risk of HIV/HCV. Understanding the value of such an approach will improve the effectiveness of design and implementation of policy and practice.

Partners in development and delivery of training should include the Departments of Justice (Correctional Services), of Health, and of Health Promotion and Protection, Capital District Health Authority (Offender Health Services), the Correctional Service of Canada (CSC), the Nova Scotia Advisory Commission on AIDS, relevant community-based agencies, and other key stakeholders.

3. **Increase Public Understanding and Awareness of the Merits of a Harm Reduction Approach**

It is recommended that greater efforts be undertaken to inform elected officials, policy-makers, and the public in general about the merits of a harm reduction approach, and the evidence base in support of prevention/harm reduction, in order to increase understanding and support for implementation of these measures. The Department of Health Promotion and Protection, with the support of the Nova Scotia Advisory Commission on AIDS, might be best positioned to take the lead on this from a public health perspective but will need to work closely with the Nova Scotia Department of Justice, Correctional Services, in support of their mutual interest in the promotion of prisoner health. The approach should be considered as part of an overall strategy.

4. **Improve Access to Methadone Maintenance Treatment (MMT)**

4.1 **Funding Stability for Community-based MMT Programs**

Given the importance of MMT in supporting offender stability and reducing recidivism, it is recommended that arrangements be made by Correctional Service of Canada, Capital District Health Authority, and Direction 180 to sufficiently support federally (and provincially) released offenders to access MMT programs in the community, and that funding stability be assured for community-based programs delivering MMT services to this population.

4.2 **Resume Offender Access to MMT Provincial Correctional Facilities**

It is recommended that procedures be implemented to immediately resume access to Methadone Maintenance Treatment (MMT) – a long recognized effective form of
treatment for opioid addiction – by inmates housed in the Province’s correctional facilities. Access to MMT should be available to opioid addicted inmates whether or not they have received MMT in the community prior to incarceration.

4.3 Develop a Provincial MMT Policy

It is recommended that, as part of the proposed *blood borne pathogens prevention and implementation strategy for provincial corrections facilities* (referred to in recommendation #1), the Nova Scotia Departments of Justice, Health, and Health Promotion and Protection, in collaboration with the Capital District Health Authority and other partners, develop a policy framework to guide the provision of methadone maintenance services in the province to ensure all Nova Scotians have access to MMT, including those housed within the province’s correctional facilities. The policy should ensure the provision of a continuum of options so that individuals have access to programs best suited to their needs and that transfers among and between programs, including upon admission to and release from a correctional institution, are seamless.

4.4 Develop MMT Guidelines

As part of this policy framework to guide the provision of methadone maintenance services in the province (as per recommendation 4.3), it is further recommended that the Nova Scotia College of Physicians and Surgeons lead the development of MMT guidelines which recognize and incorporate best practices in MMT. These guidelines should address weaning and dosage reduction practices, dosage levels, and other matters to guide professional practice standards. Development of these MMT guidelines must involve providers of MMT services, including community-based programs.

4.5 Improve Assessments upon Offender Admission to a Correctional Facility

It is recommended that steps be taken to ensure that assessments conducted upon admission to a provincial correctional facility be thorough so as to support identification of the need for, and ready access to, methadone as well as to health/sexual health counseling and testing.

5. Improve Offender Access to Counseling, Testing, and Sexual Health Services

It is recommended that both Federal and Provincial Corrections officials continue to encourage inmates to be tested for HIV and Hepatitis C on a voluntary basis in a confidential environment, undertake efforts to ensure adequate pre and post testing counseling is provided to inmates, and ensure access, through a variety of means, to confidential health/sexual health services, counseling and support. It is further recommended that procedures be reviewed to reduce barriers that may exist in accessing testing, counseling or support, with particular attention to the maintenance of inmate confidentiality as it pertains to health status.
In particular, the Nova Scotia Department of Justice, Corrections Services, the Departments of Health and Health Promotion and Protection, and the Capital District Health Authority should explore ways to ensure the provision of health/sexual health services, including testing, in a confidential and readily accessible manner.

Consideration should be given in both federal and provincial corrections to the merits of partnering with an appropriate community-based or other agency (such as Public Health Services for CSC) to provide these services as a means of increasing offender comfort around issues of confidentiality.

6. Improve Offender Access to Safe Injection and Tattooing/Piercing Equipment and Bleach

As a measure to reduce the spread of infectious disease, it is recommended that Correctional Service of Canada and the Nova Scotia Department of Justice, Correctional Services, consider introduction of Needle Exchange Programs (NEPs) providing access by inmates, without fear of retribution, to clean needles, tattoo/piercing equipment, and information in an easily accessible, safe, and confidential manner, perhaps through health services. It is also recommended that consideration be given to the provision to inmates of sterile needles with a bleach kit upon entry.

It is recommended that Corrections officials ensure bleach is available, not only by policy but in practice, in a confidential and readily accessible manner in both provincial and federal settings. It is further recommended that Nova Scotia Department of Justice, Correctional Services, provide bleach kits upon entry, as per their federal counterparts.

7. Increase Inmate Access to Safer Sex Equipment

It is recommended that Federal and Provincial Corrections officials/public health staff working in correctional facilities ensure condoms, dental dams, and lubricant are available and readily accessible in confidential manner to reduce transmission of HIV and sexually transmitted infections. Improvement in access to confidential sexual health services, as well as prevention education, should also improve access to safer sex supplies and resources.

8. Ensure Access to HIV/HCV Treatment and Enhance Measures to Support Offender Health

It is recommended that provincial corrections staff ensure offenders receiving treatment for HIV or HCV do not experience delays or disruptions in their access to treatment so as not to undermine treatment efficacy.

It is also recommended that prison staff ensure that universal hygiene standards are employed for lock down or segregation units so as not to jeopardize the health of individuals with HIV or compromised immune systems.
9. **Improve Access to Sexual Education and HIV/HCV Prevention Programs**

It is recommended that the extent of use of community-based and peer delivered sexual education and HIV/HCV prevention programs be explored and that both federal and provincial corrections officials consider using such approaches to improve program receptivity/effectiveness in reaching the target audience.

It is also recommended that Provincial Corrections officials seek to improve the extent of program offerings for women in prevention and substance abuse.

10. **Enhance Pre-release/Discharge Planning to Support Successful Offender Re-integration into the Community**

It is recommended that the discharge planning process in provincial correctional institutions be examined to identify areas where greater information and support could be provided to ensure inmates are better prepared for release and are able to access appropriate prevention, treatment, and other support services, thereby increasing the likelihood of success in making the transition to the community.

It is recommended that the Province of Nova Scotia consider pilot testing the practice of having Department of Community Services (DCS) transition workers enter prison facilities to assist in planning for release regarding issues of income support and housing as one model of effective planning and intervention.

It is also important to ensure corrections staff responsible for supervising offenders on release in the community understand MMT and its purpose, so as to better understand and manage offender risk factors for recidivism.

11. **Engage Stakeholder Support to Move Forward**

It is recommended, as a means of moving forward, that further work – such as a policy review, interviews/discussions with key informants (Corrections staff, health staff, ancillary agencies providing services to this offender population, etc.) and consultations with stakeholders – be conducted by the Nova Scotia Advisory Commission on AIDS to supplement the information in this report, to engage stakeholders in the further development of solutions to the issues raised, and to seek their support to implement the recommendations.
Acknowledgements

It is with heartfelt appreciation that I thank the focus group participants who shared so openly and candidly their “journey” through the Correctional system. They spoke of extremely difficult personal circumstances – of suffering, of struggle, and of fears – and I am both humbled and honored that they shared this with me. Their eagerness and courage to share their first hand knowledge and experiences was demonstrative of their desire to not only be heard, but to help others in similar situations – to reduce others’ suffering and improve their access to intervention, services, and support. I wish them success on their continued journey – to achieve/maintain stability and ultimately reclaim their lives.

I would also like to thank Larry Baxter, Chair, Michelle Proctor-Simms, Director, and Jennifer Heatley, Acting Research Officer, of the Nova Scotia Advisory Commission on AIDS for sharing their perspectives, ideas, and comments, and contributing to organization of the focus group as well as to the report itself. Each has a genuine desire to make a difference in the lives of those at-risk of and/or affected by HIV/AIDS and this is evident in the dedication with which they approach their work. Thanks also to Jennifer for the initial research literature and for sharing her excellent focus group session notes!

I am honored to again have the opportunity to work with Cindy MacIsaac, Director of Direction 180, who works tirelessly on behalf of this vulnerable client group and who shares her knowledge, experience, and insight with great wit and conviction.

Carolyn Marshall
Marshall Consulting
HIV/AIDS AND HEPATITIS C IN CORRECTIONAL FACILITIES:
REDUCING THE RISKS

1. INTRODUCTION

Prior to the release of Nova Scotia’s Strategy on HIV/AIDS in 2003, the Nova Scotia Advisory Commission on AIDS released a report in 2000 entitled Don’t Kid Yourself: Recommendations for Reducing HIV and Hepatitis Transmission in Nova Scotia’s Prisons. This report presented evidence and specific recommendations regarding prevention of HIV, Hepatitis C, and Hepatitis B in Nova Scotia correctional facilities, including: provision of health promotion/education for inmates, initiation and/or continuation of methadone maintenance treatment, provision of staff training, and introduction of sterile injection equipment. In October 2000, the Commission hosted a “Ministerial Roundtable on Corrections” with the Ministers of the Departments of Justice and Health to review and discuss the recommendations. The Commission wrote to both Ministers in early 2001 requesting feedback and an update on their respective departments’ response to the report. The response outlined initiatives that were either already in place and/or were being explored (e.g., continuation of methadone maintenance treatment). This was an initial step in the future efforts that would stem from the Recommended Actions of the Strategy.

Nova Scotia’s Strategy on HIV/AIDS

In 2003, the Province of Nova Scotia and various HIV/AIDS stakeholders released Nova Scotia’s Strategy on HIV/AIDS (the Strategy) to address HIV/AIDS, outlining four strategic directions with a total of 19 recommended actions encompassing a broad range of efforts to prevent/reduce the spread of the infection and improve access to care, treatment, and support of individuals affected by it. The Nova Scotia Advisory Commission on AIDS has a leadership role in implementing the Strategy, along with government, community and other partners.

One population particularly at-risk of HIV transmission includes offenders in correctional facilities. The degree of access to services and supports required by offenders with HIV/AIDS or those at-risk of acquiring HIV/AIDS is of interest to the Commission. This is acknowledged in the Strategy in a number of areas, but particularly in recommendations 3.4 and 4.1. Recommended action 3.4 seeks to “develop and implement a comprehensive prevention strategy that includes initiatives based on a harm reduction approach for different populations within a variety of service settings, including corrections.” Recommended action 4.1 references the need for a coordinated approach to implement a seamless continuum of care, treatment, and support for people living with HIV/AIDS (PHAs). It should be noted that in Leading Together1, the blueprint for a pan-Canadian response to HIV/AIDS, “people in correctional facilities” were identified as a population at-risk for HIV/AIDS requiring targeted prevention programming.

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**Background Work**

The Commission began work on development of a preliminary position paper reviewing the needs and challenges corrections-involved HIV+/at-risk individuals experience, with a view to ensuring the provision of a seamless continuum of prevention, treatment, care, and support for these offenders.

A meeting of stakeholders was held in May 2006 at which the development of a “social map”, grounded in a population health approach, was recommended to identify the needs, challenges and problems that offenders with/at-risk of HIV/AIDS encounter in their transition to/from prison to re-integration with the community. The journey was categorized into three stages, consistent with the most critical transition points for offenders, as follows:

- Stage 1: Arrest/charge/remand
- Stage 2: Incarceration (Post conviction/sentence)
- Stage 3: Pre-release planning, discharge to community

Using these stages as a framework, initial work on the position paper was completed in the summer of 2006 by an intern working with the Commission consisting of a literature review and a few stakeholder interviews.

For various reasons, work was “on hold” until 2008 when the opportunity arose to explore offenders’ views and experiences in a focus group setting using the three stages noted above as a framework, and are further defined in Section 5 of this report.

**Focus Group with Ex-Offenders At-Risk**

To further the initial work, a consultant was hired to design and facilitate a focus group with ex-offenders at-risk of HIV/AIDS and Hepatitis C to “map” their journey through the Corrections system and to identify their concerns and experiences as well as opportunities for intervention and support to reduce the risk of transmission of HIV and other blood borne pathogens (BBPs). While some work had been done with offenders nationally (Prisoners’ HIV/AIDS Support Action Network and Canadian HIV/AIDS Legal Network), and with women provincially (Direction 180), it was thought important to glean offender views from a Nova Scotia perspective.

**Purpose and Structure of the Report**

The purpose of this report is to:

- identify views and experiences of this particular offender population as it pertains to risk factors and practices associated with HIV transmission in correctional facilities
- identify potential points of intervention, access to services and supports, or other opportunities to reduce the risk of transmission of HIV
This report is intended to build on the first hand knowledge of prisoners to suggest, from their perspective, effective policies, programs, and strategies to reduce the risk of HIV transmission among this high risk population.

This report also builds on research conducted by others outlining “enabling policies” and “best and promising programs” from prison systems in Canada. It begins by outlining the greater vulnerability of prison populations to infection (HIV and HCV infection rates among prisoner populations, risk behaviours practiced by individuals prior to and during incarceration). It describes the study methods and limitations, outlines the findings of the focus group conducted with ex-offenders, provides an analysis of results, and offers recommendations for moving forward. It identifies opportunities for action to effectively reduce the risk of transmission of HIV and Hepatitis C (a captive population, access to testing and harm reduction services, effective transition planning). The report speaks to both federal and provincial correctional systems.

This report is not intended to be a comprehensive overview of the situation as it applies to the delivery of risk reduction services to offenders in this province – the study scope and resources were insufficient to conduct such a review. Rather, it is one, albeit critical, component – mapping the direct experiences of an at-risk population – in a series of efforts required to develop an integrated, coordinated response to reduce the risk of HIV transmission. It is intended to support further work (e.g. review of policy and actual practice within the province – both in the public health and corrections sphere) as it applies to offender services and the prevention of the spread of infectious disease among prisoner and related at-risk populations.

Report Caveats and Limitations

This report has a number of important limitations and caveats:

1. Exclusion of Young Offenders - This report excludes any discussion of young offenders as the legislation governing youth crime and the facilities housing young offenders differ from those pertaining to adults. While adult and young offenders/youth at-risk may share some issues in common, the legal framework requires that discussion of this topic be undertaken separately.

2. Special Needs Populations – This report is limited by the composition of the focus group. It reflects only the voices of those who participated in the focus group – adult men and women – and does not identify needs of any other populations (e.g. aboriginal offenders, offenders from other ethno-cultural communities, transgendered and transsexual populations etc.). Although efforts were made to recruit members from diverse populations, participation was completely voluntary and was dependent upon the overall composition of the client population at Direction 180 at that time. Further, there were additional issues (such as victimization) that could not be explored in this format.

3. Distinction between Federal and Provincial Corrections – Since the federal and provincial correctional systems are the responsibility of the two different levels of
government, the policies and degree of access to programs and services for inmates varies between the two levels. Focus group participants were also very aware of this and were asked to clearly distinguish between their experiences at provincial and federal institutions. The report is careful to make this distinction in its discussion and to target comments and recommendations to the appropriate level of government. The reader is advised to also note this difference.

Readers should also note that, in Nova Scotia, the delivery of health services to offenders in custody within provincial corrections institutions is the responsibility of the Department of Health (and District Health Authorities as the agents of delivery of health services), and not the Department of Justice. (See section 25 of the Correctional Services Act, S.N.S., 2005, c 37). The Capital District Health Authority (CDHA), Offender Health Services, delivers health care in adult facilities. This is somewhat unique in Canada.

4. **Scope** – The scope of this report did not permit a review of policy, programs, or services within either the federal or provincial correctional system, nor did it permit interviews to be undertaken with policy or program staff in either system. While some policy documents were consulted, it reports primarily on the first hand account of prisoners, which is critical from the perspective of discerning difficulties encountered by prisoners which put them at risk of HIV/AIDS. It is suggested, however, that both a policy review and interviews or further discussions with key informants (Corrections staff, health staff, ancillary agencies providing services to this offender population, etc.) be conducted by the Nova Scotia Advisory Commission on AIDS to supplement this report and/or assist in moving specific recommendations forward.
2. CORRECTIONAL FACILITIES IN THE ATLANTIC REGION

To help situate the reader, the following outlines federal and provincial correctional facilities for adults within the Atlantic Region.

Correctional Service of Canada

Correctional Service of Canada (CSC) operates four institutions for male offenders and one institution for women offenders in the Atlantic region as follows:

- Nova Institution for Women, Truro, Nova Scotia (multi-level – minimum, medium and maximum – security)
- Atlantic Institution, Renous, New Brunswick (maximum security)
- Dorchester Penitentiary, New Brunswick (medium-security) – which houses Shepody Healing Centre, a multi-level security centre whose main functions are to treat acutely ill inmates and provide intensive psychiatric, specialized mental health and other treatment programs to them.²
- Springhill Institution, Nova Scotia (medium security)
- Westmorland Institution, New Brunswick (minimum security)

While many inmates from Atlantic Canada are incarcerated within the region, an offender may be placed in any institution across Canada depending upon the results of the assessment and classification process.

Nova Scotia Department of Justice, Correctional Services

Nova Scotia operates five adult correctional facilities in the province: Antigonish Correctional Facility, Cape Breton Correctional Facility in Sydney, Central Nova Scotia Correctional Facility in Dartmouth/Burnside, Cumberland Correctional Facility in Amherst, and the Southwest Nova Scotia Correctional Facility in Yarmouth. The Central Nova Scotia Correctional Facility is a multi-level security prison and is the only provincially run facility in the province which houses women inmates.

The East Coast Forensic Hospital (ECFH) operated by Capital Health, is co-located with the Central Nova Scotia Correctional Facility but correctional inmates and forensic clients are kept separate at all times. The Hospital is unique within the Capital Health in that the people it serves come strictly from the judicial system and not the general population. The Hospital has two rehabilitation units with 30 beds each and a 24 bed Mentally Ill Offender Unit where court ordered assessments are performed and treatment is provided to offenders diagnosed with mental illness. The Hospital also manages the Provincial Sex Offender Program currently located on the Nova Scotia Hospital site, and provides primary health care to the Province’s corrections population through the Offender Health Services Program.


HIV and Hepatitis C in Correctional Facilities: Reducing the Risks
Both federal and provincial services provide a variety of programs intended to meet offender needs, address risk factors related to criminal behaviour, and facilitate reintegration into the community. Programs are facilitated by trained correctional services staff and, where appropriate, in coordination with other government and community agencies.
3. **RATIONALE – WHY FOCUS ON OFFENDERS AS AN AT-RISK GROUP?**

*Incarcerated Populations at Greater Risk*

Incarcerated populations have been shown to be at increased risk of blood borne and sexually transmitted infections, including human immunodeficiency virus (HIV), hepatitis C virus (HCV), and hepatitis B virus (HBV). Many Canadian offenders engage in high risk behaviours that contribute to transmission of HIV and other blood borne pathogens prior to and during incarceration, and after release into the community, exposing themselves and others to the virus. Risk behaviours include unsafe practices regarding injection drug use, tattooing, body piercing, and sexual activity.

*Numbers Incarcerated*

As of 2006, the incarceration rate was 107 persons per 100,000 population in Canada. In 2002, there were 256,873 adult custodial admissions (7,659 of which were admissions to a federal facility) and 111,906 community supervision admissions. On any given day in 2002, there were 19,674 people in provincial/territorial jails and 12,383 in federal penitentiaries. In 2002, a total of 111,906 people were released from a correctional facility, of which 7,428 were released from Correctional Service of Canada (CSC) facilities. In 2003, 34,643 inmates were incarcerated in Canada. Incarcerated individuals come from and return to our communities.

*HIV and HCV Prevalence Rate among Offenders in Canadian Prisons*

Data on detected cases of infectious disease are collected and published by the federal prison system, but not by provincial and territorial prison systems.

HIV prevalence among offenders in Canadian correctional facilities has remained at about 2% over the last 5 years; some have reported estimates between 1% and 3% - about 5-20 times higher than in the general population. Conservatively, the studies to

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date put the HIV prevalence rate in prisons at roughly 10 times the prevalence rate in the general Canadian population.\(^7\)

Recent HIV prevalence estimates are as follows: 1.6% (males) and 2.8% (females) in federal prisons; 2.1% (males) and 1.8% (females) in Ontario provincial prisons; and 2.3% (males) and 8.8% (females) in Quebec provincial prisons.\(^8\) Note that these numbers are based on cases that have either been tested or self-reported voluntarily by inmates to penitentiary authorities.

Studies estimate the prevalence of HCV in the Canadian prison population to be between 19.2 and 39.8 percent.\(^9\) It has been estimated the HCV prevalence rate in the general population is 0.8 percent.\(^10\)

Although not examined within the scope of this report, it is important to note that risk of transmission of Hepatitis B is also high with unsafe sexual activity and unsafe injecting practices. Hepatitis B is reported at higher rates among individuals who are incarcerated than among those who are not corrections involved.\(^11\)

### HIV and Associated Risk Behaviours in Correctional Institutions

#### Unclean Needle Use

A primary risk behaviour for HIV is unclean (shared) needle use\(^12\) which is exacerbated when carried out in unhygienic conditions.\(^13\) Recent estimates of national HIV prevalence and incidence indicate that 14% of the estimated 2,300-4,500 new HIV

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Infections that occurred in Canada in 2005 were among people who inject drugs (IDUs).\textsuperscript{14} Roughly one third of offenders report a history of injecting drug use, and a greater proportion of female inmates than male inmates have a history of injecting drug use.\textsuperscript{15} However, some studies place this higher. Studies have estimated that 20% to 74% of male inmates in federal institutions in Canada are or have been drug users.\textsuperscript{16} In a recent study by Calzavara and colleagues, 30% of adult inmates in Canadian provincial remand facilities (jails, detention centres and youth centres) reported a history of injection drug use, and the prevalence of both HIV and HCV infections was much higher in this male group than in the group who reported no drug use.\textsuperscript{17}

Once incarcerated, studies have also shown that some inmates continue to engage in risk behaviours with the potential for transmission of blood bone pathogens. The proportion of inmates who reported injecting drugs in federal penitentiaries was 11\% in 1995 and estimates of injecting drug use during incarceration among those with a history of injecting drug use are of a similar magnitude in provincial correctional systems.\textsuperscript{18}

In a study of women in Canadian federal prisons (n=157), 27\% were engaged in tattooing, 19\% injection drug use, 16\% received a body piercing, and 9\% were slashing or engaging in some other form of self-injury.\textsuperscript{19}

Of the 104 female prisoners who participated in a study in a British Columbia prison in which both provincial and federal prisoners were incarcerated, 21\% (22/104) reported injection drug use inside prison. Of this number, 19 reported sharing a syringe with other prisoners, and three reported not cleaning used syringes with bleach. Self-reported HIV and HCV infection rates among the prisoners were 8\% and 25\% respectively.\textsuperscript{20}

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\textsuperscript{15}Public Health Agency of Canada, HIV/AIDS Epi Updates 2007, p 122.


\textsuperscript{17}Ibid.

\textsuperscript{18}Public Health Agency of Canada, HIV/AIDS Epi Updates 2007, p 122.


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In 2006, a group of Ontario researchers reported on prevalence and predictors of HIV and HCV in Ontario jails and detention centres. Over 1900 adults and youth admitted to Ontario facilities during a 17-month period were screened for HIV and HCV and completed an interviewer-administered survey. Participants reported having engaged in the following risk behaviours during a previous period of incarceration: tattooing (21% of adults; 43% of youth); piercing (9%; 5%); and injecting drugs (16%; 8%).

Those in Quebec provincial prisons who participated in a 2003 study reported the following risk behaviours while incarcerated, a substantial portion of whom used non-sterile equipment: receiving a tattoo (37.9% of men, 4.8% of women); injecting drugs (4% of men, 0.8% of women); and piercing (2.1% of men, 4% of women).

There have been no similar research studies of risk behaviours in Nova Scotia institutions known to the author.

See also studies reported of risk behaviours of offenders resident in federal and provincial correctional institutions in Public Health Agency of Canada, *HIV/AIDS Epi Updates*, pp. 121-122.

There is also evidence that HIV and HCV are spread within Canadian prisons.

Unsafe Sexual Practices

Unsafe sex is also a risk behaviour for HIV transmission. Offender populations report very high-risk sexual practices in the community, which may continue or resume after incarceration. The population of offenders in Canada is also characterized by a high-risk sexual history, including multiple sex partners, unprotected sex with casual partners, and sex trade involvement during and prior to incarceration, partly due to the association between drug use and sex work.

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23. Among drug users, incarceration itself represents additional risk of HIV transmission. Participants in the Vancouver Injection Drug Users Study (VIDUS) who had recently been incarcerated were 2.7 times more likely to be HIV-positive than those who had not been to jail or prison. An external evaluation of the attributable risks reported in that study concluded that 21 percent of the HIV infections among injection drug users in Vancouver were likely acquired in prison. The VIDUS researchers subsequently analyzed syringe sharing in prison. They found that incarceration in the six months prior to being interviewed was associated with syringe lending by HIV-positive VIDUS study participants during that period. Similarly, among HIV negative participants, incarceration in the six months prior to being interviewed was associated with syringe borrowing during that period. VIDUS researchers have also published qualitative evidence from a small scale study of prisoners that “confirmed the previous reports that injecting within the prison environment is characterized by a pattern of syringe sharing among large networks composed of numerous individuals.” The study also found that prisoners living with HIV conceal their status from injection partners for fear that others will not lend or share with them the rare syringe that may be available. Cited in Hard Times, pp. 6-7.

In one study, 24% of women in Canadian federal prisons reported having unprotected sex with 81% of these women reporting being sexually active within the institution either through conjugal visits or same sex partners. Other US studies reported that male attitudes and behaviours with respect to same-sex acts shift the longer one is incarcerated. Men were more likely to identify as homosexual or bisexual than prior to incarceration.

Summary

These data clearly demonstrate a high prevalence of risk behaviours for HIV and HCV infection among inmates in federal and provincial/territorial prisons. In turn, there is a high prevalence of HIV and HCV infection among inmates in Canadian correctional facilities.

The concentration in prisons of people who engage in risky behaviours makes this environment an unique setting in which to focus prevention/risk reduction measures and provides a prime opportunity to reduce the risk of transmission of HIV and other BBPs. This will impact not only prisoners inside correctional institutions but others in the general population once the offender is released.

From an economic/public health perspective, the costs of treating chronic infections such as HIV and HCV are significant. Lifetime care and treatment costs for HIV were estimated in 1998 to total about $160,000 per person with HIV, while the indirect costs associated with lost productivity and premature death may be as high as $600,000 per person. Besides the risk of transmission of BBPs, there are other health risks due to unsafe practices such as abscesses and infections which can create health care cost issues.

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4. METHODS

The primary method utilized to conduct this work was a focus group supplemented by a brief review of the literature to identify salient issues and inform design of the focus group. As well, the earlier work describing the stages or critical transition points of the “corrections journey” was utilized as a framework to explore offenders’ views and experiences in the focus group. (Focus group materials appear in the Appendices).

Focus Group Criteria

Because a primary risk factor for transmission of HIV and Hepatitis C is injection drug use, a focus group was conducted with past offenders who were former active drug users and who are current clients of Direction 180 – a community-based, low threshold methadone maintenance treatment program in north end Halifax.

The focus group was comprised of former injection/and or oral opioid drug users who also had prior experience with the federal and/or provincial correctional systems, having had at least one prior conviction resulting in a sentence of incarceration. An attempt was made to recruit as diverse a group of participants as possible, in particular both men and women offenders, to ensure the unique needs of women offenders would also be identified. (Note that the client population of Direction 180 is mostly male (72%) with women representing 28% of the individuals served). Due to the size and composition of the client population, client confidentiality, and the voluntary nature of participation, participants could not be recruited based on more discrete criteria such as sexual orientation, ethnicity, living with HIV/AIDS or HCV, or other factors.

Recruitment

The Program Director of Direction 180 approached clients to explore their interest in participating in a focus group. The purpose was described as “mapping the journey” through the Corrections system to identify areas where clients experienced difficulties or where additional supports and services were needed. Clients were offered an honorarium of $50 each, in recognition of the value of their contribution, to be paid upon completion of the group session to take place the following week. Twelve clients expressed interest.

Group Composition

Twelve people participated – seven men and five women. All had been incarcerated – many repeatedly and some in both federal and provincial institutions. Participants were eager to speak and were very open and candid.

All were on methadone maintenance treatment which they received on a daily basis at Direction 180. MMT is prescribed by a licensed physician based at Direction 180 and is

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28 For a description of the client profile, see Marshall, C (2003), Direction 180, Halifax: A Model of Best Practice in Methadone Maintenance Treatment.
dispensed by nurses who observe ingestion. Some clients who have achieved stability for some time and meet other criteria are able to receive their methadone via carries, that is, they are permitted to pick up more than one day’s supply, usually through a pharmacy in their neighborhood. It is important to note that Direction 180 operates on a low threshold approach. That is, clients are not ejected from the program for drug-positive urine tests in the belief it is preferable to continue to support client’s efforts to achieve stability through MMT than withdrawing them from the service. Many clients who have been unsuccessful in other higher threshold programs, experience success with this program.29

Group Location, Safety of Participants

The focus group took place at Direction 180 in the private group meeting room March 25, 2008, from 10:00am to 3:00pm (with lunch provided). This was a location with which participants were familiar and comfortable. Prior to commencement of the group session, the facilitator reviewed the agenda, purpose and objectives; informed participants of the risks/benefits of participation; obtained consent; and secured group commitment to the “ground rules” for participation (see Appendices for further information). A Direction 180 social worker/counselor was immediately available on-site should any participant be distressed by any discussion raised. Group members were very eager to proceed.

Purpose of the Workshop

The purpose of the workshop was:

- to “map” an offender’s journey through the corrections system (both federal and provincial) to identify issues and concerns and potential points of intervention where access to services or supports may be needed
  - to support offender wellness
  - to support re-integration into the community, and
  - to reduce risk of harms associated with injection drug use, tattooing, or other risk behaviours, including the risk of transmission of HIV/AIDS or Hepatitis C.

- to identify issues, concerns, and barriers experienced by offenders, as well as proposed solutions or recommendations, associated with the following:
  - Admission to a correctional facility – adequacy of initial needs assessment
  - Access to health/sexual health services and counselling, including testing for HIV, HCV, STIs, and other BBPs
  - Confidentiality and safety
  - Access to harm reduction services and supports
    - Methadone Maintenance Treatment (MMT) – initiation, continuation

- Needle Exchange – clean needles/drug equipment, bleach
- Clean tattooing equipment
- Safer sex tools – condoms, dental dams, lubricant
- HIV and HCV education and information, services available, etc.
  - Access to drug counseling/addictions and other programs and services
  - Access to drug-free living units and therapeutic communities
  - Pre-release/Discharge Planning
  - Access to community supports – to facilitate transition to the community such as income support, affordable housing, mental health services, etc.

Objectives of the Focus Group

- to obtain input from offender’s on the journey (generally) through the correctional system (distinguishing between federal and provincial systems)
- identify issues and concerns at various points throughout the system – both of general applicability and of relevance to specific populations – Aboriginal, women, etc. if possible
- identify potential solutions from an offender perspective if time permits

Introduction/Confidentiality

The facilitator introduced herself and two representatives of the Nova Scotia Advisory Commission on AIDS (the Chair and Acting Research Officer) who were in attendance as observers. Permission was sought for them to remain. The Direction 180 Program Director was also in attendance and offered input on policy and program issues. Although no participant was asked to introduce themselves, some did so upon entry into the room. All participants were receiving methadone maintenance treatment at Direction 180 for opiate use and participants were known to each other by name as they visit the site daily to receive their methadone.

It was explained at the outset that no person would be identified in the report (unless prior permission was sought as in the case of the program director); nor would any person’s name be recorded. Although quotes might be used for illustrative purposes in the report, they would not be attributed to any particular person. The services they received from Direction 180 or any other agency would not be jeopardized or affected by their involvement with this focus group.

Sensitivity of the Subject Matter

It was anticipated that there may be some sensitivity among the group participants in discussing matters related to HIV/AIDS, sexual and injection drug use practices that may put them at risk, and health related matters generally. This was primarily dealt with by explaining that sharing individual experiences was not necessary; rather, their knowledge of what happens generally was of interest. No personal identification was required; answers would be grouped and not used to identify anyone. No personal disclosures were required; they could talk about inmates generally rather themselves specifically.
Participants could choose to participate or not, in all or some of the discussions as they saw fit, and could leave if they so chose, consistent with their comfort level.

That the session was sponsored by the Nova Scotia Advisory Commission on AIDS required explanation to put people at ease. It was explained that the Commission was interested in factors that put people at risk of HIV/AIDS and Hepatitis C and wished to learn ways the Corrections system – both federally and provincially – could better serve the needs of people who are incarcerated. As individuals who had direct experience with the system, focus group participants were in the best position to know. Hepatitis C was included as Hepatitis C prevention may be easier for inmates to discuss than HIV prevention because of stigma and discrimination/safety issues. As well, in some cases, the pathway of infection is the same.

Participants were interested in what would be done with the information. It was explained that the intent was to prepare a report that would be shared with government and others to 1) inform them about the concerns raised and 2) identify ways in which policies, programs or practices could be made better to help people with drug use problems who have been incarcerated.

Also discussed with the group were:
- the importance of respecting confidentiality – what is said in the room should stay in the room to respect each other’s privacy (although this could not be guaranteed).
- the distinction between anonymity and confidentiality – no one was technically anonymous as they knew each other, although they were not known to the facilitator.
- avoid personal disclosure if uncomfortable – Alerted participants to the limits of guaranteeing confidentiality so suggest they confine comment to the information “you can live with if you heard it on the street” (i.e. no need for in-depth personal details);
- sensitivity and respect for each other – wait until one person is done making the point, one can challenge or disagree but no ridiculing of people or ideas made.

Other Forms of Input/Validation

Participants were also offered the opportunity to offer comments separately outside of the group context if they chose by individual interview with the consultant (either telephone or in-person), sending comments in writing or by email routed through the Direction 180 Program Director, and commenting on the draft report which would be returned to the Program Director and the group for validation. Contact for interviews would be arranged to protect their confidentiality. One person expressed an interest in a face to face interview with the consultant which was arranged to take place in a private room at Direction 180 two days later but the person subsequently withdrew due to other commitments.
5. FINDINGS

Findings are grouped under subject category headings, as well as the stage of the “correctional journey”, as discussed earlier. This reflects challenges and concerns offenders encountered upon remand, admission to a correctional facility following a custodial sentence, and pre-release planning/discharge from a correctional institution. For the purposes of this report, these categories are defined as follows.

Stage 1: Arrest/charge/remand
Reflects the points at which an individual in conflict with the law first comes into contact with the correctional system. A person, once arrested and/or charged, may be released or held in a remand or detention centre pending a bail hearing, or may be denied bail and held awaiting trial (and are legally innocent as they have not yet been convicted of a crime), or may be recently convicted and awaiting sentencing or transfer to a longer term facility. Remand centres are also known as detention centres, pretrial centres, and local jails.

Stage 2: Incarceration (Post conviction/sentence)
Reflects the point at which a person has been convicted and sentenced by the courts to a period of incarceration in a provincial (a maximum sentence of 2 years less a day) or federal (a sentence of 2 years or more) correctional centre.

Stage 3: Pre-release planning, discharge to community
Reflects the point at which an offender is about to be released into the community, after having served either all or part of his/her sentence. For the purposes of this discussion, this excludes release on unescorted or escorted temporary absences as it is primarily the transition to the community that is the focus of concern rather than short term absences.

This framework of the “journey”, along with questions concerning access to harm reduction, and other services and supports during the period of incarceration from arrest to release, was used to guide discussion. Participants were asked to comment on the experiences of offenders as they “journeyed” through the correctional system. They were also specifically asked to distinguish between federal and provincial systems. About half had experience in both systems at various times. This section is interspersed with direct quotes from focus group participants to add depth.

A table summarizing focus group comments by topic and its applicability to federal or provincial institutions appears at the end of this section.

As these issues of concern applied to all stages, they are discussed primarily by topic as follows:
- Access to harm reduction services – MMT, clean needles and safe injection/tattoo equipment, bleach, safer sex tools
- Access to health services, sexual health counseling
- Access to testing for HIV and Hepatitis C
- Access to addictions HIV, HCV, education and counseling and programming
Access to drug free living units
• Pre-release planning/discharge
• Access to community supports

5.1 Access to Methadone Maintenance Treatment

By far the most significant concern voiced by participants was access to methadone maintenance treatment (MMT). This applied to all three stages of the journey through the corrections system. Overall, most comments were directed toward the provincial system.

Federal

According to policy, MMT is available, both on an initiation and continuation basis, in Correctional Service of Canada (CSC) institutions. This focus group had no comments to make with respect to access to MMT in the federal prison system with the exception of the limited availability of treatment programs in the community upon release and federal funding to support inmates in community-based MMT programs. One participant who had been released from a New Brunswick institution had to move to Nova Scotia in order to receive MMT due to the limited services available in New Brunswick. Program capacity in Nova Scotia’s Direction 180, the only community-based program in the province, is at its peak. The Program Director explained that insufficient funding to support offenders released from federal institutions into Direction 180’s program is limiting program capacity and their ability to accept more clients. As a result, Direction 180 will be cutting back on the range of services they provide by reducing primary care, their MMT dispensing hours of operation, and the number of clients they serve. This issue is discussed further later in this report.

Provincial

In relation to the provincial corrections system, offenders spoke of
• “inhumane” weaning off narcotics upon admission (remand, admission post-sentence)
• refusal to initiate MMT upon admission
• extensive waits/delay in access to MMT (3-4 days)
• refusal to continue MMT for those already on MMT (in both Halifax and Cape Breton)
• dramatic drops in methadone dosage levels upon admission and low artificial ceiling for maintenance doses, inconsistent with the inmate’s dose prior to incarceration
• rapid weaning upon release, no transfer to MMT programs in community upon release

These are described below upon initial arrest/remand, at admission, upon release.
Difficulties experienced upon arrest/remand

*Initial Assessment/dosage*
Some people spoke of difficulties with MMT dosage levels when initially arrested and held in custody. For those already on MMT, an assessment for methadone dose is usually done immediately, but this assessment does not take into account if a person has been “on a run” (using narcotics, not sleeping or eating properly), and the impact this behaviour has on heart rate and blood pressure. As a result, the methadone dose is often significantly lowered from the level previously prescribed and an insufficient amount is prescribed to control cravings creating serious withdrawal/sickness.

*Inhumane Weaning off Drugs*
The second concern voiced had to do with the need to wean people who use illicit drugs humanely to reduce their suffering. Focus group participants said there is an apparent lack of understanding about addiction and a lack of empathy for the suffering of people in withdrawal. There is a perception that doctors in the provincial prison system are under instruction to distribute as little narcotics (i.e. MMT, pain medication) as possible, with the result that incarcerated individuals with addictions do not receive the help they need.

*Delay in Access to Methadone*
Others spoke of being on methadone at arrest but denied access to MMT for a prolonged period following arrest. One person reported being forced to go four days in jail without methadone. (Methadone is ingested daily to control symptoms).

*Difficulties at Admission*

*Reduction in Maintenance Dosage*
Current practice appears to be that staff in provincial correctional facilities will not usually alter the dosage for individuals admitted for weekend sentences. However, for those admitted for longer periods of time, dosage levels were significantly reduced in a short period of time (e.g. 100mgs down to 40mgs).

It was acknowledged that, in some cases, dosage does require adjustment, particularly if clients are still in the early stages of stabilization (the process of finding a dose level that will manage the symptoms with minimal side effects). Offenders also accepted as legitimate the need to reduce MMT doses in recognition of the minimal activity levels of inmates at correctional facilities. However, many focus group participants experienced a drastic reduction in their dosage levels, due in part to a current practice of imposing an artificial limit unrelated to the level at which the person becomes symptomatic. Prior practice, developed over the last 2-3 years, was that dose reductions be based on observations of the client within the institution, such as over-sedation. Dose reductions now appear to be based on a fixed ceiling of 120mg, regardless of client response. This creates difficulty for individuals who have been prescribed higher doses, threatening any stability they may have achieved and undermining the success of the treatment. Offenders commented that if MMT doses were at comfortable levels, there would be less...
needle use (there would be no incentive to use needles as they would experience no “high”, unless using cocaine).

Denial of Access to Methadone – Initiation and Continuation

Arrangements permitting initiation and continuation had been developed between Direction 180 and the Correctional Centre, based on the needs of individuals requesting treatment, but practice appears to have changed recently with the appointment of new staff. While no written agreements or formalized protocols had been put in place, a process for sharing medication records and tracking methadone clients had been developed by nursing staff, and the prescribing physicians in both sites had developed a close working relationship with each other with the common goal of ensuring a seamless transition of care for clients.

However, the Program Director reported that staff in Central Nova Scotia Correctional Centre will no longer permit Direction 180 to initiate methadone for inmates, even for high risk cases where an individual has HIV/AIDS or is pregnant, despite a prior arrangement to do so.

Further, offenders released and receiving MMT in the community who are subsequently returned to the institution for a violation frequently do not receive MMT inside prison.

A person who is arrested while on the waiting list to receive MMT in the community will also be denied methadone in prison, despite the offender’s expressed interest in receiving it.

Access to methadone was also cited as a problem in Cape Breton as well where an individual reported being taken off methadone and given valium.

There appears to be a series of new practices in provincial institutions of denying offenders access to methadone once they are incarcerated, including withdrawing MMT from individuals already on methadone. The outcome is that access to methadone is either inconsistent or absent.

Denial of Access to Other Pain Medication/Anti-psychotic drugs

Offenders also report difficulty acquiring legitimate pain medication or other medications such as anti-psychotic drugs. For example, one individual had been prescribed methadone and benzodiazepines by a doctor but was not given either medication once in jail. Another person with chronic rheumatoid arthritis said he was not given sufficient treatment for pain and inflammation and so was forced to use other drugs in prison to cope with the pain.

Offenders said the absence of access to methadone and/or inadequate dosage, or access to legitimate pain medication “forces people to access drugs inside prison” or pressure others to divert their prescriptions or methadone inside the correctional facility.
Training of Specialists/Physicians
The training of those authorizing/prescribing methadone in provincial correctional centres was questioned; participants wondered whether these practitioners had the degree of specialization and understanding required to make decisions about MMT. There seemed to be inadequate knowledge of the benefits of a harm reduction approach.

Upon Release

Rapid Weaning/Transition to Community-based MMT Program
Offenders also reported being weaned off MMT from high levels to nothing within a short period of time just prior to release. This resulted in serious illness, threatened their stability, and undermined their ability to transition successfully into the community. (For example, one person was on 220 mgs of methadone as well as valium while in prison. In the last month, s/he was weaned off to nothing). There was no transition to a community-based methadone program.

“They are sabotaging the sobriety cycle.”

5.2 Access to Clean Needles/Tattoo Equipment and Bleach

The consequences of an opiate addicted person being denied access to methadone is continued illicit drug use. There is no legal access to clean needles and there are no needle exchange programs (NEPs) operating in either federal or provincial institutions. Consequently, offenders reported using old and used needles with potential for transmission of HIV and HCV.

“I became a junkie at Springhill.”

“9 times out of 10 you’re using a dirty needle.”

“It was rare to have a clean needle.”

“For the 14 months I was in, I used the same needle. I used a match guard to sharpen it.”

There was some discussion within the focus group about the value of a needle exchange program in prison and the potential for needle stick injury. While some expressed fear of needle stick injuries and acknowledged that this might be a fear on the part of prison guards, they felt that, should someone be interested in causing harm to another person, there were already ways (e.g. home-made knives or “shanks”) to do this in prison. Most felt the risk of injury would not be higher than currently exists and the benefits of a NEP (in reducing the spread of HIV and HCV) would outweigh this risk. One suggested that a clean needle should be distributed with the bleach kit upon admission into an institution. Another proposed that a safe injection site be set up in prison as the safest and most controlled environment in which to inject. A safe injection site would address the
concerns of both inmates and prison officials; needle use and disposal would be witnessed and controlled and the possibility of needles being used as weapons would be diminished. Greater access to MMT should also result in less need for NEPs.

**Bleach**

In the absence of access to clean needles, bleach is used as a disinfectant to clean needles and syringes. While it may have some efficacy in killing HIV (the virus that causes AIDS), research has demonstrated that it is not 100% effective against HIV and should not be considered effective at all for killing the Hepatitis C virus. However, the World Health Organization (WHO) Guidelines, along with numerous other reports, recommend the use of bleach as a means of reducing HIV and HCV transmission, in the absence of needle exchanges. WHO Guidelines recommend that where bleach is available in the community, bleach or another viricidal agent should be made available to prisoners with specific detailed instructions on cleaning injecting, tattooing and piercing equipment. WHO further recommends that in countries where clean syringes are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment to prisoners during detention and on release.

In federal correctional facilities for men and women, inmates are provided with a bleach kit upon entry. This is not the case in provincial centres.

However, although the federal prison system does openly provide bleach kits, inmates said the process for accessing bleach subsequently can be prohibitive. Although bleach is available in both federal and provincial settings for general cleaning, cleaning the shower and doing laundry, inmates say they must access bleach with discretion in both environments. Sometimes the location of bleach is a concern. Most inmates said that asking for bleach or a bleach kit in either correctional system would draw attention to themselves and provoke a request for a urinalysis test which, if found positive for drugs, would result in loss of privileges. While inmates may be told they can ask for more bleach kits if needed, focus group participants reported that “if you do, you end up getting urinalysis, put in the hole, and losing your privileges.” This inhibits access to bleach.

**Tattooing**

Tattooing is a practice that occurs frequently within correctional facilities at both federal and provincial institutions, although it is not sanctioned in either setting, with the exception of the tattoo pilot projects that operated in select federal prisons.

Correctional Service of Canada (CSC) conducted a pilot project in six prisons, including Atlantic, in Renous, New Brunswick (a maximum security facility) on safer tattooing practices in 2005–2006. The pilot project began August 1, 2005 and ended on September 29, 2006 (due to cancellation). The pilot was introduced to reduce the risk of infectious disease transmission among prisoners and the community. The pilot project had two

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30 See discussion about the efficacy and merits of using bleach to reduce HIV and HCV transmission in *Hard Time* p. 44-45.
31 WHO Guidelines 24.
components: (1) provide education to all prisoners about safer tattooing practices; and (2) provide safer tattooing services in a secure and supervised environment.

An evaluation of the program found a reduction in illicit tattooing, an enhanced level of knowledge and awareness amongst staff and prisoners regarding blood-borne disease prevention and control practices, and that the initiative was consistent with the federal government’s strategy to address HIV/AIDS. While recommendations were made to address operational and implementation deficiencies and enhance cost-effectiveness, the evaluation also recommended that CSC consider using community tattoo services and continue the education component of the Safer Practices Tattooing Initiative “[t]o maintain an enhanced level of knowledge and awareness of infection prevention and control practices.”

Offenders in the Direction 180 focus group said an informal network of tattoo artists operated within the both systems earning artists additional income, although the practice was not seen to be as prevalent in provincial institutions. One such artist did 50 tattoos a day for a total of 500 over the period of his incarceration. They described the use of toothpaste caps to hold ink and guitar strings fashioned as needles/implements with which to sketch the tattoos. Needles and implements were used and re-used (although rinsed with bleach); ink was generally discarded after each use. Illicit tattooing presents risk of transmission of HIV and Hepatitis C. Inmates highly recommended implementation/continuation of a safer tattoo project to reduce the risks. None had direct personal experience with the tattoo pilot project.

5.3 Access to Safer Sex Tools

Condoms, lubricant, and dental dams enable the practice of safer sex, reducing the potential for transmission of HIV/AIDS and HCV. Focus group participants said condoms and dental dams were accessible to individuals if they wanted them in the federal system but were much less available in the provincial system.

However, there seemed to be mixed views and experiences on how easily they could be accessed in federal institutions – some said one had to ask for them while others said they could be accessed in the washrooms. Offenders were not comfortable requesting these items in either provincial or federal corrections settings, and found it difficult to access health care services to request these items on a completely confidential basis.

5.4 Access to Health/Sexual Health Services/Confidentiality

Confidentiality and access to health care and sexual health services were issues raised by group participants. Access to health services is a concern as this is an important potential source for confidentially securing harm reduction/safer sex tools (condoms, dental dams, and bleach) as well as obtaining health related information and support, education about risks, and ways to reduce transmission.

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Provincial

Offenders said the process to access health services requires that a formal request be made via prison guards which “may be denied by prison staff if they don’t think it’s important”. The request must identify the purpose of the health visit (e.g. for testing), after which the request is prioritized. The request will not be processed if the purpose of the visit is simply identified as “private”. Delays in accessing health services were also an issue.

There was uniform lack of trust in the provincial corrections system to guard confidentiality and access health services. Participants thought guards were aware of individuals’ health issues and might inform other prisoners. Further, the Burnside facility was viewed as “so overwhelmed and overcrowded,” that they are unable to meet people’s needs.

Federal

More faith was expressed in the federal system by women both in terms of access to health services and respect for confidentiality. Women, in particular those who had resided in Nova Institution, felt comfortable talking to nurses and thought patient confidentiality would be respected.

No one had experience with the delivery of health services or sexual health care by external community-based agencies holding on-site clinics, as is the case in some federal institutions. For example, in some sites in Canada, sexual health clinics or community-based health centres visit the prison on a regular basis to deliver sexual health counseling, testing, distribute safer sex education and equipment, and HIV/HCV education and supportive counseling. Participants thought this would be an excellent way to deliver health services in a confidential environment and felt this would help reduce the risk of transmission of HIV and HCV.

5.5 Assessment and Classification, Access to Testing

Assessment and Classification
Upon admission to a correctional facility, inmates undergo an assessment and classification procedure to determine their program and other needs, as well as their security risk level, to enable decision-making about appropriate placement for the offender. The group was asked about how well they thought this process identified their needs, particularly as it relates to health, addictions, and access to methadone. They were also asked about access to testing for HIV, Hepatitis C, and STIs.

Federal

In the Federal system, there are designated assessment and classification staff and focus group participants thought the process was more thorough as a result. They reported

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33 See description of these types of services in Hard Time, pgs 26-35.
extensive observation before final placement, except for women who were always considered “medium risk” for first three months and then classified.

**Provincial**
Focus group participants perceived the provincial system to be inadequate, particularly when it came to conducting a health assessment and assessing the need for methadone as described earlier.

*Access to Testing for HIV and Hepatitis C*

Direction 180 clients thought access to testing for HIV or HCV was good in the federal system. Testing is offered at admission and strongly encouraged; indeed, some inmates thought it was mandatory. (Note that CSC policy dictates that testing is not mandatory but rather offered on a volunteer basis). In provincial centres, testing is also offered upon admission on a voluntary basis.

In both sites, former inmates say “They [corrections staff] push testing so they know what they’re dealing with”. Participants think the results of their tests are not confidential. They believe that prison staff know which inmates are HIV positive from a staff and prisoner health and safety point of view. “Everybody knows.”

They reported mixed views with respect to the adequacy of pre and post-test counseling. Although the question in the focus group was phrased to inquire about practice as it applies to inmates generally, this may have been reflective of a desire to not disclose their personal status (although some spoke freely about having Hepatitis C) or that their personal experience differed depending upon results. Some said “Yeah, they tell you all about it.” while others shrugged and said, “No, they don’t tell you much.” It was not known if/how many of the group members had tested positive for HIV or Hepatitis C so they may not be in a position to judge the adequacy of post-test counseling. Offenders reported that the approach to HIV testing in federal institutions is much different now than it was in the mid-eighties and that “times have changed”.

To the extent that concerns about confidentiality inhibit testing, options to increase inmate confidence in the confidentiality of the testing process should be explored in federal and provincial sites. Further information about how, to whom, and under what conditions this information is shared is required. More information about the nature and extent of pre- and post-test counseling in both sites is also needed.

### 5.6 Access to HIV/HCV Treatment and Hygiene Conditions

Focus group participants reported that persons with HIV/AIDS (PHAs) or Hepatitis C are transported out of the correctional facility for treatment of these diseases. Some group participants/program director reported interruptions in treatment while incarcerated, particularly for Hepatitis C.
General hygiene conditions were described as deplorable in lock-up/segregation areas. This is a particular concern for those with HIV/AIDS and compromised immune systems as they may be more vulnerable to opportunistic infections.

5.7 Access to HIV/HCV and Addictions Programming

HIV/HCV and Addictions Education and Counselling
When asked about the availability of HIV/AIDS, HCV, and addictions education and counseling, offenders responded that there were a variety of programs available in both federal and provincial institutions, including HIV and Hepatitis C education programs, but different facilities offered different programs.

Federal
Group counseling was the norm. Individual counseling was normally not available, although a few women said they could access this if they requested it. Some addictions programming was mandatory and participants made the point that unless a person was interested and wanted to learn, and ready to change their behavior, making the program mandatory was not effective. Some had been through the programs more than once and found them “repetitive” and “boring”.

Programs could be delivered by an outside agency or counselor, by trained peer counselors, or by prison staff. Peer education programs such as PEC (Peer Education Counselling), and HOPE (Hepatitis Outreach Peer Education) were mentioned, along with some developed by the Canadian AIDS Society. When asked about the delivery agent, preference was expressed for programs offered by an external community-based agency based on the belief that these agencies were more genuinely interested in the well-being of offenders than prison system officials who offer it as “part of their job.” Community-based programming was seen to be delivered “more from the heart”. Inmate Committees were identified as an important mechanism for inmates to have a voice and “change things”.

Provincial
Programs in the provincial system were of shorter duration. Offenders said there was a waiting list and since prison sentences are shorter, access can be difficult. Again, programs could be delivered by corrections personnel or by outside agencies. Peer or community-based programs were preferred for reasons already cited. Participants mentioned group programs offered covering education, work preparation, anger management, violence prevention, parenting programs, relapse prevention, self-discovery/self-esteem, as well as support offered through external agencies like Stepping Stone, a community based program that works with individuals currently or formerly involved in the sex trade and those at-risk of becoming involved. Twelve step programs, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), also conduct presentations inside the facility, although women mentioned the AA group met only once a month which was not frequent enough. No individual counseling was available in provincial centres. Group offerings for women were minimal and insufficient to meet needs, women in the focus group said.
5.8 Drug-free Living Units

Participants were asked if anyone had any experience with “drug-free living units” or “ranges” in provincial or federal correctional facilities. These are units which provide a supportive environment to inmates with a genuine desire to live drug-free.

In the federal system, these units are called Intensive Support Units (ISUs) which, according to national CSC guidelines, are “intended to provide a positive living environment for offenders who wish to remain free of alcohol and drugs and to support and reinforce offender efforts to change substance abuse behaviour.” ISUs are voluntary, and open to prisoners with substance use problems and those without “who wish to live in an institutional environment that is free of drugs and the interpersonal problems associated with inmate drug use.”

Drug-free living units and therapeutic communities present additional harm reduction options for prisoners suffering from significant and long-standing drug addiction.

Participants in the Direction 180 focus group had limited experience with and knowledge of these units. To the group’s knowledge, drug-free units are not available in provincially run institutions. One reported that Springhill has such a unit and it was thought to be very helpful. Participants were very supportive of this as another option to “help people stay clean”.

5.9 Pre-release Planning and Discharge

“I was always more nervous getting out than going in.”

“Because there is no support, you’re back on the street and then soon back in the system.”

Focus group participants were asked about the adequacy of pre-release planning to support their re-integration into the community. They felt quite prepared for release from a federal correctional facility but this was not the case when released from a provincial institution.

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34 Canadian HIV/AIDS Legal Network, PASAN (2007) *Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada.* This report also discusses a provincial “therapeutic community model” based in B.C. provincial Nanaimo Correctional Centre (Guthrie House). The therapeutic community is described as having five goals: (1) to facilitate a drug-free environment; (2) to facilitate prisoners taking responsibility for their daily living; (3) to provide treatment in a safe and supportive environment; (4) to reduce criminal thinking and anti-social behaviours among prisoners; and (5) to prepare prisoners for life in the outside community. Prisoners move through four phases: orientation (lasting three weeks to one month); primary treatment (two to three months); re-entry/transition (one to two months); and aftercare (six months or greater). Prisoners are involved in intensive, comprehensive programs, including work, training programs, core programs designed to change prisoner behaviour and reduce recidivism, and other seminars, workshops and counselling. Core programming includes topics such as violence prevention, substances abuse management, maintaining respectful relationships, and literacy. Intake to the program is provided on a continuous basis as beds become available. Prisoners seeking admission to the program may at times be placed on a waiting list.” (pg. 107).
Federal
Discharge planning was reported to be much better in the federal than in provincial
institutions (additional discharge planners have been recently hired at the federal
institutions in Atlantic Canada). Offenders reported that pre-release planning begins one
to three months ahead of time. Upon release, an offender is provided with a discharge kit
which includes clothes, a $250 gift certificate from Sears (if leaving from NOVA
Institution), money earned while incarcerated (a percentage of an inmate’s pay is put
away for release so s/he has money upon departure), travel funds (bus fare or gas money),
release papers, information about parole and conditions (where to report, etc.), and
information about services and programs in the locality or area where the inmate plans to
reside.

Inmates go to a halfway house when released on day parole, usually for at least 6 weeks
or longer, so immediate housing is not a concern and assistance in finding housing and
accessing other needed services is provided while in the halfway house. When offenders
reach their Warrant Expiry Date however, housing support is limited in Halifax to the
YMCA or Metro Turning Point.

Provincial
Conversely, in the provincial system, offenders said there was no discharge planning, no
information provided prior to or upon release as to services or supports available, and no
information about prisoner’s rights or entitlements. Some inmates said “If you know your
rights, you can put in a request for a bus ticket and an outfit but this is not offered to
you.” Most were not aware they could ask for this type of assistance. Further, prisoners
think that “People who know the system and tell other inmates about their rights can be
transferred.”

Chief among their concerns was access to income support (for food, clothing, shelter, and
immediate transportation). Inmates were released without a bus ticket to get into the
nearest town/city, without a cheque to purchase food, and without the means to secure an
apartment/boarding room. Some were forced to steal from the local shopping mall to get
money or food immediately upon release. Often when inmates are released, they have
gained weight and their clothes no longer fit due to lower physical activity levels in
prison.

Offenders cited systemic difficulties in accessing income support immediately on release.
It was difficult to get housing because “you need to meet with a worker first to get
money, you need to get out of jail to meet with a worker… you need an address to get a
dollars cheque, and a cheque to get an address.” It is difficult to get an appointment with a
program officer of the Province’s Employment Support and Income Assistance (ESIA)
program before release, so offenders have no ability to arrange an independent residence
prior to their release date. Offenders said landlords will not hold an apartment without a
deposit, nor are they anxious to rent to offenders or people on income assistance.
Although inmates could be eligible to receive a start-up cheque, in order to receive
income assistance on a regular basis, an address is required. Inmates cannot obtain an
address without first having the funds for a deposit on an apartment/boarding room.
While offenders acknowledged that they could contact ESIA for emergency assistance the day prior to release, the process of securing the required supporting documentation to obtain benefits was said to be problematic. In order to authorize ESIA benefits, a letter from the correctional institution confirming the period of incarceration is required immediately upon release but this letter is often not provided to the inmate until up to two weeks later.

ESIA benefit levels (income assistance rates) were cited as a problem. While it was acknowledged that a person on MMT (who meets other eligibility criteria) usually qualifies as a person with a disability and therefore a higher level of income support than a single employable person, assistance rates can still be inadequate to live on.35

The quality and availability of affordable housing in the Halifax area is also poor; many said they were now living in “rat-infested slums”.

The absence of pre-release planning undermines the success of inmates in transitioning to the community. Inmates recommended that, as part of release planning, they be provided with a list of available services and supports, information about their rights and access to financial and other support from the institution when released (clothes, transportation funds/bus ticket, etc.), and that a more thorough discharge planning process take place. A “starter” information kit containing at minimum $25 for food, a list of available affordable housing options, and Department of Community Services (DCS) Office contact information was recommended.

5.10 Access to Community Supports

“If I hadn’t had a good support system I would have failed.”

Women about to be released from prison could call women’s shelters accepting offenders (Adsum House, Barry House) to make arrangements for emergency accommodation as both accept female offenders transitioning to the community. From these shelters, they received support to access affordable housing and other services through a Department of Community Services social worker. However, housing options for women on MMT are limited; only Adsum House is willing to accept women offenders on MMT or active users. In the latter case, women are required to hand over their drug equipment to shelter staff who return it the next day. Drug use is not permitted on the premises. Recovery houses for women on methadone are non-existent within the Halifax Regional Municipality, as these women are considered to be actively using. Enabling women with an addiction to obtain safe housing upon release is an essential first step in the journey toward stability/recovery. The WISH Program (Women’s Integrated Supportive Housing) operated by the Halifax YWCA was also mentioned as a source of housing and support

services. Women also sought the assistance of the Elizabeth Fry Society prior to and following release, as well as Stepping Stone and Bryony House’s Outreach Program (for abused women).

Male inmates said they could access some support prior to release by contacting an outside organization such as the Salvation Army which would come in to the institution to meet with an offender before release. Clothes and funds for transportation ($60) could be obtained from the agency. Some also sought refuge, upon release from prison, from the Metro Turning Point men’s shelter (an overnight shelter for men which does not accept clients who are high or intoxicated) and from Pendleton Place (a “wet” shelter permitting entry to men with an addiction, but one cannot use drugs/alcohol while there). Also mentioned was the Freedom Foundation, a privately operated, non-profit program for men in recovery, a condition of which is that participants must attend the CORE program offered by Addiction Prevention and Treatment Services (APTS), Capital Health.

John Howard Society was also mentioned as offering support to both men and women. Society staff will go into prisons to see inmates.

Narcotics Anonymous (NA) and Alcohol Anonymous (AA) were identified as other sources of support.

Transition Workers – specially-designated staff/social workers employed by the Department of Community Services to serve the transient population – were singled out as particularly effective. Offenders who had worked with these staff found these workers to be non-judgmental, supportive, and extremely helpful in navigating an offender’s way through the maze of services and agencies whose assistance they required. Offenders felt able to discuss their needs openly with these workers who also understood MMT. The Transition Worker model was seen to be an excellent one which offenders recommended be extended to enable workers to visit inmates in correctional centres prior to release, as part of the discharge planning process.

Offenders also acknowledged that personal initiative and a sincere desire to help one’s self was required to be successful in transitioning to the community. The other critical success factor/key ingredient was access to community-based agencies with a mandate and willingness to help.

“You have to really want to help yourself.”

Relationship with Parole/Probation Officer

Focus group participants were asked what their relationship was like with their parole or probation officers, particularly as it relates to their understanding and support of methadone maintenance treatment, as well as the degree of assistance offenders receive in accessing support services.
Federal
Focus group participants reported that, prior to release, CSC staff discuss with inmates their personal support system (friends, family), job search, restrictions/conditions of their release, programs they are required to take in the community, and transfer to MMT in the community. Links are made from “inside to outside” through social workers and mental health teams.

Most inmates were eager for release but fearful as well. (One person even commented that individuals should have the option to turn down the opportunity for accelerated parole if they think they are not ready for it). Completion of an offender’s full sentence – their warrant expiry date – is also a difficult transition point for some individuals as this is the point at which they no longer have access to parole officers/social workers and others on whom they may have come to rely for support. While they acknowledge the need to achieve self-reliance and independence, it can nevertheless be difficult for some, given their personal histories and support needs.

Provincial
Offenders said they usually see their Probation officer once a month. “Some are helpful and supportive and some are not.” Focus group participants reported that while probation officers do come to see inmates prior to release to review conditions of release, they are not generally involved in helping to access supports such as housing.

5.11 Access to MMT upon Release

Access to MMT programs in the community, whether released from a provincial or federal institution, was identified as a problem. MMT programs are not available in every community, their program structure/admission criteria can be problematic/not suitable to the offender’s needs, and waiting lists can be a concern. For example, at the time of this report, MMT programs were very limited in New Brunswick so some offenders had to move to Nova Scotia to get treatment.

The waiting period can also be a problem at programs like Direction 180. There is not always room to immediately admit new clients upon release and funding shortages have exacerbated the problem. Further, while the Provincial Addictions Prevention and Treatment Services (APTS) offers programs through the District Health Authorities (some through shared service areas), this program is not always the best suited to this population, as some clients require a low threshold program to succeed. APTS requires clients to be drug-free to remain in the program. Zero tolerance for use of other substances like marijuana is viewed by offenders as unrealistic. Consequently, access to APTS detox can be difficult for clients coming from a Corrections environment. APTS programs may also have limited space.
5.12 Summary of Findings

The following table summarizes the concerns expressed by focus group participants.

**Table I: Summary of Offender Issues of Concern by Topic and Applicability to Federal or Provincial Corrections Settings**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Federal Corrections</th>
<th>Provincial Corrections</th>
</tr>
</thead>
</table>
| Methadone | • Access to community-based or government-delivered MMT programs – Availability of MMT programs in community problematic in some sites; Wait list for program admission also a concern | • Inhumane weaning off narcotics upon admission (remand, admission post-sentence)  
• Delay in access to MMT (3-4 days)  
• Dose – sudden and dramatic drops in methadone dosage levels upon admission; low artificial ceiling for MMT maintenance doses, inconsistent with the inmate’s current dose  
• Denial of access to MMT – both initiation and continuation for those already on MMT (recent practice)  
• Replacement of MMT with valium  
• Rapid weaning upon release  
• No transfer/poor continuity to MMT programs in community |
| | • Inhumane weaning off narcotics upon admission (remand, admission post-sentence)  
• Delay in access to MMT (3-4 days)  
• Dose – sudden and dramatic drops in methadone dosage levels upon admission; low artificial ceiling for MMT maintenance doses, inconsistent with the inmate’s current dose  
• Denial of access to MMT – both initiation and continuation for those already on MMT (recent practice)  
• Replacement of MMT with valium  
• Rapid weaning upon release  
• No transfer/poor continuity to MMT programs in community |
| Pain Medication | | • Denial of access to pain medication |
| Needle Exchange (NEP)/Access to clean needles, bleach | • No NEP or access to clean needles (offenders using old and used needles with potential for HIV/HCV transmission)  
• Bleach kits upon entry  
• Subsequent access to bleach varies by facility, some inmates reluctant to ask for more for fear of sanctions | • No NEP or access to clean needles (offenders using old and used needles with potential for HIV/HCV transmission)  
• No bleach kits  
• Bleach available for cleaning but access can be problematic; inmates reluctant to request bleach for fear of sanctions |
| Safer Tattoo Equipment | • Safe Tattoo pilot terminated; no access to clean equipment (offenders re-using make-shift equipment with potential for HIV/HCV transmission) | • No access to clean equipment (offenders re-using make-shift equipment with potential for HIV/HCV transmission) |
| Access to Safer Sex Tools – Condoms, Dental Dams | • Condoms, dental dams available  
• Mixed views on comfort/ease of accessibility – difficult to access health care services to request these items on a completely confidential basis | • Condoms, dental dams not available  
• Difficult to access health care services to request these items on a completely confidential basis |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Federal Corrections</th>
<th>Provincial Corrections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and Classification</td>
<td>• Thorough</td>
<td>• Inadequate, esp re: assessment for MMT, need for humane weaning off drugs, and other health concerns,</td>
</tr>
<tr>
<td>Access to Testing for HIV and Hepatitis C</td>
<td>• Testing offered at admission and strongly encouraged</td>
<td>• Testing offered at admission and strongly encouraged</td>
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<tr>
<td></td>
<td>• Unclear about adequacy of pre and post test counselling</td>
<td>• Unclear about adequacy of pre and post test counselling</td>
</tr>
<tr>
<td>Access to HIV/HCV Treatment</td>
<td>• Provided externally</td>
<td>Provided externally</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Experienced interruptions in HIV and/or HCV treatment</td>
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<tr>
<td></td>
<td></td>
<td>• Unsanitary conditions in lock-up a concern for those with compromised immune systems</td>
</tr>
<tr>
<td>Access to Health/Sexual Health Services/Confidentiality</td>
<td>• Access to health services and respect for confidentiality positive for women.</td>
<td>Process to access health services cumbersome, not confidential, discretionary, inhibits access</td>
</tr>
<tr>
<td></td>
<td>• No experience with delivery of health services or sexual health care by external community-based agencies</td>
<td>• Delays in accessing health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• uniform lack of trust in the provincial corrections system to guard confidentiality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No delivery of health services or sexual health care by external community-based agencies</td>
</tr>
<tr>
<td>Access to Addictions Programming</td>
<td>• Variety of programs available, including HIV and Hepatitis C education programs, but different facilities offered different programs.</td>
<td>Variety of programs available, including HIV and Hepatitis C education programs, but different facilities offered different programs.</td>
</tr>
<tr>
<td></td>
<td>• Questioned value of mandatory addictions programming</td>
<td>• Group counseling was the norm; no individual counseling</td>
</tr>
<tr>
<td></td>
<td>• Group counseling was the norm; individual counseling difficult to access, although some women able to access</td>
<td>• Preferred programs offered by an external community-based agency or peers to internal programming</td>
</tr>
<tr>
<td></td>
<td>• Preferred programs offered by peers or an external community-based agency to internal programming</td>
<td>• Programming for women minimal</td>
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<tr>
<td></td>
<td></td>
<td>• AA meetings for women insufficient</td>
</tr>
<tr>
<td>Drug-free Living Units</td>
<td>• Limited knowledge/ experience with units but supported idea</td>
<td>Limited knowledge/ experience with units but supported idea to help offenders &quot;stay clean&quot;</td>
</tr>
<tr>
<td>Pre-release Planning and Discharge</td>
<td>• Planning good, felt prepared.</td>
<td>Inmates felt unprepared and nervous.</td>
</tr>
<tr>
<td></td>
<td>• Discharge kit provided upon release which includes clothes, money earned while incarcerated, travel funds (bus fare or gas money), release papers, information about parole and conditions,</td>
<td>No discharge planning, no information provided prior to or upon at release as to services or supports available, and no information about prisoner’s rights or entitlements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No discharge kit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Most inmates not informed of</td>
</tr>
<tr>
<td>Topic</td>
<td>Federal Corrections</td>
<td>Provincial Corrections</td>
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<td>-----------------------------</td>
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</tr>
</tbody>
</table>
| Pre-release Planning and Discharge | and information about services and programs in the locality or area where the inmate plans to reside.  
  - Inmates go to a Halfway House when released on day parole, usually for at least 6 weeks or longer, so immediate housing is not a concern.  
  - Assistance in finding housing and accessing other needed services is provided while in the halfway house. | potential assistance available.  
  - Inmates can request a bus ticket and an outfit  
  - Access to income support (for food, clothing, shelter, and immediate transportation) is problematic and uncoordinated. Some forced to steal to get money or food. |
| Access to Community Supports |                                                                                     |                                                                                         |
| Access to MMT Upon Release |  - Access to MMT was cited as critical to offender stability/recovery  
  - MMT programs are not available in every community, their program structure/admission criteria can be problematic/not suitable to the offender’s needs, and waiting lists can be a concern. |  - Access to MMT was cited as critical to offender stability/recovery  
  - Either 1) no transfer to community-based programs or 2) poor transition to, and continuity between, MMT programs in community and in corrections  
  - MMT programs are not available in every community, their program structure/admission criteria can be problematic/not suitable to the offender’s needs, and waiting lists can be a concern. |
6. ANALYSIS AND RECOMMENDATIONS

6.1 Current Policy Framework

International Legal Framework

Canada is a signatory to and/or participant in a number of international and domestic treaties, legislation, regulations, and guidelines pertaining to human rights and treatment of prisoners, and harbours legal obligations as a result. (For an overview of applicable international and Canadian human rights treaties, legislation, guidelines, and other standards related to prison conditions, see the section on human rights outlined in Hard Time, pgs. 13-18.) Enshrined in this legal framework is that prisoners retain their basic human rights once imprisoned; prisoners do not surrender their rights upon incarceration, but instead retain all rights “subject to the restrictions that are unavoidable in a closed environment.” This includes (from the United Nations Universal Declaration of Human Rights), the right to equality and non-discrimination, right to life, right to security of the person, right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment, right to enjoyment of the highest attainable standard of physical and mental health, right to privacy, and the right to an effective remedy for violations of human rights (italics authors own).

Further, key international instruments reveal a general consensus around the principle of equivalence of health services, that is, that prisoners should have access to a similar level of health services as is available to others in the community, as expressed in the World Health Organization’s Guidelines on HIV Infection and AIDS in Prisons 36 and the United Nations Joint Programme on HIV/AIDS (UNAIDS) Handbook for Legislators on HIV/AIDS. 37

There are a number of guidelines which pertain to HIV/AIDS and prisoner access to HIV/AIDS-related services specifically. The UNAIDS and Office of the United Nations High Commissioner for Human Rights International Guidelines on HIV/AIDS and Human Rights states:

Prison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to HIV-related prevention information, education, voluntary testing and counselling, means of prevention (condoms, bleach and clean injection equipment), treatment and care and voluntary participation in HIV-related clinical trials, as well as ensure

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36 The WHO (World Health Organization) Guidelines on HIV Infection and AIDS in Prisons recommend that the standard of health care provided to prisoners must be comparable to that available in the general community (i.e., the principle of “equivalence” of health services), including with respect to prevention programs. WHO, WHO Guidelines on HIV Infection and AIDS in Prisons, 1993 WHO/GPA/DIR/93.3.

37 Similarly, WHO, the United Nations Joint Programme on HIV/AIDS (UNAIDS) and the Inter-Parliamentary Union recommend that prisoners be provided with “access equal to the outside community” in relation to HIV-related prevention and care services. UNAIDS, IPU, Handbook for Legislators on HIV/AIDS, Law and Human Rights. UNAIDS: Geneva, 1999, pp. 61, 63.
confidentiality, and should prohibit mandatory testing, segregation and denial of access to prison facilities, privileges and release programmes for HIV-positive prisoners. Compassionate early release of prisoners living with AIDS should be considered [para 29(e)]. 38

The United Nations Office on Drugs and Crimes (UNDOC) has also produced HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response which “provide[s] a framework for mounting an effective national response to HIV/AIDS in prisons that meets international health and human rights standards, prioritizes public health, is grounded in best practices, and supports the management of custodial institutions.” The UNODC Framework includes 100 specific actions framed around 11 principles representing an “international consensus” on effective prison management in the context of HIV/AIDS.39

Delivery of Health Services in Corrections in Canada

The federal prison system is governed under the Corrections and Conditional Release Act (CCRA) and the accompanying regulations (Corrections and Conditional Release Act (CCRA), SC 1992, c 20; SOR/92-620). Under sections 85 to 88 of the CCRA, CSC is mandated to provide every prisoner with essential health care and reasonable access to mental health care that will contribute to his or her rehabilitation and reintegration into the community.

Delivery of Health Services in Corrections in Nova Scotia

Provincial and territorial prison systems are created under provincial and territorial laws. Nova Scotia legislation was amended in 2005 to transfer responsibility for prison health care from the Department of Justice to the Minister of Health, the Minister responsible for health services to the general population in Nova Scotia. Services are delivered through the Capital District Health Authority.

In 2004, Nova Scotia endorsed a harm reduction approach with the adoption of Standards for Blood Borne Pathogens Prevention Services in Nova Scotia.40 This document acknowledges that leadership and coordination is required to implement an integrated approach to BBP prevention that targets common risk factors, promotes wellness and supports harm reduction, recognizing that integrated approaches will provide the greatest benefit (p. 2). The document goes on to describe the standards as denoting set of expectations that must be achieved and “addressing what elements of programs and services need to be the same no matter where the service is delivered or by what agency.” (p.3) (emphasis added).

Standard #3 requires that District Health Authorities (DHAs) ensure that all Nova Scotians, especially those at-risk, have reasonable access to BBP prevention services

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through a variety of mechanisms including direct service delivery, contracting out or partnerships/service agreements among or between districts or with relevant service delivery partners (p. 10).

With respect to the delivery of harm reduction services within provincial correctional facilities, the document indicates that MMT is continued if inmates have already been initiated on MMT, either through Addiction Prevention and Treatment Services (APTS) Methadone Services or Direction 180, the only sites offering MMT at the time.41 (Some physicians were and continue to be licensed to prescribe methadone privately in their offices. Since 2004, MMT has been offered through APTS in Sydney, Cape Breton, as well.) In 2004, the practice was to transfer inmates from other correctional institutions outside Metro to the Central Nova Scotia Correctional Facility in Burnside, and arrangements were made with local pharmacies to provide methadone until the transfer occurred. With average stays being 60 days, Corrections was reluctant to initiate people on MMT who had not already been on MMT elsewhere.

6.2 Analysis, Evidence Review and Recommendations

This section
a) reviews the concerns raised by the focus group participants
b) examines the research evidence regarding prevention/harm reduction interventions, and
c) offers recommendations to address the situation.

It is important to preface this analysis by restating that, although policy and other source documents were consulted, this report did not conduct a comprehensive policy or practice review within federal or provincial institutions; nor were interviews conducted with corrections staff, or with those delivering health services within correctional facilities, to identify their views and practices. However, while it is important to verify what policy and practices are in place, it is also important to learn from the lived experiences of offenders at-risk of HIV/HCV. Not only are they an equally valid source of how policy and practice guidelines, to the extent they exist, are actually applied within prison walls, but they have invaluable knowledge and advice as to how best to prevent/reduce transmission of HIV/HCV in correctional settings.

These areas of concern should be further explored with a view to 1) further clarifying policy and practice 2) identifying barriers to implementation of these approaches, and 3) developing collaborative mechanisms by which policy and practice can be amended to reduce risk of transmission of HIV and other BBPs among prisoner populations and support smooth transition of offenders into the community.

Although participants in this focus group were consulted about their concerns and experiences with both federal and provincial correctional institutions, and many had personal experiences in both systems, the primary concerns were with the provincial

corrections. Most of these issues were around access to harm reduction services, notably methadone maintenance treatment, and with preparation for release.

6.2.1 Blood Borne Pathogens Prevention Services in Correctional Settings

Nova Scotia’s Strategy on HIV/AIDS, adopted in 2003, speaks to the need for harm reduction services within correctional facilities. Since adoption of the AIDS Strategy and inception in 2004 of Nova Scotia’s Blood Borne Pathogens Standards for Prevention Services, little has been done to enhance prevention/harm reduction services provided within provincial corrections institutions. Indeed, it appears fewer prevention and harm reduction services and treatment options are available now than in 2004 with the reduction in access to MMT. By comparison, the federal system is far better equipped to address these issues than its provincial counterpart. While it is recognized that offenders in federal institutions are serving far longer sentences for more serious crimes, the provincial system affords an opportunity for earlier intervention and prevention of transmission of HIV and HCV, and one that may be sufficient to re-direct drug users into treatment, including MMT should this be suitable for the offender. It appears there is no strategy within the provincial correctional services environment to address prevention/reduction of HIV/HCV transmission.

The costs of treating an HIV or HCV infection, of lost productivity due to illness, of crime to support a drug addiction, of the spread of infection to others, far outweigh the costs of providing an effective response.


It is recommended that the Province of Nova Scotia develop a strategy to guide development of services to reduce transmission of HIV/HCV and other blood borne pathogens within provincial correctional facilities, similar to and consistent with the overall Blood Borne Pathogens Standards for Prevention Services. This document should address the concerns raised in this report and outline how and what measures will be introduced to reduce the risk of transmission and support offenders to improve their health, consistent with the evidence base. It should address inmate access to

- methadone maintenance treatment
- clean needles/tattoo equipment
- safer sex tools
- HIV/HCV prevention education
- confidential health/sexual health counseling
- testing and counseling
- HIV/HCV treatment
- transition support to re-enter the community

Partners in development of such a strategy should include the Departments of Justice (Correctional Services), of Health, and of Health Promotion and
Protection, Capital District Health Authority (Offender Health Services), the Correctional Service of Canada (CSC), the Nova Scotia Advisory Commission on AIDS, relevant community-based agencies, and other key stakeholders. This includes access to MMT and other health/sexual health, prevention and harm reduction services, as well as addiction prevention, treatment, and other programs to support offender re-integration into the community. Links must also be made with the Department of Community Services to ensure offender access to income and employment support and housing where needed upon release. It is essential that partners work together to ensure collaboration, continuity of care, and sufficient resources.

Adequate resources must be provided to support implementation of such a strategy. This includes the provision of adequate funding support to ensure program capacity is sufficient to meet demand for service in the community once an offender is released.

An approach which supports the offender to access methadone treatment, to reduce their exposure to HIV/AIDS and Hepatitis C while in prison, and to successfully re-integrate into the community is critical, not only for the health of the offender, but for public health (reduced transmission) and safer communities (reduced crime).

6.2.2 Prevention/Harm Reduction Education and Training

In order to support implementation of such a strategy within correctional institutions, it is important that all involved – health and corrections staff, both policy and service delivery – have an understanding of the value of these prevention and harm reduction approaches in order to be effective.

The Provincial Blood Borne Pathogens Standards for Prevention Services speak to the need for trained human resource personnel (Standard 5) in the delivery of BBP prevention services requiring all staff engaged to demonstrate knowledge, skills, and competencies appropriate to the service provided and consistent with evidence (Standard 5.2). However, province-wide training was not conducted on the standards to support implementation or to ensure health human resources were adequately prepared to deliver prevention services.

It also appears there is a basic lack of understanding of addictions among some staff who deliver services to prisoners with an addiction. Addiction is the result of a complex layer of social, individual/behavioural, and other factors and training in this area, particularly for corrections staff involved in holding prisoners for short term periods (e.g. bail hearing) should help contribute to humane weaning practices and alleviate the suffering of opioid addicted persons who are arrested and held in custody.
**Recommendation 2: Provide Prevention/Harm Reduction Education and Training.**

It is recommended, in order to support implementation of the proposed *blood borne pathogens prevention and implementation strategy for provincial corrections facilities* (as per recommendation 1), that information, education, and training about prevention/harm reduction approaches and their value in reducing the risk of transmission of HIV/AIDS, Hepatitis C and other blood borne pathogens, be provided to all those involved in the delivery of services to prison populations, especially populations with an addiction/drug users, HIV+ and HCV+ persons, and those at-risk of HIV/HCV. Understanding the value of such an approach will improve the effectiveness of design and implementation of policy and practice.

**6.2.3 Public Awareness of Harm Reduction**

Elected officials who make public policy decisions are influenced both by the beliefs of the populace/their constituency and by public officials. Politicians, the public in general, and government policy makers may not always be sufficiently informed about the merits of a harm reduction approach and the research evidence in support of such measures, yet their support is vital to the implementation of sound public policy and harm reduction measures.

**Recommendation 3: Increase Public Understanding and Awareness of the Merits of a Harm Reduction Approach**

It is recommended that greater efforts be undertaken to inform elected officials, policy-makers, and the public in general about the merits of a harm reduction approach, and the evidence base in support of prevention/harm reduction, in order to increase understanding and support for implementation of these measures.

**6.2.4 Access to Methadone Maintenance Treatment (MMT)**

*Access in Federal Facilities*

MMT has been widely available in federal correctional facilities since 2002. For the most part, participants had no comments about access to MMT in federal prisons, with the exception of limited program capacity and inadequate funding to support federally released offenders in community-based MMT programs. MMT is a critically important component of successful offender rehabilitation and re-integration. The inability of offenders once released to continue MMT in a program most suited to their needs seriously undermines offender stability and contributes to criminal behaviour. Substance
use/addiction is a significant criminogenic risk factor in this population. This is also true for offenders released from provincial correctional institutions.

In order to ensure offenders on MMT within a correctional facility experience a smooth transition to the community upon release, adequate funding to ensure sufficient program capacity in methadone maintenance treatment programs must be available in the community.

**Recommendation 4:** Improve Access to Methadone Maintenance Treatment (MMT)

**Recommendation 4.1:** Funding Stability for Community-based MMT Programs

Given the importance of MMT in supporting offender stability and reducing recidivism, it is recommended that arrangements be made by Correctional Service of Canada, Capital District Health Authority, and Direction 180 to sufficiently support federally (and provincially) released offenders to access MMT programs in the community, and that funding stability be assured for community-based programs delivering MMT services to this population.

**Access in Provincial System**

In relation to the provincial corrections system, offenders spoke of

- inhumane weaning off narcotics upon admission (remand, admission post-sentence)
- extensive waits/delay in access to MMT (3-4 days)
- complete denial of access to MMT – both on an initiation and continuation basis
- insufficient dosage of MMT (dramatic drops in dosage levels upon admission and low artificial ceiling for maintenance doses, inconsistent with the inmate’s dose prior to admission)
- rapid weaning upon release, no transfer to MMT programs in community upon release

Over the period of time discussed with inmates, practice seems to have fluctuated greatly; some offenders received methadone but at lower doses than in the community program, and sometimes after prolonged delays, while others were denied access to MMT completely, even if they were already receiving MMT in the community. Some reported inhumane weaning practices. Access to pain medication for legitimate chronic pain conditions was also difficult for some offenders.

Although arrangements had been made between Direction 180 and the Burnside corrections site to continue MMT for Direction 180 clients while incarcerated, and to initiate some inmates upon inmate request, this practice appears to have been suspended, inconsistent with the Province’s own BBP Standards. It is unclear what policies are
being applied within provincial correctional facilities but it appears to have resulted in less access to MMT since the introduction of the BBP Standards.

Further, dose reductions and the imposition of an artificial dosage ceiling created difficulty for individuals who had been prescribed higher doses, threatening any stability they may have achieved and undermining the success of the treatment.

Participants clearly said the absence of or inconsistent access to methadone in sufficient doses forces people to access illicit drugs inside prison. Further, rapid weaning prior to release and the absence of arrangements to facilitate transfer to an MMT program in the community upon release is short-sighted. Not only does it leave the offender without effective treatment, in effect setting the offender up to fail, it jeopardizes public health and safety by forcing the offender to return to street drugs to keep from getting sick and engage in criminal activity to procure those illicit drugs. This also poses an increased risk of transmission of HIV and Hepatitis C.

There is an apparent lack of understanding about addiction and a lack of empathy for the suffering of people in withdrawal. The need to wean people who use illegal drugs/narcotics humanely to reduce their suffering is not only a compassionate response which respects their human rights and dignity but one which represents a responsible public health approach. Delays in access to MMT also result in unnecessary suffering.

There seems to be inadequate knowledge or acceptance of the evidence-based benefits of a harm reduction approach, and the benefits of MMT by those responsible for the delivery of health services in the provincial corrections system. At minimum, there appears to be a lack of collegiality in approach to shared clients/patients, and differences in the understanding, management, and treatment of persons with opiate addiction.

Direction 180 was cited in a national study as a model example for the delivery of MMT within prisons. This report recommended that “Community health clinics should consider initiating methadone in provincial prisons where methadone is not being initiated. Direction 180 has shown that this practice can assist prisoners while incarcerated. People who were street-involved people before incarceration may have found it difficult to get to community-based services while they were actively using drugs, and bringing such services to the prison may be their first opportunity to utilize them. This practice should be seriously considered to promote community health-care standards in prison.” 42

There is a need for compatible policies and protocols (initiation, continuation, dosage, elimination of delays/interruption in treatment, seamless transition to treatment upon release, information sharing between treatment programs, etc.) governing methadone maintenance treatment (MMT) throughout the province, including its application to individuals within correctional facilities. Development of these MMT guidelines must involve the Nova Scotia College of Physicians and Surgeons as the professional body.

42 Hard Time, p 54.
responsible for regulating the province's medical profession, and community-based as well as other providers of MMT services. This does not, by definition, mean that all programs must operate the same; rather, that a continuum of options should exist so that offenders are placed in programs best suited to their needs, and transitions between programs and correctional facilities are guided by best practice.

To be effective, MMT guidelines must be accompanied by training and education opportunities, consistent with recommendation #2, not only for all those involved in the delivery of health care services to individuals with addictions, including those within correctional centres, but for prison staff; and a supportive government policy environment which supports a coordinated continuum of service options.

Further, greater access to MMT will likely reduce the need for needle exchange programs.

It is recognized in international law/practice guidelines that prisoners retain their rights when admitted to a correctional facility including the right to 1) not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment, 2) enjoyment of the highest attainable standard of physical and mental health (UN Universal Declaration of Human Rights) and 3) to receive a similar level of services as that available in the community. That prisoners retain access to MMT to the same degree as residents in the wider community is in keeping with this legal framework. It is not only consistent with observance of international law and guidelines, reflective of a response by a just society, but it is also sound public health policy.

Evidence

Methadone Maintenance Treatment

The effectiveness and acceptability of MMT in prisons have been shown in studies in Australia, Western Europe, Canada, USA, and Iran. Kaldor and colleagues surveyed four randomized control MMT prison interventions in the U.S., France, and Australia and found that injection drug use and associated needle sharing was reduced, re-entry in the community was facilitated, re-incarceration risk was reduced, heroin use declined significantly, and there was a positive effect on institutional behaviour. Correlated by duration and stability of MMT program participation, HIV transmission declined. Further, evidence suggests that MMT may help to reduce risk of overdose for those nearing release.


Recommendation 4.2: Resume Offender Access to Methadone Maintenance Treatment in Provincial Correctional Facilities

It is recommended that procedures be implemented to immediately resume access to Methadone Maintenance Treatment (MMT) – a long recognized effective form of treatment for opioid addiction – by inmates housed in the Province’s correctional facilities.
MMT should be available to opioid addicted inmates whether or not they have received MMT in the community prior to incarceration.

**Recommendation 4.3: Develop a Provincial Methadone Maintenance Treatment Policy**

It is recommended that, as part of the proposed Blood Borne Pathogens Prevention and Implementation Strategy for Provincial Corrections Facilities (referred to in recommendation #1), the Nova Scotia Departments of Justice, Health, and Health Promotion and Protection, in collaboration with the Capital District Health Authority and other partners, develop a policy framework to guide the provision of methadone maintenance services in the province to ensure all Nova Scotians have access to MMT, including those housed within the province’s correctional facilities. The policy should ensure the provision of a continuum of options so that individuals have access to programs best suited to their needs and that transfers among and between programs, including upon admission to and release from a correctional institution, are seamless.

**Recommendation 4.4: Develop MMT Guidelines**

As part of this policy framework to guide the provision of methadone maintenance services in the province (as per recommendation 4.3), it is further recommended that the Nova Scotia College of Physicians and Surgeons lead the development of MMT guidelines which recognize and incorporate best practices in MMT. These guidelines should address weaning and dosage reduction practices, dosage levels, and other matters to guide professional practice standards. Development of these MMT guidelines must involve providers of MMT services, including community-based programs.

**Recommendation 4.5: Improve Assessments upon Offender Admission to a Correctional Facility**

It is recommended that steps be taken to ensure that assessments conducted upon admission to a provincial correctional facility be thorough so as to support identification of the need for, and ready access to, methadone as well as to health/sexual health counseling and testing.
6.2.5 Access to Counseling, Testing, and Sexual Health Services

Nationally it has been estimated that approximately 30% of HIV+ and 70% of HCV+ people are unaware of their status.\textsuperscript{43} Up to two-thirds of federal inmates report having had a previous HIV test,\textsuperscript{44} although it is not clear whether they had been tested in the community, in the provincial/territorial system at the time of admission or during the current incarceration, or during a previous federal or provincial incarceration. Currently, all newly admitted inmates to a federal penitentiary are offered a thorough medical examination, which includes a risk factor screening questionnaire for blood borne and sexually transmitted infections. Those who are at-risk and do not know their infection status are encouraged to participate in testing for these infections, including HIV. As is the case in provincial/territorial prisons, testing for HIV and other blood borne and sexually transmitted infections in federal prisons is voluntary. Inmates with a known or self-reported HIV infection on admission are offered confirmatory testing (not screening). However, some inmates may not disclose risk and may refuse a blood test.\textsuperscript{45}

Knowledge of status is critical to obtaining early treatment of the disease and improving personal health outcomes as well as preventing transmission to others. While testing is available and encouraged, offenders in this study do not trust the information will remain confidential. Offender concerns about confidentiality (and the potential punitive repercussions in prisons) act as a barrier to health/sexual health counseling and risk reduction (safer sex and safer drug use). The adequacy of pre and post testing may also influence risk reduction behaviours.

\textbf{Evidence}

\begin{center}
\textbf{Voluntary Counselling and Testing}

Voluntary counselling and testing (VCT) programs raise awareness, provide education, dispel myths, reduce levels of HIV-related discrimination, and detect those in need of care and treatment (2,8,11). VCT studies have shown that, without offering routine HIV screening, most infections remain undiagnosed (8,24). VCT is provided in Canadian institutions upon request and to those who show signs of infection, although the type of testing varies by jurisdiction (2). Pre- and post-test counselling should be offered in the prison setting, but it is currently not provided uniformly even though it is ‘policy’ in Canadian federal prisons (16).

\end{center}

The efforts of federal corrections authorities to provide access to provincial public health nurses from New Brunswick as an alternative means to access testing and health

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\textsuperscript{43} Epi Updates, 2007. \\
\textsuperscript{45} Public Health Agency of Canada. \textit{HIV/AIDS}, p 120.
\end{flushleft}
counseling in a confidential manner is to be applauded. Greater efforts by prison/health officials to ensure inmates are able to access health and sexual health services in a confidential and easily accessible manner are needed.

**Recommendation 5: Improve Offender Access to Counseling, Testing, and Sexual Health Services**

It is recommended that both Federal and Provincial Corrections officials continue to encourage inmates to be tested for HIV and Hepatitis C on a voluntary basis in a confidential environment, undertake efforts to ensure adequate pre and post testing counseling is provided to inmates, and ensure access, through a variety of means, to confidential health/sexual health services, counseling and support. It is further recommended that procedures be reviewed to reduce barriers that may exist in accessing testing, counseling or support, with particular attention to the maintenance of inmate confidentiality as it pertains to health status.

In particular, the Nova Scotia Department of Justice, Corrections Services, the Departments of Health and Health Promotion and Protection, and the Capital District Health Authority should explore ways to ensure the provision of health/sexual health services, including testing, in a confidential and readily accessible manner.

Consideration should be given in both federal and provincial corrections to the merits of partnering with an appropriate community-based or other agency (such as Public Health Services for CSC) to provide these services as a means of increasing offender comfort around issues of confidentiality.

**6.2.6 Access to Safe Injection and Tattooing/Piercing Equipment and Bleach**

Offenders in this study reported use of unsterile injection drug and tattooing equipment while in prison and that lack of access to MMT (in provincial facilities) along with lack of access to clean needles/tattooing equipment (in both federal and provincial institutions) were contributing factors. They also reported difficulties in accessing bleach in both corrections settings.

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Evidence

Needle Exchange Programs
Numerous national jurisdictions (e.g., Switzerland, Germany, Spain, Moldova, Kyrgyzstan, Belarus, Armenia and Scotland) have introduced needle-exchange programs in a variety of prisons, with overwhelmingly positive results, and a number of other jurisdictions (e.g., Iran and Ukraine) have taken steps toward introducing them. Dolan, Rutter and Wodak conducted a systematic review of 19 needle exchange programs in Swiss, German and Spanish prisons and reported a stable or decreased level of drug use, a decline in needle sharing, and a plateau or a reduction in the transmission of HIV. Needles were used and disposed of correctly. Prison needle exchange programs reduce harm to inmates by taking used syringes out of circulation and reducing HIV and HCV transmission rates.


Safe Tattooing
Recently, government authorities terminated a ‘safe’ tattooing pilot program initiated in August 2005 by the CSC audit branch. The Canadian HIV/AIDS Legal Network maintains that the tattoo program could save money if it saves five or more HIV seroconversions. CSC has indicated it costs about $29,000 a year to treat a person with HIV, while HCV treatment costs about $25,000 a year. However, the Canadian Taxpayers Federation and other groups believe the tattoo project wasted taxpayers’ money. Chief Public Health Officer of Canada, Dr. David Butler-Jones, maintains that the $600,000 project was not given enough time for full evaluation and that harm reduction measures such as safe tattooing are an integral element of any comprehensive HIV/HCV prevention strategy. While it seems that support for safe tattooing in prisons is not widespread, the benefits appear to outweigh the costs.


Bleach
Bleach is used to clean shared needles and helps to reduce HIV transmission. Bleach is not universally provided or accessible in federal and provincial Canadian prisons. In one study, women (n=53) in nine Canadian institutions had problems accessing bleach confidentially and in sufficient quantity. Studies have raised doubts about the effectiveness of bleach in decontamination of injecting equipment and conditions in prisons further reduce the probability that injecting equipment may be effectively decontaminated. Bleach programs can only be regarded as a second-line strategy to needle exchange programs.

**Bleach**

While the efficacy of using bleach to eliminate HIV has been well established in laboratory studies, 100 field studies have cast considerable doubt on the likelihood that bleach or other disinfectants could ever be effective in real-life conditions. The probability of effective decontamination is further decreased among prisoners. Evidence from Australia indicates that a substantial proportion of prisoners who inject drugs do not avail themselves of bleach when it is made available. This may be attributable to the fact that disinfecting injecting drug equipment is a time consuming procedure; prisoners may be reticent to engage in any activity that increases the risk that prison staff will be alerted to their illicit drug use. Finally, and of great significance for the health of prisoners because hepatitis C virus is so prevalent in many prison systems, bleach is not fully effective in killing the hepatitis C virus.


**Recommendation 6: Improve Offender Access to Safe Injection and Tattooing/Piercing Equipment and Bleach**

As a measure to reduce the spread of infectious disease, it is recommended that Correctional Service of Canada and the Nova Scotia Department of Justice, Correctional Services, consider introduction of Needle Exchange Programs (NEPs) providing access by inmates, without fear of retribution, to clean needles, tattoo/piercing equipment, and information in an easily accessible, safe, and confidential manner, perhaps through health services. It is also recommended that consideration be given to the provision to inmates of sterile needles with a bleach kit upon entry.

It is recommended that Corrections officials ensure bleach is available, not only by policy but in practice, in a confidential and readily accessible manner in both provincial and federal settings. It is further recommended that Nova Scotia Department of Justice, Correctional Services, provide bleach kits upon entry, as per their federal counterparts.

**6.2.7 Access to Safer Sex Equipment**

Offenders reported discomfort and difficulty accessing condoms and safer sex tools in federal and provincial correctional centres, largely due to the means by which they could be accessed, lack of access to sexual health services as a potential means of distribution, and the potential for punishment if caught using the tools. This is also closely tied to HIV/HCV prevention/risk reduction education so inmates are aware of and encouraged to use safer sex practices.
**Evidence**

**Condoms, Safer Sex Equipment**

The qualitative findings of studies indicate that institutional barriers and the conditions of parole currently promote unprotected sexual intercourse, increase the risk of HIV and STD transmission, and perpetuate unstable and abusive relationships. Yap, Butler and Richters studied men in the Australian prison system and reported that consensual and non-consensual male-to-male sex and male sexual assaults declined after the introduction of condoms into prisons. The authors postulate that the presence of condoms and dispensing machines in Australian prisons may have raised awareness and reinforced HIV/AIDS prevention messages.

Myers and colleagues evaluated an HIV prevention case management program for men and women leaving California prisons. The case management program consisted of a client centered needs assessment, care and treatment planning, referrals to community resources, liaison work with parole agents, and HIV risk reduction education and counselling. Participants who received case management increased abstinence or resorted to 100% condom use compared to baseline behaviour data.


**Recommendation 7: Increase Inmate Access to Safer Sex Equipment**

It is recommended that Federal and Provinicial Corrections officials/public health staff working in correctional facilities ensure condoms, oral dams, and lubricant are available and readily accessible in confidential manner to reduce transmission of HIV and sexually transmitted infections. Improvement in access to confidential sexual health services, as well as prevention education, should also improve access to safer sex supplies and resources.

**6.2.8 Access to HIV/HCV Treatment**

Although medication for HIV or HCV for inmates of the provincial correctional system is provided in-house, other treatments/assessments are provided outside the correctional institution. Focus group participants reported experiencing disruptions in their treatment when resident in provincial institutions. Concerns were also expressed about the lack of hygienic conditions in lock down or segregation units.

**Recommendation 8: Ensure Access to HIV/HCV Treatment and Enhance Measures to Support Offender Health**

It is recommended that provincial corrections staff ensure offenders receiving treatment for HIV or HCV do not experience delays or disruptions in their access to treatment so as not to undermine treatment efficacy.

It is also recommended that prison staff ensure that universal hygiene standards are employed for lock down or segregation units so as not to
jeopardize the health of individuals with HIV or compromised immune systems.

6.2.9 Access to Sexual Education and HIV/HCV Prevention Programs

Offenders acknowledged having access to HIV and HCV prevention programs, addictions programs, and a number of other programs, although programming varied among institutions. More information is needed as to the extent of HIV/HCV prevention/risk reduction programming in the provincial and Atlantic federal correctional facilities. Offenders expressed a strong preference for community-based and/or trained peer-delivered programs. Program offerings for provincially incarcerated women were particularly scarce. Evidence suggests that sexual education and prevention programs can change risk behaviour. It also suggests that peer delivered programs are more effective in producing behaviour change.

Evidence

**Sexual Education and HIV Prevention**

In a California prison setting, Wolitski and the Project START team surveyed 552 young men in an enhanced sexual education intervention. Prior to the intervention, unprotected intercourse with main partners was reported by 76% of participants and nearly half had unprotected sex with a non-main partner. After the study was over, significantly lower rates of unprotected sex were reported among inmates who received enhanced interventions compared to those who received a single-session intervention.


**Peer-based Education Programs**

Braithwaite, Stephens and Treadwell used peer educators to deliver HIV prevention messages in prison and found significant changes in reduced substance use, sexual risk taking, and higher health and condom self-efficacy. The group that received peer education experienced more significant behaviour change than the control group. Another peer-based program called Project Wall Talk observed decreases in high risk sexual activities, injection drug use, and needle sharing upon release from prison. Similarly, the U.S. peer-based Beyond Fear Program produced an increase in HIV knowledge and behaviour, positive condom attitudes, intentions regarding not sharing needles, and peer education self-efficacy. Peer education models in correctional environments appear to be educationally effective for HIV prevention.


**Recommendation 9: Improve Access to Sexual Education and HIV/HCV Prevention Programs**

It is recommended that the extent of use of community-based and peer delivered sexual education and HIV/HCV prevention programs be explored and that both federal and provincial corrections officials consider using such
approaches to improve program receptivity/effectiveness in reaching the target audience.

It is also recommended that Provincial Corrections officials seek to improve the extent of program offerings for women in prevention and substance abuse.

6.2.10 Pre-release/Discharge Planning

Pre-release planning was noted as particularly ineffective (if indeed non-existent) in the provincial correctional system. More information is needed on the discharge planning process in provincial institutions and how links are made with other provincial services to facilitate offender transitions to the community. While it is acknowledged that community-based agencies provide much support to newly released offenders, it appears that a greater role by provincial prison officials in interviewing offenders to determine their needs, informing them of services and supports available within and outside of the institution (financial support, clothing, etc.), and facilitating access to these supports and agencies prior to release would be much more effective. A “starter” information kit containing at minimum $25 for food, a list of available affordable housing options, and Department of Community Services (DCS) Office contact information was recommended by ex-offenders interviewed in this study. The provision of support from a variety of sources was cited as a critical factor in helping offenders achieve stability and a successful transition to the community. Community agencies and Department of Community Services Transition Workers were particularly helpful in this regard.

**Recommendation 10: Enhance Pre-release/Discharge Planning to Support Successful Offender Re-integration into the Community**

It is recommended that the discharge planning process in provincial correctional institutions be examined to identify areas where greater information and support could be provided to ensure inmates are better prepared for release and are able to access appropriate prevention, treatment, and other support services, thereby increasing the likelihood of success in making the transition to the community.

It is recommended that the Province of Nova Scotia consider pilot testing the practice of having Department of Community Services (DCS) transition workers enter prison facilities to assist in planning for release regarding issues of income support and housing as one model of effective planning and intervention.

It is also important to ensure corrections staff responsible for supervising offenders on release in the community understand MMT and its purpose, so as to better understand and manage offender risk factors for recidivism.
6.2.11 Engaging Stakeholders

In order to move forward with implementation of these recommendations, it will be necessary to engage the support of various stakeholders. Further discussions will be required to identify barriers and concerns that may need to be addressed as these recommendations are considered for implementation. This study did not permit exploration of existing policies, or the challenges and perspectives of Corrections staff, CDHA Offender Health Services, or others with an interest in the delivery of health/sexual health services and harm reduction approaches to offenders.

**Recommendation 11: Engage Stakeholder Support to Move Forward**

It is recommended, as a means of moving forward, that further work – such as a policy review, interviews/discussions with key informants (Corrections staff, health staff, ancillary agencies providing services to this offender population, etc.) and consultations with stakeholders – be conducted by the Nova Scotia Advisory Commission on AIDS to supplement the information in this report, to engage stakeholders in the further development of solutions to the issues raised, and to seek their support to implement the recommendations.

6.3 Conclusion

HIV and HCV infection are significant health issues facing inmate populations and are also significant public health issues as inmates originate from and return to communities. Because risk behaviours practiced by offenders before, during, and after release also pose risk for the community, effective targeted education, prevention, and harm reduction measures are critical. Correctional health is closely intertwined with public health and public safety from a crime prevention perspective. Incarceration provides a unique opportunity to arrest/change offender risk behaviours, reduce the risk of transmission of HIV and HCV, and provide access to methadone maintenance treatment for opioid dependence (and therefore reduced needle use).

Prisoners have the right to access prevention, care, treatment and support while incarcerated. Offenders should be able to access services equivalent to those available in the community including methadone maintenance treatment; needle exchanges/safer tattoo equipment; safer sex equipment; HIV/HCV prevention/harm reduction education; testing, counseling and sexual health services in a confidential environment; HIV/HCV treatment; and support services prior to release. The evidence firmly supports the efficacy of such measures in meeting public health (e.g. reduced transmission) and public safety (e.g. reduced crime) objectives. Sound public policy should be informed by and be based on solid research evidence.

Nova Scotia has formally accepted the need for a harm reduction approach and acknowledges the benefits of such an approach, as reflected in the BBP Standards which

*HIV and Hepatitis C in Correctional Facilities: Reducing the Risks*
includes reference to harm reduction in corrections settings, and as reflected in Nova Scotia’s Strategy on HIV/AIDS. These benefits (increased stability and improved health outcomes of inmates, reduced crime, reduced risk of transmission of BBPs, and others) accrue not only to inmates, but to prison staff and the public as well as offenders will be released into the community. Current practice in Corrections, particularly in provincial facilities, appears to be inconsistent with these standards.

The practice of denying access to MMT in provincial centres is not helpful; indeed, incarceration presents an unique opportunity to become stable on MMT in a controlled environment with its concomitant benefits of offender stability, reduced use of drugs/crime to acquire drugs, and reduced potential for transmission of BBPs – both inside and outside prison once the inmate is released. MMT is accepted and has been widely available in federal correctional facilities since 2002.

According to ex-offenders themselves, the provincial corrections system is ineffective in supporting offender behaviour change, reducing risk of transmission of HIV/HCV, supporting offender integration into the community upon release, and is missing opportunities to impact the health and safety, not only this population of offenders, but of the broader community.

There is also a public health imperative.

Programs undertaken to prevent the spread of HIV, HCV and other blood-borne infections will benefit prisoners, staff and the public. It will protect the health of prisoners, who should not, by reason of their imprisonment, be exposed to the risk of a deadly condition. It will protect staff; lowering the prevalence of infections in prisons means that the risk of exposure to these infections will also be lowered. It will protect the public by virtue of the fact that most inmates are in prison only for short periods and are then released into their communities.47

It is vital that people with legal responsibility for prisoners and/or for public health (elected officials, prison authorities, prison health staff, prison security staff, and provincial and local public health authorities), non-governmental and community-based organizations with a mandate to protect and promote prisoner and community health, and offenders themselves work together to ensure strategies, policies and programs are effective. This will help to ensure that various perspectives, experiences and skills are reflected.

It is also important to monitor and evaluate these policies and programs on an ongoing basis to determine whether HIV and HCV prevention and harm reduction polices are being followed and whether programs are meeting the needs they were intended to meet. Development of an accountability framework to ensure results are shared to increase transparency and accountability is a critical component of an effective response.

It is acknowledged that many of these measures constitute secondary prevention; it is also important to focus on the root causes of crime and addiction and the contributing factors to risk behaviours from a population health and social determinants of health/crime prevention point of view.

This report documents the experiences of individuals at-risk of HIV and HCV in correctional settings and identifies opportunities to reduce risk with a number of prevention and harm reduction interventions – interventions which have been tried elsewhere and which the research evidence identifies as effective. The greatest priorities voiced by focus group participants are improved access to methadone maintenance treatment and improved discharge planning in provincial correctional centres. To not proceed to implement some of the most critical of these recommendations would be a missed opportunity. The very lives of individuals are at stake.
WORKSHOP:
FOCUS GROUP– DIRECTION 180 CLIENTS

Tuesday, March 25, 2008
10:00-3:00

AGENDA

10:00  Introductions
Review of agenda, purpose, and objectives of workshop
Participant Expectations
Some “Ground Rules”

10:15  “Mapping the Journey”
Review of 3 stages
Stage 1: Arrest/charge/Remand
Stage 2: Conviction/Incarceration
Stage 3: Pre-release planning, discharge to community

12:00  Lunch

1:00  Stages/suggestions for change

2:45  Conclusion/honorariums/next steps/wrap up
1. Welcome and Introductions

Welcome. Thank you for agreeing to participate in the session today. We really appreciate the time that you’ve taken to talk with us. This is an opportunity for you to share your thoughts and experiences and have a say in the way that things are structured in the future – in hopes of improving the Corrections system and making things better for others.

On behalf of the Nova Scotia Advisory Commission on AIDS, we have been asked to explore with you some issues and experiences related to the Corrections system – both federally and provincially.

The Commission is interested in what puts people at risk and ways the system can improve the way it responds to the needs of people who are incarcerated. As people who have gone through the corrections system, you know best how these things affect people’s lives.

We hope to take the information you share with us so we can inform government and others about the problems and identify ways in which policies, programs or practices can be made better to help people with drug use problems who have been incarcerated.

No one will be identified in our report; nor will even record your name. The services you receive from Direction 180 or any other agency will not be jeopardized by your involvement with this focus group here today.

Introductions

- of participants (? if desired, respecting confidentiality, consistent with their wishes)
- facilitator
- observers

2. Review of Agenda, Purpose, Objectives of workshop

Purpose of the Workshop:

- To “map” an offender’s (PHAs, injection drug users, or those at risk of acquiring HIV/AIDS or Hepatitis C) journey through the corrections system (both federal and provincial) to identify issues and concerns and potential points of intervention where access to services or supports may be needed
  - to support offender wellness
  - re-integration into the community, and
• To reduce risk of harms associated with injection drug use, tattooing, or other risk behaviours, including the risk of transmission of HIV/AIDS or Hepatitis C.

• To identify issues, concerns, and barriers experienced by offenders, as well as proposed solutions or recommendations, associated with the following:
  o Admission to a facility – adequacy of needs assessment
  o Access to testing – HCV, HIV
  o Confidentiality
  o Safety
  o Access to harm reduction services and supports
    ▪ clean needles/syringes/drug equipment; bleach
    ▪ MMT – initiation, continuation
    ▪ condoms, dental dams, lubricant
    ▪ education and information about how HIV/HCV is spread, services available, etc.
  o Access to ancillary services – drug counseling/addictions services, income support, affordable housing, mental health, legal aid, etc.

Objectives of the Workshop:

• to obtain input from offender’s on the journey (generally) through the correctional system (distinguishing between federal and provincial systems)
• identify issues and concerns at various points throughout the system – both of general applicability and of relevance to specific populations – aboriginal, women, etc.
• identify potential solutions from an offender perspective if time permits

3. Review

• Expectations of participants – response/clarification of what will/will not be covered - “Does that fit with what you expected would be covered?”

• “Parking Lot” concept – a place for other issues not directly relevant to today’s topics but that may require further exploration or response

4. Our Expectations/Informed Consent – Some “Ground Rules”

  General
  • No personal identification - Your answers will be grouped with those of others being interviewed and will not be used to identify you in any way. A comment might be used to make a point but it will not have your name attached to it.
  • Your answers will not jeopardize or affect in any way the services you receive from this program.
  • no personal disclosures required - you can talk about inmates generally vs you specifically
- sensitivity of subject matter – we may be asking about access to harm reduction tools like clean needles and bleach and condoms BUT again it’s not you or your experience that we are interested in; rather, the experience of inmates generally; and secondly (right of refusal) you do not have to discuss it at all if you don’t want to or don’t feel comfortable – feel free to participate or not in all or some of the discussion
- availability of a counselor – if you feel disturbed or bothered by something we’ve talked about in here today, feel free to ask to talk to a Direction 180 counsellor or social worker or Cindy

Does that sound ok to you?

Group Agreement - develop these with the group and secure their agreement
- The importance of respecting confidentiality – what is said in the room should stay in the room BUT there is no guarantee of this
- distinction between anonymity and confidentiality – no one is technically anonymous here
- Avoid personal disclosure if uncomfortable – Alert participants to impossibility of guaranteeing confidentiality so confine comment to those you can live with if you heard it around town (i.e. no need for in-depth personal details);
- Sensitivity to each other
- Respect and Courtesy – wait until one person is done making the point, one can challenge or disagree but no ridiculing of people or ideas made

Solicit agreement of group on these “rules”

5. Agreement to Proceed
- Explain use of flip chart and note taker
- Questions?

Ready to proceed? Any questions?
APPENDIX C

FOCUS GROUP WITH OFFENDERS – DIRECTION 180 CLIENTS

FOCUS GROUP GUIDE

1. Thinking about your journey through the Correctional systems, can you tell me what issues you encountered or things you found difficult at:

   ARREST/CHARGE/RELEASE/REMAND

   ADMISSION TO AN INSTITUTION/INCARCERATION

   PRE-RELEASE PLANNING/DISCHARGE

   (Remember to distinguish between federal and provincial correctional systems).

2. Are people/inmates able to access:
   - methadone maintenance treatment?
   - clean needles for injection use? Bleach?
   - safer sex equipment like condoms, dental dams?
   - sterile equipment for tattoo use?
   - testing for HIV, Hepatitis C, or sexually transmitted diseases? How adequate was pre and post test counseling? How adequate was the initial assessment and classification process in identifying offender health needs?
   - health/sexual health counseling? How/by whom was it delivered?
   - education and information about how HIV/HCV is spread? How/by whom was it delivered?
   - Drug counseling/addictions services and programs, drug free units
   - Community supports and ancillary services - income support, affordable housing, mental health, legal aid, community programs – Did you have difficulty accessing services prior to and upon release? How adequate was the discharge planning process in preparing you/an inmate for release? How helpful was your parole/probation officer in helping you access needed services outside prison? Did they understand MMT/support your access to methadone?

3. Other general comments?

Thank you again for your input. We appreciate you taking the time to make this contribution. Your views are important. You will have the opportunity to review the report before submission.
SELECTED REFERENCES


Nova Scotia Advisory Commission on AIDS. **Position Paper (draft) on the Need for a Continuum of Prevention, Care, Treatment And Support Needs Of HIV+/At-Risk Corrections-Involved Individuals Transitioning to/from their Community in Nova Scotia,** 2006.


