Health care in provincial correctional facilities

Submission of the Canadian HIV/AIDS Legal Network, HALCO and PASAN
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Introduction

The **Canadian HIV/AIDS Legal Network** ("Legal Network") promotes the human rights of people living with, at risk of or affected by HIV or AIDS, in Canada and internationally, through research and analysis, litigation and other advocacy, public education and community mobilization. The Legal Network has been involved in extensive government and community consultations regarding a wide range of legal and policy issues related to HIV, and has developed particular expertise on prison law and policy, especially as they relate to people who are at risk of HIV and hepatitis C virus (HCV) infection as a result of injection drug use.

The **HIV & AIDS Legal Clinic Ontario (HALCO)**, founded in 1995, is a community legal clinic serving the legal needs of low-income people in Ontario who are living with HIV. It is the only such organization in Canada. The clinic is governed by a board of directors, the majority of whom must be persons living with HIV. In addition to providing direct legal services, HALCO staff engage in public legal education, law reform, and community development initiatives. Since 2001, HALCO has responded to almost 900 correctional law-related legal issues, including matters related to health care services and segregation. HALCO, along with the Legal Network and PASAN, intervened in *Simpson v. Ontario (Community Safety and Correctional Services)*, HRTO File Number 2015-19800-I (resolved without a hearing), a matter before the Human Rights Tribunal of Ontario involving discriminatory segregation in a provincial correctional institution. In addition, HALCO has participated in a number of health fairs in correctional institutions across Ontario, and acted as counsel in three inquests related to deaths of persons with HIV in correctional institutions.

Prisoners with HIV/AIDS Support Action Network (PASAN) was formed in 1991 as a grassroots response to HIV in the Canadian prison system. It is the only community-based organization in Canada exclusively providing HIV and HCV prevention, education and support services and whole health and harm reduction education to prisoners, ex-prisoners and their families, including those in Ontario provincial institutions.

We appreciate the opportunity to comment on health care in Ontario provincial correctional facilities and to draw the attention of the Ministry of Health and Long-Term Care and the Ministry of Community Safety and Correctional Services ("Ministries") to certain elements of health care in Ontario prisons, which are relevant from the perspective of human rights, public health and health equity.

The health of prisoners is a public health concern. Prisoners come from the community, and the vast majority return to it. Everyone in the prison environment — prisoners, prison staff and service providers — also benefits from enhancing the health of incarcerated patients. Yet, according to the Office of the Ombudsman for Ontario, over half of almost 4000 complaints received from those incarcerated in Ontario's adult correctional facilities in 2016–2017 involved significant concerns about health care, including access to doctors or specialists, delays in receiving certain types of treatment or problems in receiving medication.[1] Similarly, in 2015–2016, more than 60% of over 4000 complaints from those in custody related to problems with health care, including a lack of access to particular medications or to medical staff and treatment.[2]

It is a well-established legal principle that prisoners do not surrender their rights upon incarceration, but instead retain all rights subject to the restrictions that are unavoidable in a prison environment. Prisoners are entitled to enjoy the highest attainable standard of health as guaranteed under international law, and prison health care should be equivalent to that available in the community. As such, the following recommendations to improve health care in Ontario provincial correctional facilities are a matter of ethical and legal obligation under human rights legislation, the *Canadian Charter of Rights and Freedoms* ("Charter") and international human rights guidance on health care in prison settings.

1. How can we improve health outcomes for detained and incarcerated patients?

I. Substance use and harm reduction

As your Ministries are well aware, to a great extent, prisons are home to people who have been socially marginalized, including people who are dependent on drugs. Despite sustained efforts to prevent drug use by people in prison, the reality is that drugs can and do enter prisons. According to Canada's former federal correctional investigator, "There has never been a prison that I am aware of anywhere in the world that has been able to be contraband-free, including illicit drugs. Canada does not stand alone in that challenge."[3]

In a criminal justice environment where the majority of people report recent drug use at the time of admission to custody and there are high rates of substance use disorders among people in jails and prisons,[4] it should come as no surprise that **many prisoners use drugs, often by injection** — a fact confirmed by numerous studies.[5] For example, in one study of 500 adult males in a provincial detention centre in Ontario, more than 56% of participants reported use of opioids, cocaine, crack or

[1] Ombudsman Ontario, *2016-2017 Annual Report*, Office of the Ombudsman of Ontario, July 27, 2017. Available at www.ombudsman.on.ca/Files/sitemedia/Documents/Resources/Reports/Annual/AR2017-EN-Final.pdf.
[2] Ombudsman Ontario, *2015-2016 Annual Report*, Office of the Ombudsman of Ontario, November 2, 2016. Available at www.ombudsman.on.ca/Files/sitemedia/Documents/Resources/AR%202015-2016/1718-OmbudAR-ENG-Web_1.pdf.
[3] Testimony of Mr. Howard Sapers, Correctional Investigator of Canada, Office of the Correctional Investigator to the Standing Committee on Public Safety and National Security, 1st session, 42nd Parliament, May 31, 2016.
[4] F. Kouyoumdjian et al., "Physician prescribing of opioid agonist treatments in provincial correctional facilities in Ontario, Canada: A survey," *PLoS ONE* 13(2) (2018): e0192431.
[5] See, for example, E. van der Meulen, "'It Goes on Everywhere': Injection Drug Use in Canadian Federal Prisons," *Substance Use & Misuse*, February 22, 2017, and D. Zakaria et al., *Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey*, Correctional Service of Canada, March 2010.

methamphetamine in the previous year and 12.2% had injected drugs.[6] Evidence from Ontario further reveals that the risk of death from overdose is high among prisoners compared to the general population, especially at the time of release.[7] In light of this correctional environment, we provide a number of recommendations for specific programs that would alleviate concerns under human rights legislation and the Charter, improve health outcomes for detained and incarcerated patients in the area of infectious disease and substance use, and that would also promote health equity among the disproportionate number of Indigenous and racialized prisoners in Ontario provincial correctional facilities.

a. Prison-based needle and syringe programs (PNSPs)

Because of the scarcity of injection equipment in prison, prisoners who inject drugs are more likely to share injecting equipment than in the community, thereby increasing their risk of contracting HIV and HCV. As in many other countries, the extent of injection drug use in Canada's prisons has led to significantly higher rates of HIV and HCV among prisoners than in the community as a whole. Studies suggest that about 30% of those in federal facilities and 15% of men and 30% of women in provincial facilities are living with HCV, and 1–2% of men and 1–9% of women are living with HIV.[8] Indigenous prisoners, in particular, have much higher rates of HIV and HCV than non-Indigenous prisoners. Indigenous women in federal prisons, for example, are reported to have rates of HIV and HCV of 6.03% and 44.8%, respectively.[9] At the same time, an estimated 45% of new HIV infections among Indigenous Peoples are attributed to injection drug use — more than four times the estimate for the population as a whole.[10]

Programs that ensure access to sterile injecting equipment are therefore an important component of a comprehensive approach to reducing the vulnerability of prisoners to HIV and HCV infection. The best available evidence strongly suggests that in countries where prison-based needle and syringe programs (PNSPs) exist, such programs

- reduce risk behaviour and infection;
- reduce overdose;
- do not increase drug consumption or injecting;
- do not endanger staff or prisoner safety;
- have other positive outcomes for the health of people in prison, including increasing referrals of users to drug treatment programs; and
- have been successfully introduced in various prison environments, including custodial settings for detainees on remand.

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[6] F. Kouyoumdjian et al., "Drug use prior to incarceration and associated socio-behavioural factors among males in a provincial correctional facility in Ontario, Canada," *Canadian Journal of Public Health* 105(3) (May 9, 2014):e198-202.

[7] Supra note 4.

[8] F. Kouyoumdjian et al., "Health status of prisoners in Canada," *Canadian Family Physician* 62(3) (March 2016): 215–222.

[9] CSC, *Health Services Quick Facts: Human Immunodeficiency Virus (HIV) Age, Gender and Indigenous Ancestry*, September 2016 and CSC, *Health Services Quick Facts: Hepatitis C Virus (HIV) Age, Gender and Indigenous Ancestry*, September 2016.

[10] Public Health Agency of Canada, *Summary: Estimates of HIV Incidence, Prevalence and Proportion Undiagnosed in Canada*, 2014.

These findings were confirmed in *Prison Needle Exchange: Review of the Evidence*, a 2006 review by the Public Health Agency of Canada (PHAC) undertaken at the request of the Correctional Service of Canada (CSC),[11] and again in 2015 in *Needle Exchange Programs in a Correctional Setting: A Review of the Clinical and Cost-Effectiveness* by the Canadian Agency for Drugs and Technologies in Health (CADTH), a federal, provincial and territorial government agency tasked with reviewing and making recommendations on health technologies.[12] PNSPs have also been recommended by organizations including the Ontario Medical Association,[13] the Canadian Medical Association,[14] the Canadian Human Rights Commission,[15] the Correctional Investigator of Canada[16] and UN agencies including the World Health Organization (WHO), the Joint UN Programme on HIV/AIDS (UNAIDS) and the UN Office on Drugs and Crime (UNODC).[17] Notably, PNSPs are considered by a diverse body of UN agencies as one of 15 "key interventions" for HIV prevention in prisons[18] and there is guidance from both the UNODC and Canadian research on how to implement these essential programs.[19]

Failing to implement PNSPs places prisoners who inject drugs — arguably individuals with the most severe drug dependence — at risk of HIV, HCV and other bacterial and viral infections, many of whom may have relied on needle and syringe programs in the community prior to their incarceration. Undoubtedly, Indigenous prisoners are disproportionate affected by this failure because they are overrepresented in correctional facilities and, as noted above, are four times more likely to be infected with HIV as a result of injection drug use. This denial of health care also aggravates public health by contributing further to the harms associated with unsafe drug use. The provision of sterile injection equipment to people in prison benefits not only the prisoners who use drugs, but also other prisoners and prison staff who face much lower risk of accidental needle-stick injuries in a regulated needle and syringe distribution program. Such programs also benefit the public as a whole, by lowering the considerable expense of HIV and HCV treatment.

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[11] Public Health Agency of Canada, *Prison needle exchange: Review of the evidence, report prepared for Correctional Service of Canada*, April 2006.

[12] Canadian Agency for Drugs and Technologies in Health, *Needle Exchange Programs in a Correctional Setting: A Review of the Clinical and Cost-Effectiveness*, September 3, 2015.

[13] Ontario Medical Association, *Improving our Health: Why is Canada Lagging Behind in Establishing Needle Exchange Programs in Prisons? A Position Paper by the Ontario Medical Association*, October 2004.

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

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

[16] See Annual Reports of the Correctional Investigator 2003–2004, 2005–2006, 2006–2007, 2009–2010 and 2015–2016.

[17] See OHCHR and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, *Consolidated Version*, UN Doc. HR/PUB/06/9, 2006, Guideline 4 at para. 21(e); WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*, 1993, Guideline 24; WHO*, Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector*, 2008; and UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response*, 2006, Recommendation no. 60.

[18] UNODC, ILO, UNDP, WHO and UNAIDS, *HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions*, 2013.

[19] See, for example, UNODC, *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings*, 2014. Available at www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/ADV_COPY_NSP_PRISON_AUG_2014.pdf and Ryerson University Department of Criminology, Canadian HIV/AIDS Legal Network, PASAN, *On point: Recommendations for prison-based needle and syringe programs in Canada*, 2016. Available at www.aidslaw.ca/site/on-point-recommendations-for-prison-based-needle-and-syringe-programs-in-canada/?lang=en.

b. Opioid substitution treatment (OST)

Opioid substitution treatment (OST) or opioid agonist therapy (OAT) is an evidence-based and cost-effective treatment for the management of opioid dependence. In prisons, OST has proven "effective in reducing the frequency of injecting drug use and associated sharing of injecting equipment" while "reducing drug-seeking behaviour and thus improving prison safety."[20] Recent studies have also found that providing prisoners with OST during incarceration is associated with a reduced risk of death after release from prison.[21] As the WHO, UNODC and UNAIDS have recommended, "[p]rison authorities in countries in which OST is available in the community should introduce OST programmes urgently and expand implementation to scale as soon as possible."[22] These same agencies also consider OST in prison to be one of 15 "key interventions" for HIV prevention in prisons.[23]

In Ontario, a provincial Methadone Treatment and Services Advisory Committee recommended in 2016 that the Ministry of Community Safety and Correctional Services "work with the treatment community to address … barriers and ensure that prisoners with [opioid use disorder] have access to OAT treatment at any point during their involvement with the criminal justice system — before, during, and immediately after their incarceration" while the Ministry of Health and Long-Term Care work with service providers where OST patients reside, including correctional facilities, to ensure that "patients on opioid agonist therapy are able to continue treatment in an uninterrupted fashion when admitted; and they provide rapid access to opioid agonist therapy, when clinically indicated or if requested by the patient at any point during their treatment."[24]

Increasing access to OST within Ontario's provincial prisons is especially pressing in light of the prevalence of substance use, and in particular opioid use, and increasing reports of overdose and overdose fatalities behind bars.[25] Yet research has identified and described multiple barriers that must be addressed to promote continuation and initiation of OST in Ontario correctional facilities, including lack of linkage with community-based providers and Ministry of Community Safety and Correctional Services' policy and procedures.[26] Prisoners have noted, for example, that unless an individual is already on OST prior to incarceration, there is no formal process to initiate treatment unless they are pregnant

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[20] WHO, UNODC and UNAIDS, *Evidence for Action Technical Papers: Interventions to address HIV in prisons: drug dependence treatments*, 2007.

[21] J. Marsden et al., "Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England," *Addiction* 112(8) (2017):1408–18. pmid:28160345 and L. Degenhardt et al., " The impact of opioid substitution therapy on mortality post-release from prison: retrospective data linkage study," *Addiction* 109(8) (2014):1306–17. pmid:24612249.

[22] UNODC, ILO, UNDP, WHO and UNAIDS, *HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions*, 2013.

[23] Ibid.

[24] Methadone Treatment and Services Advisory Committee, *Final Report*, June 9, 2016. Available at http://health.gov.on.ca/en/public/programs/drugs/ons/docs/methadone_advisory_committee_report.pdf.

[25] F. Pan, "'Lots of drugs' in Hamilton Barton Street jail, former inmate testifies at inquest," *CBC*, April 20, 2018. Available at www.cbc.ca/news/canada/hamilton/hamilton-jail-overdose-inquest-acheson-kenneth-albert-1.4629144.

[26] Supra note 4. Further, an Ontario Ministry of Correctional Services, *Health Care Services Policy and Procedures, Methadone HCV 01 21 01*, October 1999 provides only for the possibility of OST initiation for pregnant prisoners: "Based on a clinical decision, an opiate dependent pregnant inmate not already on a methadone maintenance programme may be considered for initiation for methadone."

and opioid-dependent.[27] This omission is unacceptable given the acute medical need. Your Ministries must (i) introduce a formal policy to initiate prisoners on OST based on community standards; (ii) ensure there are sufficient staff and resources to safely manage OST programs in Ontario correctional facilities; and (iii) ensure greater support for OST programs from institutional health care and administrative staff. For people with opioid use disorder, OST is essential health care and can mean life or death. It must be provided to everyone in custody who needs it.

c. Naloxone

There is an opioid crisis in Canada. In 2017, over 4000 people in Canada died from opioid-related causes, including over 1000 in Ontario alone.[28] As in the community as a whole, a growing number of prisoners in Ontario correctional facilities are overdosing — sometimes fatally — behind bars.[29]

Naloxone can temporarily reverse an opioid overdose and is an exceedingly safe medication. Moreover, a growing body of evidence supports widespread access to naloxone as a means of reducing the toll of the opioid crisis,[30] leading Health Canada to reclassify its status in March 2016 and make it available without a prescription.[31] As a result, since June 2016 participating Ontario pharmacies have offered free injectable naloxone to Ontario residents with a health card.[32] Effective March 27, 2018, all Ontario pharmacies have been able to also dispense intra-nasal naloxone spray and injectable naloxone (including to people without an Ontario health card or who do not wish to provide identification) through the Ontario Naloxone Pharmacy Program.[33]

While we applaud these positive steps in the community, prisoners in Ontario correctional facilities do not receive the same standard of care. Naloxone is only accessible to health care staff and in seemingly limited circumstances, to correctional officers.[34] Prisoners are not permitted to have naloxone kits inside

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[27] Supra note 25 and F. Pan, "Jail inquest exposes overcrowding, limited monitoring and little access to methadone," *CBC*, April 10, 2018. Available at http://www.cbc.ca/news/canada/hamilton/hamilton-jail-overdose-death-inquest-day-2-1.4613648.

[28] P. Loriggio, "New data show spike in Ontario opioid deaths in 2017," *Globe and Mail*, March 7, 2018. Available at www.theglobeandmail.com/news/national/new-data-show-spike-in-ontario-opioid-deaths-in-2017/article38233469/.

[29] Supra note 25 and P. White, "Spike in inmate deaths raises questions around opioid crisis in Ontario's prisons," *Globe and Mail*, March 11, 2018. Available at www.theglobeandmail.com/news/national/serious-questions-remain-five-months-after-mans-suspected-overdose-in-ontario-jail/article38274018/.

[30] A. Cressman et al., "Availability of naloxone in Canadian pharmacies: a population-based survey," *CMAJ* 5 (November 8, 2017):E779-E784.

[31] Health Canada Prescription Drug Status Committee, *Notice: Prescription Drug List (PDL): naloxone*, 2016. Available at www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/prescription-drug-list/notice-naloxone.html.

[32] Ontario Public Drug Programs Division, *Ontario Naloxone Program for Pharmacies (ONPP) Frequently Asked Questions for Pharmacy Dispensers: Providing Publicly Funded Naloxone Kits and Claims Submission Using the Health Network System*, May 12, 2017. Available at www.health.gov.on.ca/en/pro/programs/drugs/opdp_eo/notices/fq_exec_office_20160817.pdf.

[33] Ministry of Health and Long-Term Care Ontario Public Drug Programs, *Notice from the Executive Officer: Funding of Naloxone Nasal Spray through the ONPP and Updates to the Existing Program*, March 21, 2018. Available at www.health.gov.on.ca/en/pro/programs/drugs/opdp_eo/notices/exec_office_20180321.pdf.

[34] R. Richmond, "Corrections officers get naloxone training," *London Free Press*, January 10, 2018. Available at http://lfpress.com/2018/01/10/corrections-officers-get-naloxone-training/wcm/eaa37b9d-758d-642e-886e-77067a18b10a.

their cells, in the event their cellmates suffer an opioid overdose. Ontario inmates are only given nasal spray naloxone kits when they are released from custody.[35]

Correctional health care staff will not always be immediately available in overdose situations, yet the time taken to respond to an opioid overdose can mean the difference between life and death. Training all prisoners on naloxone administration and ensuring all prisoners have access to naloxone kits (including nasal naloxone sprays) in their cells will save lives. Incarceration should not be a death sentence for people who use drugs.

Recommendations:
In order to uphold ethical and legal obligations under human rights legislation and the Charter and meaningfully address health outcomes for detained and incarcerated patients who use drugs, we urge your Ministries to immediately undertake the following in all Ontario correctional facilities:

- implement needle and syringe programs;
- scale up opioid substitution therapy, including initiation according to community standards for all prisoners who require it; and
- ensure direct access to naloxone for all prisoners.

Appropriate resources must be devoted to the above. Planning and implementation must take place in consultation with prisoner groups and community health organizations — and take into account the need for culturally appropriate and gender-specific programs — to ensure operational success.

II. Incarcerated patients living with HIV

a. Stigma and discrimination

As noted above, studies suggest that about 1–2% of men and 1–9% of women in federal and provincial institutions are living with HIV.[36] Unfortunately, people living with HIV or AIDS continue to experience stigma and discrimination, arising from fear and ignorance about the disease and/or hostility and existing prejudices about the groups most affected by it (e.g., gay men, people who inject drugs, Indigenous communities, migrant communities). Attitudes and opinions toward people living with HIV were most recently assessed in a national study in 2012.[37] Many people in Canada still report feeling uncomfortable having contact with a person with HIV or AIDS.[38] Twenty-four percent would be somewhat or very uncomfortable wearing a sweater previously worn by someone with HIV, while 49% say that they would feel uncomfortable using a restaurant drinking glass once used by a person living with HIV.[39] These attitudes persist behind bars, driven in part by widespread ignorance and unfounded fears about the risk of HIV transmission.

[35] Ontario, *Recognize and temporarily reverse an opioid overdose*, March 16, 2017. Available at www.ontario.ca/page/get-naloxone-kits-free#section-1.
[36] Supra note 8.
[37] EKOS Research Associates, *2012 HIV/AIDS Attitudinal Tracking Survey: Final Report*, October 2012. Available at http://www.catie.ca/sites/default/files/2012-HIV-AIDS-attitudinal-tracking-survey-final-report.pdf.
[38] Ibid.
[39] Ibid.

Our organizations are aware of a number of reports of prisoners being shunned by other prisoners and correctional staff as a result of their HIV-positive status. The Ontario Human Rights Commission recognizes that HIV and related medical conditions are disabilities under the Ontario *Human Rights Code* and persons who have or are believed to have HIV are protected from discrimination and harassment.[40] Treating prisoners living with HIV differently, and in some cases going so far as to segregate prisoners on the basis of their HIV status can constitute discrimination. Prisoners should not be segregated, including based on their HIV status. As the 2017 report on Segregation in Ontario by the Independent Review of Ontario Corrections noted, "the decision to place a person in segregation results in the most complete deprivation of liberty authorized by law," yet "segregation is the default tool to manage individuals" — including those "individuals who feel unsafe when left alone in general population units."[41] In keeping with the Review's recommendations, your Ministries must take steps to significantly limit and ultimately end the use of administrative segregation. In the short term, prisoners should only be segregated in the most exceptional circumstances, such as when they request it themselves. When segregation does take place pending its elimination, procedural protections must be put in place, in line with the recommendations of the above Review.

Recommendation:
In order to uphold ethical and legal obligations under human rights legislation and the Charter, we urge your Ministries to consult with community groups, including AIDS service organizations, and:

- develop HIV-related evidence-based resources and trainings, including those that dispel myths about HIV and its modes of transmission, and provide these resources and training to all correctional staff and prisoners; and

- ensure that prisoners are not segregated, including based on their HIV status, in the absence of the most exceptional circumstances or as a last resort.

b. Continuity of care

The transition from community to prison and from prison to community poses additional challenges for people living with HIV, who must contend with disruptions to their HIV treatment, care and support. Most incarcerated patients with HIV eventually return to their communities, yet programs to facilitate re-engagement with health and social services at the time of transition are often not available. As noted above, a frequent complaint made by those incarcerated in Ontario's adult correctional facilities to the Office of the Ombudsman for Ontario involve concerns about access to doctors or specialists, delays in receiving certain types of treatment and problems in receiving medication.[42] In particular, research has found incarceration to be associated with non-adherence to, interruptions in or discontinuation of HIV treatment.[43] Not only does this affect the health of an incarcerated patient, including increased morbidity and mortality and the development of drug resistance, but disruptions in HIV treatment pose

[40] Ontario Human Rights Commission, *Policy on HIV/AIDS-related discrimination*, November 27, 1996. Available at www.ohrc.on.ca/so/node/2454.
[41] Independent Review of Ontario Corrections, *Segregation in Ontario*, March 2017. Available at www.mcscs.jus.gov.on.ca/english/Corrections/IndependentReviewOntarioCorrections/IndependentReviewOntarioCorrectionsSegregationOntario.html#recommendations.
[42] Ombudsman Ontario, *2016-2017 Annual Report*, Office of the Ombudsman of Ontario, July 27, 2017 and Ombudsman Ontario, *2015-2016 Annual Report*, Office of the Ombudsman of Ontario, November 2, 2016.
[43] W. Small et al., "The impact of incarceration upon adherence to HIV treatment among HIV-positive injection drug users: a qualitative study," *AIDS Care* 21(6) (2009):708-714.

additional risks to public health, since HIV treatment is a highly effective strategy for preventing HIV transmission.

Recommendation:
We urge your Ministries to work with community organizations, medical experts and health care providers to ensure that measures are taken to ensure continuity of HIV treatment (and other medical care) in Ontario provincial correctional facilities and guarantee access to HIV care, treatment and support.

III. Other health care issues of relevance to infectious disease

a. Safer tattooing

In 2006, a group of Ontario researchers reported on prevalence and predictors of HIV and HCV in Ontario jails and detention centres.[44] 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. Among the behaviours that participants reported having engaged in during a previous period of incarceration, tattooing was the most prevalent (21% of adults; 43% of youth). As one 2016 study of Ontario prisoners further noted, "Sharing needles and tattooing and piercing equipment, including in custody, likely contributes to … high rates [of blood-borne infection]".[45] Despite this, Ontario prisons have not implemented a program to address the potential transmission of HIV and HCV through tattooing.

Safer tattooing in prison has been piloted and evaluated in Canada. In 2005, CSC piloted a Safer Tattooing Practices Initiative, which saw the implementation of tattoo rooms in six federal institutions, including one men's institution in Bath, Ontario. A subsequent CSC evaluation measuring outcomes of the Initiative concluded that it demonstrated the potential to reduce harm and exposure to health risk, including HIV and HCV infection, as well as to enhance the health and safety of staff, prisoners and the general public — all while resulting in long-term cost savings.[46] The same evaluation also demonstrated that the program provided important employment opportunities for prisoners and marketable skills upon release into the community.[47] Although the federal government eventually terminated the Initiative claiming that it was not cost-effective, the evaluation itself did not bear this out.[48] Initiatives to prevent HIV and other infections in prison by reducing the reuse of equipment used for tattooing, piercing and other forms of skin penetration have also been recommended by numerous UN agencies.[49] More recently, there have been renewed calls from the Office of the Correctional Investigator to re-introduce safer tattooing sites in federal prisons.[50]

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[44] L. Calzavara et al., *Prevalence and Risk Factors for HIV and Hepatitis C in Ontario's Jails and Detention Centres (2003-2004)*, University of Toronto, 2006.
[45] Supra note 8.
[46] M. Nakef, *Correctional Service Canada's Safer Tattooing Practices Pilot Initiative*, CSC, January 2009. Available at www.csc-scc.gc.ca/text/pa/ev-tattooing-394-2-39/index-eng.shtml.
[47] Ibid.
[48] W. Kondro, "Prison tattoo program wasn't given enough time," *CMAJ* 176 (3) (January 30, 2007): 307-308. Available at www.cmaj.ca/content/176/3/307.
[49] UNODC, ILO, UNDP, WHO and UNAIDS, *HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions*, 2013.
[50] Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2016-2017*, June 28, 2017. Available at www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20162017-eng.aspx#s2. See also Office of the

Recommendation
In order to meaningfully address health outcomes for detained and incarcerated patients, we urge your Ministries to consult with prisoner groups and community health organizations and undertake to implement safer tattooing programs in all Ontario correctional facilities, taking into account the need for culturally appropriate and gender-specific programs to ensure operational success.

b. Access to pain management medication

People living with HIV are more likely to suffer from chronic, disabling pain.[51] Yet, in general, prisoners who seek effective pain medications, including medications prescribed for them in the community, may get labelled by correctional or health care staff as "drug-seeking" and are treated with suspicion.[52] Over the past two decades, appropriate pain management has been recognized as a fundamental human right by health, human rights and prisoner advocates and as a legal obligation owed to prisoners by governments.[53]

In our experience, access to medications to treat pain continues to be a significant problem experienced by prisoners in Ontario correctional facilities. While there may be safety and security concerns with prescribing and dispensing of opioid-based and other controlled medications — in the community and in prison settings — prison officials cannot rely on security concerns to deny prisoners' right to essential health care, including access to appropriate treatment for pain. Prisoners living with HIV should not be denied access to pain medications for non-clinical reasons except where prison authorities can demonstrate that safety concerns cannot be addressed without causing "undue hardship," which is the legal standard imposed under Ontario's *Human Rights Code*. Evidence-based clinical practice guidelines for the management of chronic non-cancer pain and chronic pain in people living with HIV have recently been published.[54] The inappropriate withholding of pain medications from prisoners cannot be justified and amounts to an infringement of prisoners' Charter and human rights.

Recommendation
We urge your Ministries to work with community organizations, medical experts and health care providers, to ensure that measures are taken to safeguard access to pain management medication in

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Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2015-2016*, June 30, 2016. Available at www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20152016-eng.aspx.

[51] C.O Cunnigham, "Opioids and HIV Infection: From Pain Management to Addiction Treatment," *Topics in Antiviral Medicine*, 2018 Apr;25(4):143-146. Available at www.ncbi.nlm.nih.gov/pubmed/29689538; J.S. Merlin et al, "Cost-effectiveness of a chronic pain intervention for people living with HIV (PLWH)," *Journal of Medical Economics,* 2018 Feb;21(2):122-126. Available at www.ncbi.nlm.nih.gov/pubmed/28880698; J.S. Merlin, "Chronic Pain in Patients with HIV: What Clinicians Need to Know," *Topics in Antiviral Medicine*, 2015 Aug-Sep;23(3):120-4.. Available at www.ncbi.nlm.nih.gov/pubmed/26518396.

[52] T. M. Watson, "A Painful Situation: Access to Medication in Prisons," Canadian Drug Policy Coalition. Available at http://drugpolicy.ca/blog/2015/02/a-painful-situation-access-to-medication-in-prisons/

[53] F. Brennan et al, "Access to Pain Management —Still Very Much a Human Right," *Pain Medicine*, Volume 17, Issue 10 (2016): pp. 1785–1789. Available at https://academic.oup.com/painmedicine/article/17/10/1785/2270355

[54] R. D. Bruce et al, "2017 HIV Medicine Association of Infectious Diseases Society of America Clinical Practice Guideline for the Management of Chronic Pain in Patients Living With Human Immunodeficiency Virus," *Clinical Infectious Diseases: an official publication of the Infectious Diseases Society of America,* 2017 Oct 30;65(10):1601-1606. Available at www.ncbi.nlm.nih.gov/pubmed/29091230 and J. W. Busse et al, "Guideline for opioid therapy and chronic noncancer pain," *CMAJ,* May 08, 2017 189 (18) E659-E666. Available at www.cmaj.ca/content/189/18/E659.

Ontario provincial correctional facilities, in accordance with evidence-based clinical practice guidelines for the management of chronic pain.

2. What improvements need to be made to the correctional health system?

As noted above, access to health care in correctional institutions is a human right. Under Canadian and international law, prisoners deserve the same level of care and protection available to people outside prison, and their right to health includes having access to tools to protect themselves from infection. In particular, the "principle of equivalence" entitles people in detention to have access to a standard of health care equivalent to that available outside prison, including preventive measures comparable to those available in the general community. The right of people in prison to access health care equivalent to that available in the community is reflected in declarations and guidelines from WHO,[55] UNODC[56] and UNAIDS,[57] and most recently in the *UN Standard Minimum Rules for the Treatment of Prisoners* (the "Nelson Mandela Rules"), which call for health care services to be organized "in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence."[58] Of particular relevance to the harm reduction measures recommended above, the former UN Special Rapporteur on the right to health has stated, "If harm reduction programmes and evidence-based treatment are made available to the general public, but not to persons in detention, that contravenes international law."[59] Going further, the former Special Rapporteur noted that "in the context of HIV and harm reduction, this demands implementation of harm reduction services in places of detention *even where they are not yet available in the community*, as the principle of equivalence is insufficient to address the epidemic among prisoners" [emphasis added].[60]

To ensure prisoners enjoy a standard of health care that is at least equivalent to that which is available outside of correctional institutions, the principle of equivalence should be explicitly articulated in the *Correctional Services Transformation Act*, 2018. In order for incarcerated patients to receive "patient-centred, equitable health care services" that address their "health needs and promote their well-being," your Ministries have a legal and ethical obligation to provide care that conforms to professionally accepted standards and is equivalent to services provided in the community. This should be specified in the legislation.

Moreover, as other organizations, including the Correctional Health Care Coalition (of which the Legal Network and PASAN are members) has already recommended, it is vital to continue the process of transferring responsibility for health care services from the Ministry of Community Safety and Correctional Services to the Ministry of Health and Long-Term Care, with full implementation by the end

[55] WHO, *WHO Guidelines on HIV Infection and AIDS in Prisons*.
[56] UNODC, WHO and UNAIDS, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings*.
[57] UNAIDS, "Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996," in *Prison and AIDS: UNAIDS Point of View* (Geneva: UNAIDS, 1997), p. 3.
[58] UN General Assembly Resolution A/RES/70/175, *UN Standard Minimum Rules for the Treatment of Prisoners*, 17 December 2015, Rule 24(2).
[59] A. Grover, UN Special Rapporteur on the Right to the highest attainable standard of physical and mental health, *Report of the UN Special Rapporteur on the Right to the highest attainable standard of physical and mental health*, UN Doc. A/65/255 (August 6, 2010), para. 60.
[60] A. Grover and R. Lines, "From equivalence of standards to equivalence of objectives: the entitlement of prisoners to health care standards higher than those outside prisons," *International Journal of Prisoner Health* 2,4 (2006): 269–280.

of 2019. The preamble of the *Correctional Services Transformation Act*, 2018 includes, among other principles, that the people of Ontario and their Government "affirm our obligation to provide safe and humane custody and care, including through the provision of adequate conditions of confinement and appropriate, patient-centred, equitable health care services that respect clinical independence and provide continuity of care with services provided in the community." To comply with this obligation, Ontario should learn from the experience of correctional reform in other jurisdictions including British Columbia, Alberta and Nova Scotia. Among other things, a transfer of responsibility for health care services would promote the principle of equivalence, clinical independence, and continuity of care for incarcerated patients.

Recommendations:
Broad improvements to correctional health care require a legislative and governance framework that upholds the right of incarcerated patients to the highest attainable standard of health. To help meet that legal and ethical obligation, we urge your Ministries to:

- include a provision in the *Correctional Services Transformation Act*, 2018 that refers to the principle of equivalence, entitling people in detention to have access to a standard of health care equivalent to that available outside prison and conforms to professionally accepted standards, including preventive measures comparable to those available in the general community; and

- continue the process of transferring responsibility for health care services from the Ministry of Community Safety and Correctional Services to the Ministry of Health and Long-Term Care, with full implementation by the end of 2019.