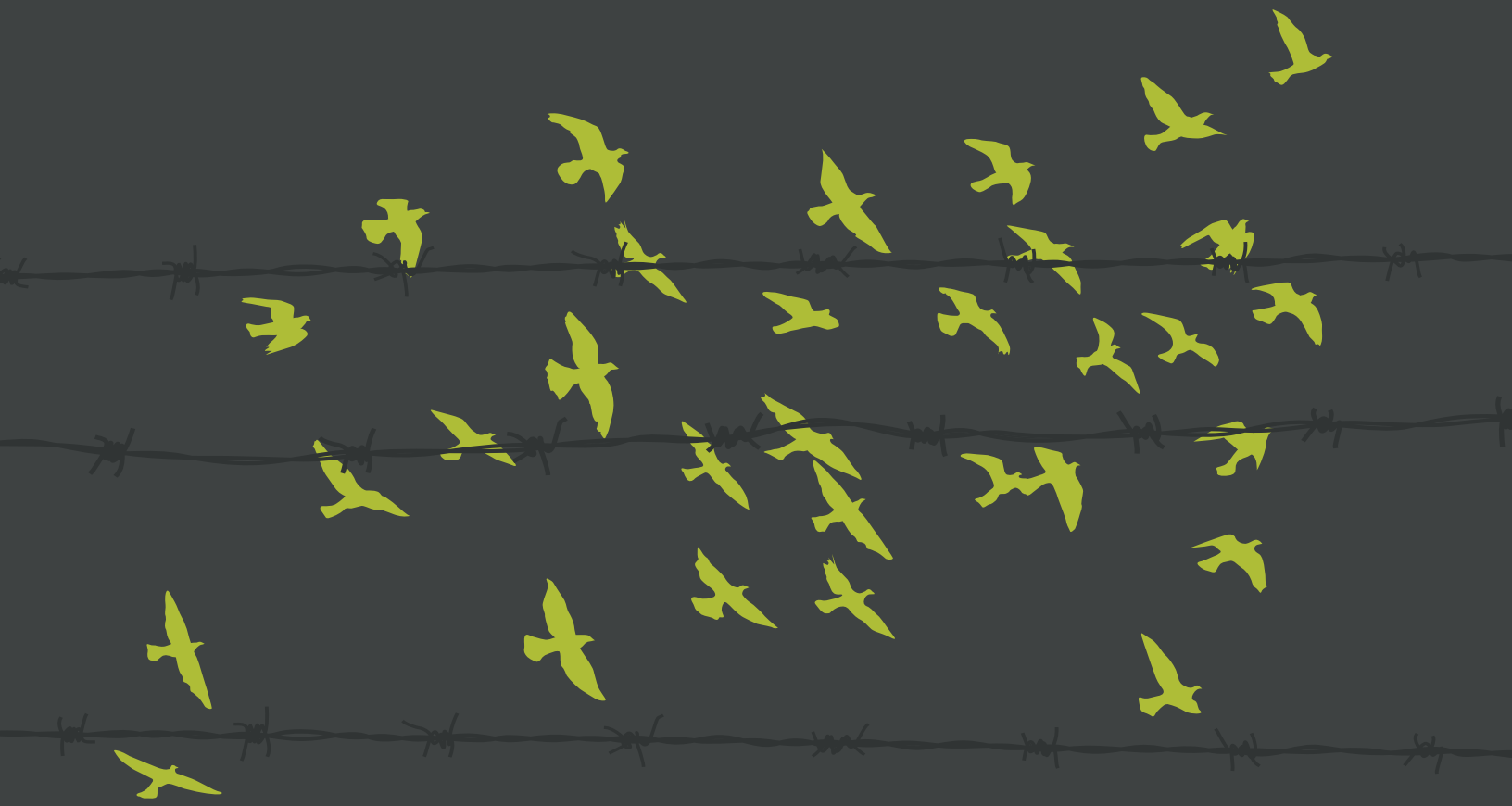
HARD TIME PERSISTS

HEALTHCARE AND HARM REDUCTION IN CANADA'S PRISON SYSTEM



HIV LEGAL NETWORK
RÉSEAU JURIDIQUE VIH

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About the HIV Legal Network

The HIV Legal Network promotes the human rights of people living with HIV or AIDS and other populations disproportionately affected by HIV, punitive laws and policies, and criminalization, in Canada and internationally. We do this through research and analysis, litigation and other advocacy, public education, and community mobilization.

The HIV Legal Network works on the land now called Canada, which is located on treaty lands, stolen lands, and unceded territories of Indigenous groups and communities who have respected and cared for this land since time immemorial. We work to address the ongoing injustices and resulting health inequities faced by Indigenous Peoples. They contribute to the disproportionate impact of the HIV epidemic on Indigenous communities and the mass incarceration of Indigenous people in the prison system. We are committed to learning to work in solidarity and to dismantling and decolonizing practices and institutions to respect Indigenous Peoples and Indigenous ways of knowing and being.

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Introduction

Incarcerated people have a right to health — they are entitled to healthcare that is at least equivalent to that which is available in the community.[1]

Yet, in Canada, that right is not consistently respected or protected. Incarcerated people are regularly denied healthcare, including tools to protect themselves from known risks. As a result, their health suffers, with implications for public health, as the vast majority of people in prison return to their communities.

In 2007, the HIV Legal Network (Legal Network) published *Hard Time: HIV and Hepatitis C Prevention Programming for Prisoners in Canada,* exploring health and harm reduction policies and practices in Canada's provincial, territorial, and federal prisons.[2] Then, as now, the Legal Network confirmed that everyone benefits from improved healthcare in prison, and that imprisonment is not a justification for the denial of healthcare. The Legal Network identified important gaps in policy and practice in the provision of healthcare, which fuel the transmission of HIV, hepatitis C (HCV), sexually transmitted and blood-borne infections (STBBIs), and other harms in prison and beyond. The Legal Network thus called for prison and health authorities to work together to improve healthcare in prison.

In 2023 and 2024, we conducted a fresh assessment of healthcare and harm reduction policies and practices in Canada's provincial, territorial, and federal prisons. Through open-source research and access to information requests, we identified and analyzed more than 200 healthcare and harm reduction policies applicable to prisons across the country (see Appendix 1 for the policies). We conducted over 25 interviews with stakeholders, including formerly incarcerated individuals, people who work in or for prisons, and community organizations supporting the rights of people in prison.[3]

In the nearly two decades since *Hard Time*, healthcare in prison has improved. Yet, significant gaps remain, which are particularly pronounced for Indigenous people, racialized people, gender-diverse people, and women. Until these gaps are addressed, STBBIs will pervade throughout the country.[4] Prison and health authorities must act to promote and protect the health of all people, irrespective of their legal status.

> ***We are so far behind… We have got a lot of work ahead of us when it comes to harm reduction… I have been in this game a long time with corrections, mental health, addictions, and now justice. I have met some of the most beautiful souls, and every day that they are alive is a miracle. I am going to do anything I can to ensure that you are safe, because you deserve it. You deserve dignity."***
>
> – Stakeholder, Native Council of Prince Edward Island
> (Interview with the HIV Legal Network, September 27, 2023)

TERMINOLOGY

"Prison": Facilities designated by provincial, territorial, or federal authorities to hold individuals who are awaiting trial, awaiting sentencing, or carrying out sentences. In some cases, these facilities are also used to hold individuals for immigration purposes.[5]

"Incarcerated people" or **"people in prison":** Adults who are deprived of their liberty, in provincial, territorial, or federal prisons, due to interactions with the criminal legal system. They may be awaiting trial, awaiting sentencing, or serving sentences. In some cases, these individuals are detained for immigration purposes. Other terms, such as "prisoner" or "inmate," are used only in direct quotations from outside sources.

Context: Prison Health and Human Rights

Every year, tens of thousands of people enter prisons in Canada.[6] Between 2022 and 2023, over 12,000 people were held in federal prisons and over 22,000 in provincial and territorial prisons.[7]

Before entering prison, these individuals are more likely than the general population to be living with health conditions, such as HIV and HCV.[8] In prison, the risk of STBBI transmission and acquisition increases, as well as other harms, as people are barred from necessary healthcare services. As a result, health tends to deteriorate during a prison stay — particularly as people are often forced to rely on prison authorities, rather than health authorities, for healthcare that is rarely equivalent to community standards. Thus, people regularly leave prison in worse condition than when they entered.[9] Evidently, prison and health authorities are failing to live up to their human rights obligations to people in prison.

UNDERSTANDING PRISON ADMINISTRATION IN CANADA

In Canada, provincial, territorial, and federal governments share responsibility for prison administration.

Provincial and territorial governments administer prisons for people who are serving sentences of less than two years and for those on remand (i.e. imprisonment while awaiting trial or sentencing). Most people in prisons are on **remand** — which can range from several days to several months.[10] A smaller proportion are serving sentences, the majority of which are less than one month.[11]

The federal government, via **Correctional Service Canada (CSC),** administers prisons for people serving sentences of at least two years. Between 2020 and 2021, 45% of people in federal prisons were serving sentences of between two and five years, and 26% were serving life (or indeterminate) sentences.[12]

The ongoing impacts of colonialism and the continued marginalization of Indigenous, Black, and other racialized individuals has resulted in the gross overrepresentation of these populations in prison.[13] In 2023, Indigenous people represented 32% of the federal prison population, while making up just 5% of the total adult population.[14] Alarmingly, Indigenous women now account for half of all women in federal prisons.[15] Since 2016, the number of Indigenous people in prison has increased, while the number of white people in prison has decreased.[16] Similarly, between 2021 and 2022, Black adults represented 8% of the federal prison population, while comprising approximately 4% of Canada's adult population.[17] The overrepresentation is mirrored at the provincial and territorial level.[18] These populations are subject to harsher treatment throughout the criminal legal system: they are more likely to be denied bail, sentenced to custody, placed in higher security prisons, and exposed to greater use of force in prison.[19]

UNDERSTANDING HEALTHCARE ADMINISTRATION IN CANADA'S PRISONS

The administration of healthcare in Canadian prisons varies by jurisdiction. At the federal level, CSC is responsible for providing "essential healthcare" and "reasonable access to non-essential healthcare" that conforms to "professionally accepted standards."[20] Healthcare is delivered by CSC Health Services, which is under the ultimate jurisdiction of the Ministry of Public Safety. At the provincial and territorial level, the provision of healthcare is the responsibility either of the jurisdiction's ministry of health or of their ministry of justice or public safety (see p. 9, "Whole-of-Government Approach").

In Canada, people who already face significant barriers to healthcare are often the targets of criminalization and other punitive responses.[21] For instance, the criminalization of drug possession, and other activities related to drug use, pushes people to use drugs alone and away from healthcare providers to avoid stigma, punishment, or criminalization.[22] These legal barriers deter people who use drugs from obtaining safe drug use materials, thus increasing their risk of acquiring or transmitting STBBIs and experiencing other adverse outcomes, such as toxic drug deaths.

Unsurprisingly, STBBIs are common in prison.[23] For instance, HIV prevalence is estimated to be about 1% of the prison population, compared to about 0.15% of the general population.[24] Similarly, while about 1% of all Canadians have been exposed to HCV, the rate is closer to 25% in prison.[25] STBBIs are common in prison not only because people entering prison are more likely to be living with STBBIs, but also because people in prison do not have access to adequate care, despite the frequency of drug use, sex, and tattooing in prison.[26] Inadequate access to harm reduction and other health measures also fuels an increasing number of toxic drug deaths among people in prison.[27] As a result, people in prison experience mortality rates higher than the general population.[28]

For several populations, the lack of adequate healthcare is linked to the fact that their unique needs are regularly ignored. Specifically, culturally appropriate and gender-specific services for Indigenous people, racialized people, gender-diverse people, and women are often unavailable or inadequately provided. For instance, a study of provincial and federal prisons from 1994 to 2020, found a lack of access to basic services for women, including contraception and prenatal care.[29] Women who experience incarceration are thus exposed to worse health outcomes — with higher rates of HIV and other STBBIs, abnormal Pap tests, and unplanned pregnancies.[30]

Indeed, healthcare is one of the most common complaints among people in Canadian prisons. In 2023, the Office of the Correctional Investigator (OCI) found that, between 2022 and 2023, healthcare in federal prisons accounted for 12% of the complaints received, second only to conditions of confinement.[31] Similar findings have been made in provincial and territorial prisons.[32]

> *"People who experience long term incarceration [have] a life span 20 years reduced from the general Canadian population. That is a crisis. People should not be sentenced to an early death by prison."*
>
> – Nyki Kish, Associate Executive Director, Canadian Association of Elizabeth Fry Societies (Interview with the HIV Legal Network, February 1, 2023)

Human Rights

While the right to health is not explicitly protected in Canadian legislation, a broad right is nonetheless derived from the *Canadian Charter of Rights and Freedoms* (the *Charter*) and its protection of the right to life, liberty, and security of the person.[33] The right is also derived from Canada's human rights obligations, including the right to the highest attainable standard of health reflected in many international conventions that Canada has ratified.

At a minimum, the right to health in Canada encompasses the right to access healthcare,[34] including harm reduction services — although the scope of this right has been contested by governments and in courts.[35] International human rights norms dictate that healthcare must be available in sufficient quantity, accessible without discrimination, responsive to the needs of different populations, and of good quality.[36] Governments must refrain from denying or limiting equal access, including to incarcerated people.[37]

People who enter prison retain these rights "subject to the restrictions that are unavoidable in a closed environment."[38] As clarified by the *United Nations Standard Minimum Rules for the Treatment of Prisoners* (the *Mandela Rules*), people in prison have "the same standards of healthcare that are available in the community" — often termed the **"principle of equivalence."** In other words, incarcerated people must be provided healthcare without discrimination based on their legal status.[39] Healthcare in prison must be consistent with standards, guidelines, and accountability mechanisms applicable to the broader community. Moreover, because people's liberty, autonomy, and ability to protect their own health is constrained in prison, governments are expected to give a degree of priority to healthcare in prisons.[40] Government must aim to achieve health *outcomes* in prison that are equivalent to the community.[41]

Canadian courts have interpreted the *Charter* protection for the health and well-being of people in prison with reference to the principle of equivalence.[42] Yet, today, jurisdictions across Canada are falling well short of meeting such obligations in practice.

> ***The provision of healthcare for prisoners is a State responsibility. Prisoners should enjoy the same standards of healthcare that are available in the community and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status. Healthcare services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence."***
>
> – *UN Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules),* UN General Assembly, A/RES/70/175, January 8, 2016, Rule 24.

Healthcare and Harm Reduction in Canada's Prisons

Throughout the last several decades, the World Health Organization (WHO) and other international bodies have developed guidelines to achieve a rights-based approach to healthcare in prisons.[43] These guidelines provide a standard against which healthcare in Canadian prisons can be assessed.

Specifically, the WHO and others have called on states to implement:

1. A whole-of-government approach, wherein healthcare in prison is provided by the government department responsible for healthcare throughout its jurisdiction;
2. Universal, voluntary STBBI testing, treatment, and counselling;
3. STBBI education programs, provided by qualified peers and community organizations;
4. Low barrier access to safer sex supplies, including condoms, dental dams, and lubricant;
5. Low barrier access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP);
6. Low barrier access to the continuance or initiation of Opioid Agonist Treatment (OAT);
7. Low barrier access to naloxone, including direct access for incarcerated people;
8. Low barrier access to sterile needles and syringes;
9. Low barrier access to bleach;
10. Lower barrier access to safer tattooing and piercing programs; and
11. Programs that are responsive to the specific needs of different populations, such as Indigenous individuals, racialized individuals, trans individuals, and women.

The principle of equivalence also warrants the consideration of programs that have not yet been addressed internationally, but that are already available in the broader community. At the time of writing, this requires prison authorities to provide, for example, low barrier access to overdose prevention services, drug testing, and/or safer supply.

In the following sections, we elaborate on the requirements for each of these healthcare standards, as developed by international bodies **("Guidance")**. We then describe the extent to which jurisdictions in Canada are meeting those standards **("Observations")**. Finally, we highlight policies **("Enabling Policies")** and practices **("Promising Practices")** that are moving jurisdictions closer to the international standards.

As revealed below, no jurisdiction in the country currently meets these standards. Some jurisdictions have adequate policies, but those policies are not consistently met in practice. Some jurisdictions engage in promising practices, without any policies to which they can be held accountable. Others fail to live up to the standards in both policy and practice.

> *Prison health is public health. Compassion is easy. Everything is really that simple. The systems are messed up."*
>
> – Olivia Gemma, Former Provincial Hepatitis C Coordinator, PASAN (Interview with the HIV Legal Network, March 10, 2023)

1. A Whole-of-Government Approach

Guidance: The WHO calls on states to adopt a whole-of-government approach to the provision of healthcare in prison.[44] That is, government ministries must work together, rather than in isolation, to provide healthcare in prison. In particular, ministries responsible for healthcare in the community, in collaboration with ministries responsible for prison administration, must be responsible for healthcare in prison, to enable equivalence in care.[45] In practice, the approach requires that ministries of health employ and oversee healthcare providers working in prisons, facilitating clearer lines of accountability with respect to professional and ethical obligations, including prioritizing patient health, obtaining informed consent, and maintaining confidentiality.[46] The approach allows for healthcare in prison to form part of the broader jurisdiction's healthcare strategy, such that individuals are not needlessly divorced from care during incarceration.

> **A Whole-of-Government Approach**
>
> *The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community, in particular:*
>
> *(a) The duty of protecting prisoners' physical and mental health and the prevention and treatment of disease on the basis of clinical grounds only;*
>
> *(b) Adherence to prisoners' autonomy with regard to their own health and informed consent in the doctor-patient relationship;*
>
> *(c) The confidentiality of medical information, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others…"*
>
> – *Mandela Rules,* UN General Assembly, A/RES/70/175, January 8, 2016, Rule 32(1).

Observations: In six of fourteen jurisdictions — Alberta, British Columbia, Newfoundland, Northwest Territories, Nova Scotia, and Quebec — healthcare in prison is delivered by the same ministry of health that provides healthcare to the broader population. In the remaining jurisdictions, healthcare in prison is delivered by the ministry responsible for corrections.

Is healthcare in prison administered by the Ministry of Health?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
No	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	No	Yes	No

In the six jurisdictions that have transferred healthcare to the health ministries, providing healthcare that is equivalent to that in the community is more clearly a priority. In policy, Nova Scotia, Alberta, and British Columbia clarify that healthcare staff in prison are employees of their jurisdictions' healthcare authorities.[47] Helpfully, in Nova Scotia, the health ministry publishes a document detailing the healthcare that people will be able to access in prison, providing information to which it can be held accountable.[48] In British Columbia, the Centre for Disease Control is engaged in an ongoing project to ensure that healthcare policies in prison are in line with provincial standards.[49]

Some of the policies also state that healthcare must be prioritized over prison administration in certain circumstances. For instance, British Columbia policy states that healthcare providers must be consulted before a person is transferred, and that transfers can only occur once the healthcare providers have confirmed the person concerned is fit for transfer.[50] Prior to an individual's release, healthcare personnel must be consulted, to ensure that necessary healthcare supports in the community are in place. The jurisdiction's policy also confirms that healthcare providers are specifically barred from conducting drug testing for non-medical reasons.[51] Northwest Territories legislation stresses that healthcare is "under no circumstances to be withheld as punishment."[52]

In many respects, the promises in policy are reflected in practice. For instance, across these jurisdictions, there are procedures in place to ensure continuity of care, such that healthcare coverage is maintained, and medical history is consistently available.[53] Many of these practices are further detailed in the "Promising Practices" section below (at p. 15).

Even so, these six jurisdictions continue to face important challenges in providing healthcare in prison that is at least equivalent to the community. One stakeholder from Nova Scotia described the devaluation of healthcare in prison by the health ministry, which treats prison health as an "add on" rather than an integral part of the jurisdiction's healthcare strategy.[54] In 2023, the East Coast Prison Justice Society in Nova Scotia also found, through their engagement with men in provincial prisons, "security considerations often win out over health," incarcerated people feel their health is not taken seriously, and they are restricted from making complaints directly to provincial health authorities.[55] In 2023, the Alberta Public Interest Commissioner found that healthcare standards were not being met in prison, including pain management and drug withdrawal protocols, which posed a "substantial and specific danger to life, health, or safety."[56]

These concerns are even more apparent in the jurisdictions where healthcare in prison is delivered by the ministry responsible for corrections, including CSC, Manitoba, New Brunswick, Nunavut, Ontario, Prince Edward Island, Saskatchewan, and the Yukon. In these jurisdictions, healthcare is not systematically prioritized. Policies and practices are more easily overtaken by the priorities of ministries responsible for corrections.

In policy, for instance, many of these jurisdictions give little attention to healthcare. In Manitoba, a 2019 inquest into a death at the Winnipeg Remand Centre found that the justice ministry did not have any regulations for the provision of healthcare in prison,[57] and only one new health-related policy has been published since 2019.[58] Similarly, in 2018, the Auditor General for New Brunswick found confusion among healthcare and prison authorities regarding who was responsible for healthcare in corrections, as responsibility is not delineated in policy, which continues to be the case today.[59] Similar findings have been made in Ontario, Nunavut, Saskatchewan, and the Yukon,[60] though Saskatchewan and the Yukon have begun to develop and publish more health-focused policies in the past few years.[61]

The devaluation of healthcare is reflected in practice, with most of these jurisdictions devoting insufficient resources to the adequate provision of healthcare in prison. In Manitoba, the 2019 inquest found that people detained at the centre had insufficient access to healthcare staff and that the centre's medication distribution system was a "throwback to the 1960s."[62] In Saskatchewan, in 2018, the Auditor found that nurses do not receive sufficient, or any, orientation or training when hired, despite the high rate of turnover and the fact that nurses bear most of the responsibility for healthcare in the province's prisons.[63] To this day, Saskatchewan lacks a clear resourcing plan for healthcare in prisons.[64] In Ontario, a 2017 review found that the system is "geared mainly at addressing the most acute and urgent medical conditions," and healthcare is viewed as just one among many programs offered.[65]

> *If I had 20 appointments, they missed 10, without fail… You don't get consistent treatment… You don't realize you miss [your appointment] until you go to your [next one] and realize you were supposed to go four months ago. They tell you that you are not allowed to know when your appointment is for security reasons… Every single day, nurses give out the wrong medication… The doctors, the nurses, the guards all talk about your medical charts, your medical procedure, all day every day… There is no confidentiality."*
>
> – George Flowers, detained at Toronto South Detention Centre from 2017 to 2022 (Interview with the HIV Legal Network, February 22, 2023)

In these settings, healthcare is more easily co-opted by operational considerations and apparent security concerns. For instance, one key stakeholder described healthcare providers at federal prisons being regularly pulled into policing, by reporting disciplinary infractions to prison staff.[66] Another confirmed that, in federal prisons, medication adherence can be added to parole conditions, leading to re-incarceration if a person obtains a different diagnosis or different medication in the community.[67] While section 86.1 of the *Corrections and Conditional Release Act* (legislation governing federal corrections) formally recognizes the professional autonomy and clinical independence of CSC healthcare professionals, the OCI has repeatedly noted that CSC's current health services delivery model is not "sufficiently independent," describing, for example, how "patient-provider confidence is not always practiced as medical staff may need to disclose information or work closely with security staff and prison authorities."[68] Similarly, in Manitoba, the 2019 inquest concluded that "healthcare needs are sometimes prioritized differently than they would be in a purely medical environment."[69] For instance, nurses are often pulled away from healthcare duties, such as medication distribution, to help with prison administration, such as admissions procedures.

The lack of emphasis on healthcare also translates to widely inconsistent practices between prisons and community, and a lack of continuity of care from community to prison and vice versa. In the federal context, incarcerated people being released are often responsible for connecting themselves to care in the community because prison healthcare staff have limited capacity to make necessary referrals.[70] Yet, parole officers and parole boards deem individuals as not ready for parole if they do not have enough "community supports," which includes connections to harm reduction, HIV, mental health, and other supports. In Manitoba, healthcare in prisons has been described as "islands cut off from the rest of the medical community," where every person entering the system is disconnected from their community healthcare and enters a silo of prison healthcare.[71] Upon admission, "existing diagnoses are revisited, existing prescriptions re-evaluated, and community resources well engaged with the [person] are not integrated into their correctional healthcare plan."[72] Similar findings have been made in New Brunswick, Ontario, Saskatchewan, and Nunavut.[73]

> *The role of a health provider in prison should be to have undivided loyalty to your patient, be an advocate for them, understand all the ways that prisons are really harmful for health, and to not be complicit in any of that. Be an advocate for your patient."*
>
> – Nicole Kief, Policy Director & Senior Legal Advocate, Prisoners' Legal Services (Interview with the HIV Legal Network, January 12, 2023)

> **Corrections in Ontario: Directions for Reform**
>
> *[The] fragmentation of healthcare responsibility bears emphasis: [people in prison] receive healthcare services that are delivered and managed in isolation from those provided to virtually everyone else in the province, absent the dedicated resources, experience, expertise, strategic vision and mandate of the ministry responsible for health. [The Ministry of Community Safety and Correctional Services (MCSCS)], as a ministry, has no particular expertise in the design, delivery, management, or oversight of either healthcare or public health services, or in the development of appropriate healthcare strategies for any patient population, let alone the complex and vulnerable correctional population. There is no general requirement for MCSCS to align its correctional healthcare services with [the Ministry of Health and Long-Term Care (MOHLTC)] services and objectives, or to consult with MOHLTC when developing healthcare policies."*
>
> — Independent Review of Ontario Corrections Team, *Corrections in Ontario, Directions for Reform,* September 2017, available at https://files.ontario.ca/solgen-corrections_in_ontario_directions_for_reform.pdf.

Unsurprisingly, throughout the country, repeated calls have been made for *all* jurisdictions to transfer responsibility for healthcare in prison to health authorities. In 2023, the OCI repeated its recommendation for CSC to implement an independent healthcare model.[74] That same year, the Ontario Chief Coroner's Expert Panel on Deaths in Custody called for steps to be taken to ensure equivalence between healthcare in prison and healthcare in the community, including the full integration of programs and policies provided by the health ministry in the rest of the community.[75] And in 2019, the Provincial Court of Manitoba called for prison healthcare to be provided by the health ministry.[76]

ENABLING POLICIES

***Access to Health Care* (Nova Scotia)** confirms that healthcare in prison is the responsibility of Nova Scotia Health.[77] Nova Scotia Health and Correctional Services must guarantee medical, mental health, and dental healthcare in prisons across the province. All individuals must always have access to healthcare — correctional staff must contact emergency and non-emergency medical services if ever there is a need, particularly when healthcare staff are not available.

Client Diversion of Medications Policy and ***Procedure* (British Columbia)** affirm that healthcare providers must maintain their independence from prison authorities.[78] Anyone who is suspected of distributing or found to have distributed their medication in an unauthorized manner (i.e. "diverting") will not have their medication discontinued as a form of discipline. Instead, any prescriber's decision to change medication must be based on a clinical review, considering the safety of the person with the prescription and the safety of the person receiving the medication in an unauthorized manner.

***Patient and Family Guide* (Nova Scotia)** clearly outlines the healthcare that is to be provided in prison, establishing an accessible standard to which the health ministry may be held accountable.[79] In some prisons, the guide is accessible to incarcerated people who are given tablets with internet access. The guide confirms that, upon admission, people will receive healthcare assessments and receive necessary care and treatment. Upon release, they will be given up to 14 days' worth of their prescriptions, to facilitate continuity of care. Notably, the guide outlines the rights that people in prison have to care and commits to providing the same quality of care as that in the community.

***Collaborative Practice and Sharing Health Information* (Newfoundland)** highlights the need for collaboration among healthcare staff, which serves people's best interests.[80] Collaboration entails timely communication among healthcare staff to determine the best course of action. Only the "minimum amount of information to achieve the purpose should be shared."

PROMISING PRACTICES

Personal Health Numbers (British Columbia) facilitate continuity of care upon admission, transfer, and release from prison.[81] Personal Health Numbers are unique lifetime identifiers that give healthcare providers, both inside and outside prisons, access to incarcerated people's medical histories, allowing providers to maintain healthcare within and beyond prison.

Corrections Transition Teams (Alberta) support continuity of care upon release, for incarcerated people living with mental health or substance use concerns. The teams provide short-term case management and connect individuals to mental health and substance use services, financial support, and affordable housing options.[82]

Harm Reduction Team Referral Process **(Newfoundland)** facilitates continuous care for people who have been released from prison.[83] Healthcare staff refer incarcerated people to a Harm Reduction Team prior to release. This Harm Reduction Team includes nurse practitioners, registered psychiatric nurses, pharmacists, occupational therapists, and peer support workers, who operate a clinic and do mobile outreach in the community. The Harm Reduction Team then assigns each referred person to a clinician in the community who meets the individual before release if possible, or in the community as soon as possible.

2. STBBI Testing, Treatment, and Counselling

Guidance: The WHO has long called on states to provide voluntary and confidential STBBI testing, treatment, and counselling in prisons.[84]

Specifically, universal STBBI testing must be offered regularly.[85] Testing must not be coerced — it must only be completed with "informed consent, pre-test information, post-test counselling, protection of confidentiality, and access to services that include appropriate follow-up."[86] Informed consent includes providing information on the reasons for testing and the consequences of being tested, the right to refuse testing, and the possible results of testing.[87] Pre- and post-test counselling is particularly important for testing and treating highly stigmatized conditions like HIV and HCV. Pre-test counselling includes information about the relevant condition, including its risk factors, and the advantages and disadvantages of testing.[88] Post-test counselling includes a clear communication of test results, their implications, and the need for follow-up care and health promotion strategies, and an assessment of the person's understanding of their results.[89] Counselling allows individuals to come to terms with the fear, guilt, and stigma that may accompany their results, and develop strategies to treat their condition.[90] Confidentiality applies at all stages, including pre-test counselling, testing, the communication of the result, post-test counselling, and follow-up care.[91]

> **HIV in Prison**
>
> ***Compulsory testing of prisoners for HIV is unethical and ineffective and should be prohibited. Voluntary testing for HIV infection should be available in prisons when available in the community, together with adequate pre- and post-test counselling. Voluntary testing should only be carried out with the informed consent of the prisoner. Support should be available when prisoners are notified of test results and in the period following. Test results should be communicated to prisoners by health personnel who should ensure medical confidentiality."***
>
> – UNAIDS, *WHO guidelines on HIV infection and AIDS in prisons,* UNAIDS/99.47/E (1999).

STBBI treatment must be provided pursuant to treatment guidelines applicable to the broader community.[92] That is, people living with HIV must have immediate access to antiretroviral treatment (ART), as well as other supports, including nutritional supplements and treatment adherence support. Individuals living with HCV must be offered direct acting antiretroviral (DAA) treatment as soon as possible, regardless of their history of drug use or prior HCV diagnosis. Treatment and care must not be interrupted during transitions between prisons or between prison and community.[93]

Other interventions to prevent STBBIs must also be available, including STBBI education, safer sex materials, sterile needle and syringe programs, and OAT. These interventions are discussed further below.

Observations: Few jurisdictions provide comprehensive STBBI testing, treatment, and counselling in policy or practice. Several jurisdictions have policies regarding testing, treatment, and counselling, but none are comprehensive. Few jurisdictions provide HCV treatment or counselling in practice.

Is regular, universal STBBI testing, treatment, and counselling provided in policy?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
No	No	No	No	No	No	–	No	No	–	No	No	No	No

"–" indicates information unavailable.

Newfoundland is one of few jurisdictions with a policy on STBBI testing and treatment in prison.[94] The policy meets the international standard in emphasizing the need for informed consent and confidentiality, guaranteeing comprehensive pre- and post-test counselling, and detailing steps for follow-up care. Notably, the policy confirms that people who test positive for HIV, HBV (hepatitis B), or HCV must be referred to specialists for treatment. The policy falls short of the human rights standard, however, because it does not clarify when, how often, or how people in prison can access STBBI testing.

British Columbia also comes close to meeting the WHO guidelines in policy. Their policy clearly states that incarcerated people must have access to voluntary and confidential STBBI testing, upon admission and upon request,[95] confirms that pre- and post-test counselling is given to those who request HIV and HCV testing, and that ongoing counselling and support is provided to those who test positive. However, the BC policy does not specifically require HIV and HCV treatment — even though this was included in a previous version of the policy.

CSC's policy has become less clear in recent years. Until 2015, CSC had a policy that would have largely met the WHO guidelines: they provided STBBI testing upon admission and regularly during incarceration, pre- and post-test counselling, and "humane treatment and support."[96] Now, CSC simply states that "Sexually Transmitted Infections" guidelines are under review and that "Infection Prevention and Control Guidelines" exist.[97] Promisingly, the Legal Network has received information from CSC indicating that the guidelines will soon be published, and that they largely retain these elements from the previous version.

In Nunavut, policy similarly emphasizes the importance of testing upon admission, based on informed consent and confidentiality.[98] It confirms that people receive treatment for their conditions, and that HIV and HCV are referred to designated physicians for treatment. The policy fails, however, to confirm whether testing is available upon request, and is silent on whether counselling is provided. Notably, policy specific to Aaqqigiarvik Correctional Healing Facility (the largest prison in the territory) emphasizes the need to provide counselling, particularly following an HIV diagnosis.[99]

The Yukon policy also confirms that people are tested upon admission, through a voluntary and confidential process.[100] The policy is unclear as to whether testing is available upon request, whether pre- and post-test counselling is offered, and whether all conditions are referred to treatment. The policy thus allows for a significant deviation from the international standard.

New Brunswick, Nova Scotia, and Saskatchewan also have policies related to STBBI testing, treatment, and counselling.[101] However, those policies are far from comprehensive. They state that people will be screened for STBBIs upon admission, and will be initiated into appropriate treatment or referred to healthcare providers in the community. None mention confidentiality, availability of testing upon request, or counselling. Saskatchewan is the only jurisdiction to mention informed consent.

Ontario has an information guide for incarcerated people that states that people can be tested for "HIV, hepatitis, and sexually transmitted infections," and that, for those who test positive, "treatment options will be discussed."[102] The guide is otherwise silent on consent, confidentiality, and counselling.

Is regular, universal STBBI testing accessible in practice?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Yes	Yes	Yes	No	No	No	–	–	No	No	Yes	Yes	No	No

"–" indicates information unavailable.

Few jurisdictions seem to make STBBI testing is accessible in practice. CSC, Alberta, British Columbia, Prince Edward Island, and Newfoundland all offer universal STBBI testing upon admission, as well as regularly and/or upon request throughout incarceration.[103] Notably, one stakeholder revealed that people in federal prisons in Quebec can face language barriers to accessing tests, as they are required to make their requests in writing, on a document that is sometimes only provided in French.[104] Prison staff have purportedly directed individuals to find their own translators.

In other jurisdictions, STBBI testing is even less accessible (e.g. only offered upon request in some prisons and/or to certain individuals).[105] For instance, in Quebec, most people must request STBBI testing.[106] While there is a government body, "Service intégrés de dépistage et de préventions des infections transmissibles sexuellement et par le sang" (SIDEP), that comes into prisons to do testing, their visits are irregular and their follow-ups are inconsistent.[107]

Is pre- and post-HIV and HCV test counselling provided in practice?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
No	Yes	No	–	Yes	Yes	–	–	No	–	No	No	No	Yes

"–" indicates information unavailable.

Few jurisdictions offer pre- and post-test counselling at all. British Columbia, New Brunswick, Manitoba, and the Yukon are the exceptions. In British Columbia, people have access to trained counsellors and/or peers.[108] Healthcare staff also facilitate private phone calls to provincial peer support groups, such as at the BC Hepatitis Network, AIDS Vancouver, and Unlocking the Gates.[109] In New Brunswick, social workers offer counselling, and public health officials conduct follow-ups to connect people to community supports.[110] Public health officials in Manitoba and the Yukon provide counselling, which stakeholders confirmed is equivalent to that provided in the community.[111]

Other jurisdictions offer alternatives to counselling that fall short of international standards. For instance, in Prince Edward Island, people are given an opportunity to sit down with the healthcare team and obtain information on their diagnosis.[112] In Alberta, people diagnosed with HIV or HCV *for the first time* are given an opportunity to sit down with their healthcare provider to discuss their diagnosis.[113] In Ontario and Newfoundland, counselling *may* be provided if individuals ask for counselling and counsellors are available.[114] Stakeholders confirmed that CSC does not consistently offer counselling.[115]

> *She had just done her HIV test… She really wanted the results. The nurse practitioner, or whoever had taken the test, said to her, 'It's probably positive, just go away' … She refused to leave until she got her results, and then she was [segregated] for almost two years. It was horrific."*
>
> – Emilie Coyle, Executive Director, Canadian Association of Elizabeth Fry Societies (Interview with the HIV Legal Network, February 27, 2023)

Is HIV and HCV treatment continued and initiated in practice?														
	CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
HIV	Yes	Yes	Yes	Yes	Yes	Yes	–	–	Yes	–	Yes	Yes	Yes	Yes
HCV	Yes	Yes	No	No	No	No	–	–	–	No	No	Yes	Yes	No

"–" indicates information unavailable.

Most jurisdictions offer STBBI treatment, including for HIV. They initiate treatment for new diagnoses and continue treatment that began in the community. That treatment is, however, often disrupted by delays in accessing care upon admission, during transfers between prisons, or upon release from prison. Treatment is also negatively affected by conditions in prisons — such as inadequate nutrition for people living with HIV.[116] Additionally, in some jurisdictions, like the Yukon, treatment is only available to people who are sentenced, and not to people on remand. Often, remand is so long that people are released with "time served."[117] Thus people can be barred from treatment, even if they are incarcerated for months.

Of particular concern, few jurisdictions initiate HCV treatment in prison.[118] That is, most jurisdictions will only continue HCV treatment that was initiated in the community and will not initiate HCV treatment for a diagnosis made in prison. The common justification is that people are not in prison for long enough to complete a full course of treatment, only have access to one round of publicly funded treatment, and are unlikely to complete their treatment in the community.[119] Some jurisdictions, like Ontario, will thus only initiate HCV where someone has a sentence that is longer than the course of treatment, or where the illness has progressed to an advanced stage.[120] Other jurisdictions, like Quebec, will refer a person with an HCV diagnosis to HCV treatment providers in the community post-release.[121]

Yet, studies have confirmed that initiating HCV treatment in prison can be a highly effective tool in reducing rates of HCV.[122] Moreover, CSC, British Columbia, Prince Edward Island, and Nova Scotia have shown that it is possible to effectively initiate HCV treatment in prison, even where people are not imprisoned for long periods.[123] Notably, in British Columbia, HCV treatment initiation is possible thanks to a change to the healthcare system, which now fully covers HCV treatment for people in prison and maintains coverage following release.[124] While Quebec and Newfoundland do not currently initiate HCV treatment, their ministries of health have indicated that they are working towards making this available.[125]

Finally, informed consent and confidentiality in STBBI testing, treatment, and counselling is a significant concern across the country.[126] For instance, in Ontario, a stakeholder noted that they sometimes did not think they could refuse medical tests.[127] Another stated that they did not always know what they were being treated for.[128] As one stakeholder explained, "You have to know that you can say no, and in a coercive environment, why would people think they can say no?"[129]

> *Even if you are in the room with the doctor, the door won't be fully shut. The door will be open a little bit, and there will be a correctional officer standing outside who is in earshot of everything. So even though healthcare is supposed to be confidential, and people's HIV status and HCV status is supposed to be confidential, you have a correctional officer there who can hear everything… The correctional officers aren't supposed to know who has what… but they somehow know, and they somehow seem to let each other know."*
>
> – Pam Young, Program Manager, Unlocking the Gates (Interview with the HIV Legal Network, March 9, 2023)

Similarly, numerous stakeholders stated that confidentiality is near impossible in prison, where people are under constant observation, even in healthcare settings. In British Columbia and Ontario, correctional officers are often present in healthcare units, including during medical discussions with healthcare providers.[130] In Newfoundland, correctional officers are often within earshot of discussions with healthcare providers in the medical unit.[131] In Prince Edward Island and Quebec, requests to see healthcare providers must be made in writing, which first pass through correctional officers.[132] In all jurisdictions, correctional staff are known to make revealing comments or speak openly about private healthcare information.[133] Confidentiality is also difficult to maintain because of the way that treatment is provided. For instance, people can discern what conditions others have by seeing their names on medications,[134] or by seeing the same people go to see the same specialist on a regular basis.[135]

ENABLING POLICIES

Testing, Treatment, and Reporting of Sexually Transmitted Infections, HIV, and Blood Borne Infections **(Newfoundland)** confirms that individuals in prison have access to non-nominal testing, which is to be conducted based on informed consent.[136] Individuals receive pre-test counselling. Test results are shared within two weeks and accompanied by post-test counselling. Healthcare staff are provided with professional development to ensure they have a current knowledge of counselling techniques. Individuals who test positive for HIV, HCV, or HBV are referred to specialists for treatment.

HCV Treatment Process **(Newfoundland)** explains that everyone who receives two positive tests at least six months apart qualify for HCV treatment.[137] People are then connected to healthcare providers in the community, to facilitate continuity of HCV care. People who are still receiving treatment at the time of release are given two weeks' worth of medication upon release, as well as the contact information for their community healthcare provider.

Inmate Health Care Services Policy **(British Columbia)** confirms that, upon admission, nurses offer STBBI testing, and that testing is also available upon request during incarceration.[138] Testing is voluntary, and requests for testing are made directly to healthcare staff. Pre- and post-test counselling is also provided to those who request HIV and HCV testing, and ongoing counselling is available, through healthcare, to anyone who tests positive for HIV and/or HCV.

Screening and Treatment for Sexually Transmitted Infections **(Yukon)** states that STBBI screening is part of the routine admission process at Whitehorse Correctional Centre and confirms that testing is confidential and based on informed consent.[139] Nurses are encouraged to adopt "an open attitude" and to consult "clients in a supportive environment" to "enhance client comfort level to discuss sexual health and provide health promotion."

PROMISING PRACTICES

British Columbia Centre of Excellence in HIV/AIDS (BC) is a research, treatment, and education facility, recognized globally as a leader in HIV and related conditions.[140] Funded by the provincial government, under PharmaCare, the organization provides HIV treatment at no cost to all eligible individuals, including people in prison.[141]

Test, Link, Call (BC) is a project run by the BC Centre for Disease Control, BC Mental Health & Substance Use Services, BC Hepatitis Network, and Unlocking the Gates.[142] The project aims to improve access to HCV treatment following release from prison, by providing participants with free cellphones and six-month unlimited talk and text plans, which are set up with apps and websites designed to support participants (e.g. pill reminder apps). Participants are offered connections to Peer Health Mentors, who meet with them upon release from prison and help them access health and social care.

Hepatitis C Training Program (Ontario), developed by the Ontario government, University Health Network, and CATIE, is a pilot project to train healthcare staff in prison on HCV, giving providers the tools necessary to expand access to testing, treatment, and counselling, and link people to care in the community.[143] The program is provided online, through the Corrections Centre for Professional Advancement and Training system, and consists of educational videos, reflection activities, and knowledge assessments.

Follow Up Information after Release: Maviret & Epclusa **(Newfoundland)** is provided to individuals receiving HCV treatment on release from prison.[144] The sheet explains that individuals should be given two weeks' worth of medication upon release and directs them to contact the prison to obtain their medication if released unexpectedly. People are directed to specific healthcare providers in the community, if not already connected to a provider.

3. STBBI Education

Guidance: Education is central to the WHO's strategy to prevent STBBI transmission in prisons.[145] Incarcerated people and staff working in prison must receive accurate, non-judgemental, and relevant education on STBBIs, including how STBBIs are (and are not) transmitted, how to use safer sex materials, and how to tattoo and use drugs without risking HIV or HCV transmission.[146] The education must also address the stigma linked to STBBIs, in particular HIV and HCV, and the stigma directed towards particular groups, such as people who use drugs and men who have sex with men. The education should be available in multiple languages, and responsive to the needs of different audiences, such as Indigenous people, racialized people, trans people, and women.

STBBI education for incarcerated people should be provided by prison staff, as well as trained peers and/or community organizations.[147] As STBBI education will necessarily touch on behaviours that are criminalized (e.g. drug possession), or otherwise punished (e.g. sex) or stigmatized (e.g. same-sex intimacy) in prison, peers and community organizations can facilitate more frank conversations.[148] Information from peers is also more likely to be trusted than information coming from prison staff.[149]

Observations: STBBI education is not prioritized, in either policy or practice. In most jurisdictions, STBBI education in prison only occurs thanks to efforts by community organizations, who are in the best position to provide such education, but who are not adequately supported or funded. STBBI education is treated as secondary to other priorities, and thus easily discarded by authorities.

Is STBBI education required by policy?													
CSC	BC	AB	SK	MB	YK	NT	NU	ON	QC	NL	PE	NS	NB
–	Yes	No	Yes	No	Yes	–	No	No	–	Yes	No	No	No

"–" indicates information unavailable.

British Columbia, Saskatchewan, Newfoundland, and the Yukon are the only jurisdictions to require STBBI education in policy. Yet, none of these jurisdictions meet the WHO guidelines. While British Columbia requires STBBI prevention education to be developed for incarcerated people and prison staff,[150] the policy does not speak to the manner in which education is to be provided. Saskatchewan requires that nurses provide STBBI education to incarcerated people as part of their health assessment upon admission and upon request,[151] but the policy does not mention staff education or address how education will be provided to meet the needs of incarcerated people. Similarly, in Newfoundland and Yukon policy, nurses conducting STBBI testing must be knowledgeable on STBBIs, and people in prison must receive information about STBBI prevention during testing.[152] The policies are silent on how STBBI education is provided more broadly to prison staff and incarcerated individuals, or how STBBI education can be adapted to meet the needs of incarcerated people.

In Ontario, the *Inmate Information Guide for Adult Correctional Facilities* simply states that volunteers may come into the prisons to provide additional programs, and that such programs "may include health education."[153] In most other jurisdictions, the only policies that touch on STBBI prevention focus on precautions that staff can take to avoid STBBIs, such as information on various cleaning procedures.[154]

Is STBBI education prioritized in practice?													
CSC	BC	AB	SK	MB	YK	NT	NU	ON	QC	NL	PE	NS	NB
No	No	No	–	Yes	No	–	–	No	Yes	No	No	No	No

"–" indicates information unavailable.

In practice, only two jurisdictions systematically prioritize STBBI education: Quebec and Manitoba. In Quebec, SIDEP teams lead education programming for incarcerated people and prison staff across the province.[155] The teams provide group and one-on-one sessions on HIV, HCV, and other STBBIs.[156] The SIDEP programming is complemented by STBBI education provided by community organizations, who are granted regular access to prisons.[157] In Manitoba, the health ministry regularly provides STBBI prevention education to incarcerated people.[158] Peer programs are available, as well as programs provided by community organizations, such as Nine Circles Community Health Centre.[159] Notably, it is not clear whether STBBI education in Manitoba details safer drug use or safer tattooing (as both are strictly punished) or whether staff receive regular education.

In Newfoundland, comprehensive STBBI education is not guaranteed, particularly as community organizations are not consistently provided access to prisons to provide such education.[160] However, since healthcare in prison was transferred to the health ministry in 2022, there appear to be efforts to prioritize education, with healthcare staff emphasizing STBBI education for incarcerated people, and facilitating peer-led education.[161] Additionally, correctional officers must now complete STBBI prevention and harm reduction training — although there are concerns about how comprehensive these trainings are and whether all staff are receiving the training.

In most other jurisdictions, education is not prioritized, and education programs are inconsistent. There are prevailing misconceptions that STBBI education for incarcerated people is not necessary because drug use, tattooing, and sex are not allowed in prison, and that STBBI education for staff is not necessary.[162] Instead, education depends on community organizations, which are regularly barred from prisons.[163] For instance, in British Columbia, staff education is optional in practice, and education for incarcerated people largely depends on the prison, with only some prisons offering strong education programs provided by community organizations on STBBI prevention, testing, and care.[164]

ENABLING POLICIES

Infection Control and Prevention **(British Columbia)** requires that all prisons have comprehensive STBBI education programs for both prison staff and incarcerated people.[165] The programs must discuss STBBIs generally, and certain conditions, such as HIV and HCV, specifically. The programs must, at a minimum, provide information on STBBI prevention measures, and instructions on the use of STBBI prevention tools, such as condoms, lubricants, and bleach. Incarcerated people and prison staff must also have opportunities to update their knowledge. The policy does not describe whether the education programs can be provided by peers or community organizations, or whether the programs are to be adjusted to be responsive to individual needs.

Communicable Disease Management **(Saskatchewan)** requires that all incarcerated individuals receive STBBI education during their initial health assessment upon admission or upon request.[166] Education must touch on STBBI prevention practices. Public health authorities may help to provide education, through regular visits and education activities, and during testing programs. The policy is silent on staff education, as well as how the education will be responsive and sensitive to individual needs.

Testing, Treatment, and Reporting of Sexually Transmitted Infections, HIV and Blood-Borne Infections **(Newfoundland)** confirms that healthcare staff are provided with education on counselling techniques and issues related to STBBIs.[167] During pre-test counselling, incarcerated people are provided with education about safer sex and harm reduction.

Screening and Treatment for Sexually Transmitted Infections **(Yukon)** explains that, during STBBI screening, nurses offer STBBI education, including around risk reduction.[168] Nurses also provide education on other sexual health areas they identify as important and provide incarcerated individuals time to ask questions.

PROMISING PRACTICES

PASAN (Ontario) is a community-based organization that provides health and harm reduction support, education, and advocacy to people in prison across Canada.[169] With federal and provincial funding, PASAN conducts HIV prevention education programs in many prisons in Ontario. For instance, through Peer Educators Groups, formerly incarcerated people living with HIV serve as educators to currently incarcerated people. PASAN also provides free training to people who work with prison-affected individuals, on topics including HIV in prison, harm reduction, and stigma and discrimination.

You Matter Project: Pathways to care for STBBIs (British Columbia), developed by the BC Centre for Disease Control and BC Mental Health & Substance Use, recommends STBBI education programs for incarcerated individuals, prison staff, and healthcare staff.[170] For incarcerated people, STBBI education should be provided in multiple different formats (such as through printed materials, peer-led workshops, and presentations by guest speakers), and should detail how STBBIs can be prevented, tested, and treated in prison. For prison staff, STBBI education should be provided upon hiring, with annual refreshers, and cover general information about STBBIs, stigma and misconceptions attached to STBBIs, the importance of confidentiality, as well as trauma-informed care and cultural safety.

Walking the RED Path Project: Re-forging Connections, Empowering Indigenous Women to Heal, and Driving Change for a Healthy Future (CSC), developed by Native Women's Association of Canada, provides Indigenous women, girls, Two-Spirit, transgender, and gender-diverse people with information on STBBIs, healthy relationships and sexuality, as well as other resources and supports.[171] The project is currently implementing trauma-informed, evidence-based, culturally competent training to employees in CSC prisons, to be able to better support incarcerated Indigenous individuals. The training programs, developed in collaboration with Indigenous women, Two-Spirit, transgender, and gender-diverse individuals, cover Indigenous histories and health relationships, HIV and HCV, STBBI prevention and harm reduction, and traditional healing and supports.

Peer Health Rep Program (CSC), developed by the Canadian Collaboration for Prison Health and Education, engages incarcerated people as peer leaders (Peer Health Reps) to provide support, education, and resources around STBBI prevention.[172] Peer Health Reps provide confidential one-on-one peer support, distribute educational resources regarding STBBI prevention and harm reduction, develop and deliver "myth busting" workshops, and contribute to program development.

4. Safer Sex Supplies

Guidance: The WHO confirms that condoms, dental dams, and water-based lubricant are essential to STBBI prevention in prisons.[173] These safer sex supplies must be free and discreetly accessible in multiple locations (such as healthcare units, shower areas, workshop rooms, and day rooms),[174] without requiring incarcerated people to request them, as few will want to disclose that they engage in same-sex sexual intimacy, or be punished for engaging in sex, which is often prohibited in prison.[175] Safer sex supplies must also be accompanied by information about proper use.[176]

> **Safer Sex Supplies in Prison**
>
> ***No prison system allowing condoms has reversed its policy, and none has reported security problems or any other relevant major negative consequences. In particular, it has been found that access to condoms is unobtrusive to the prison routine, represents no threat to security or operations, does not lead to an increase in sex within prisons, and is accepted by most prisoners and correctional officers once it is introduced. Usually support for condom provision increases once [a program] has started."***
>
> – WHO, UNAIDS, UNODC, *HIV and AIDS in places of detention: A toolkit for policymakers, programme managers, prison officers, and health care providers in prison settings,* 2008, available at www.unodc.org/documents/hiv-aids/V0855768.pdf.

Observations: Safer sex supplies are largely inaccessible throughout Canada's prisons. Few jurisdictions mandate the provision of safer sex supplies in policy. Among the jurisdictions that require the provision of supplies, most do not make supplies meaningfully accessible in practice.

Are safer sex supplies accessible (i.e. without the need to request them) pursuant to policy?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Yes	Yes	No	No	No	No	–	No	No	–	No	No	No	No

"–" indicates information unavailable.

CSC and British Columbia have policies that require condoms, dental dams, and water-based lubricants to be provided.[177] According to the policies, the items must be freely available in multiple locations, without the need for incarcerated people to request them. British Columbia policy confirms that supplies are not to be considered contraband, and that information on the use of safer sex supplies must be available.

Saskatchewan also has a policy requiring condoms, dental dams, and safer sex education to be provided in prisons.[178] However, the policy also states that incarcerated people must request safer sex supplies from nursing staff, and that sex is prohibited and may result in disciplinary sanctions — deterring anyone from accessing such supplies. Similarly, in Ontario and Nova Scotia, the information guides for people in prison state that condoms and dental dams are available upon request from healthcare staff.[179]

> *If people are going to have sexual contact, they should have the right to do it as safely as possible. They are already taking a risk by connecting with somebody else. The risk shouldn't be compounded by not having safer sex supplies."*
>
> – Alicia Gordon, Formerly incarcerated woman
> (Interview with the HIV Legal Network, March 6, 2023)

Are safer sex supplies accessible (i.e. without the need to request them) in practice?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
No	No	No	–	Yes	No	–	–	No	Yes	No	No	No	No

"–" indicates information unavailable.

Manitoba and Quebec appear to be the only jurisdictions in which the reality of sex in prisons is accepted, and in which incarcerated individuals are provided with free and discreet access to safer sex materials, with limited risk of punishment. In Manitoba, prison administration encourages safer sex, and makes condoms, dental dams, and lubricant freely accessible in the medical units and in release packages.[180] In Quebec, SIDEP teams coordinate the provision of condoms, dental dams, and lubricant in each prison, making them freely accessible in infirmaries, canteens, and through healthcare providers.[181]

> *There is no access to condoms or lubricant. Not even with the health unit, with the nurses... I know they are using rubber gloves because relationships are happening. Everybody needs to love and to belong somewhere. All humans."*
>
> – Stakeholder, Native Council of Prince Edward Island
> (Interview with the HIV Legal Network, September 27, 2023)

In other jurisdictions, sex is widely stigmatized and punished, posing a barrier to access where supplies are otherwise available. For instance, CSC, British Columbia, Nova Scotia, Newfoundland, and Ontario all provide safer sex supplies in at least some of their prisons.[182] However, in some instances people must "out" themselves if they want to access supplies, and security officers regularly charge or otherwise punish people discovered having sex.[183] For instance, in CSC prisons, safer sex supplies are available in vending machines, but supplies often run out, meaning incarcerated people must approach healthcare staff to obtain supplies.[184] A stakeholder reported that people caught having *consensual sex* in CSC institutions can receive sexual assault charges, with far-reaching impacts, including on their parole.[185] In Newfoundland, safer sex supplies are freely available in the medical unit, but an appointment is necessary to go there.[186] Similarly, in Ontario and Nova Scotia, safer sex supplies are available only through requests to healthcare staff.[187] As one stakeholder noted, "people are really forced to take a chance for that intimacy."[188]

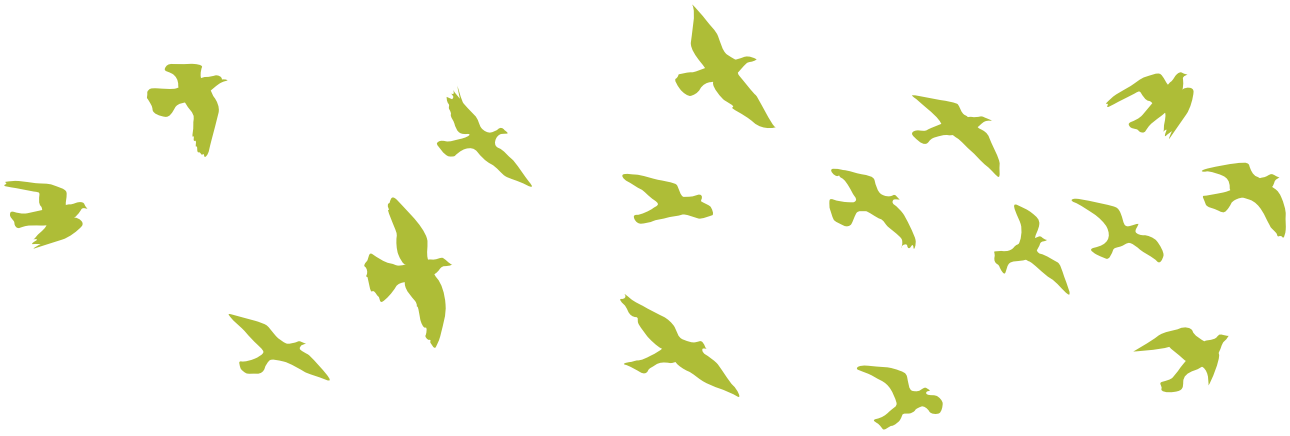
> *[Prison staff] think people will use [condoms] to hide drugs in themselves, or that people can use condoms and make weapons… These ideas of what could happen are much more than the reality of it. How do you get that break or that opportunity to then implement? With condoms, let it run a year and see that there is no safety incident. We can show that this can actually work."*
>
> – Stakeholder, Alberta Health Services
> (Interview with the HIV Legal Network, February 9 and 16, 2023)

Other jurisdictions do not provide any safer sex supplies, on the basis that sex is prohibited in prison and therefore should not occur.[189] Yet, sex is known to be happening — be it "long-term relationships, transactional relationships, or sexual assault, sex is happening all the time."[190] Notably, in the Yukon, one stakeholder reported that information on safer sex has been banned on the basis that it is "pornography."[191]

ENABLING POLICIES

***Commissioner's Directive 800 – Health Services* (CSC)** requires that STBBI control and harm reduction items, including "non-lubricated, non-spermicidal latex condoms, water-based lubricants, individually packaged dental dams," are provided in prisons.[192] The items must be discreetly accessible to people in prison in at least three locations in each CSC prison, as well as in private family visiting units, so that no one is required to request these items from staff.

***Condoms* (British Columbia)** confirms that prison administrators have a duty to reduce the risk of STBBIs in prison, and that condoms, dental dams, and lubricants must be provided to meet that duty.[193] Safer sex supplies must be freely available in healthcare units and living units. Education on the proper use of condoms must also be provided. Staff who discover unopened condoms, dental dams, or lubricant packages must not confiscate them. Instead, they must maintain the confidentiality, and respect the privacy, of the person in possession of the items.



5. Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis

Guidance: WHO guidance confirms that PrEP and PEP are essential to prevent HIV transmission in prison.[194] PrEP must be continued for individuals with prescriptions from the community, and initiated for those who are at risk and wish to be on the medication.[195] PEP must be accessible to incarcerated people, and to prison staff, who are exposed to HIV through exposure to blood or other bodily fluids.[196] PEP must be provided promptly and discreetly by prison healthcare services. People who are exposed to violence must also have access to effective complaint mechanisms and protection measures.[197]

UNDERSTANDING PREP AND PEP

PrEP refers to a set of antiretroviral drugs that prevents HIV transmission, when taken regularly by individuals who are not living with HIV.[198] Drug levels must remain high in the body for PrEP to be effective. Indeed, when taken daily, PrEP has been shown to significantly reduce the risk of transmission — reducing 86% of HIV transmission overall, and 100% of HIV transmission through sexual context.[199]

PEP refers to a set of antiretroviral drugs that is taken after possible exposure to HIV to prevent transmission.[200] PEP must be taken as soon as possible after an exposure, up to a maximum of 72 hours, and then daily for 28 days. When taken as recommended, PEP has been shown to reduce the risk of HIV transmission by more than 80%.[201]

Observations: Despite their proven efficacy in preventing HIV transmission, neither PrEP nor PEP are prioritized in policy or practice. Most jurisdictions do not mention PrEP or PEP in policy, and few stakeholders had any knowledge about PrEP or PEP practices in prison.

Are PrEP and/or PEP provided pursuant to policy?														
	CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
PrEP	–	No	No	No	No	No	–	No	No	–	No	No	No	No
PEP	Yes	No	No	–	No	–	–	No	No	–	No	No	No	No

"–" indicates information unavailable.

No jurisdiction provides PrEP in policy. CSC comes closest by stating on its website that incarcerated people have access to "pre- and post-exposure prophylaxis therapy."[202] Despite apparently developing a policy on the provision of PrEP in prison in 2018, such a policy is not presently accessible.[203]

CSC is the only jurisdiction to require that PEP be available in prison, pursuant to policy. Specifically, CSC requires that sufficient PEP be available to treat incarcerated people and staff who are exposed to blood and/or other bodily fluids.[204] The PEP policy must be followed in the event of a sexual assault.[205] To note, Saskatchewan and the Yukon have policies to respond to sexual assaults in prisons, which prioritize healthcare, but neither mentions PEP. The Saskatchewan policy states a hospital escort must be arranged for the affected incarcerated people as soon as possible, and that prison nurses must provide "interventions within their scope of practice and training until care is transferred to emergency medical services."[206] The Yukon policy is more limited, establishing a procedure only for affected prison staff, and not incarcerated people, to be transferred to the closest hospital or clinic as soon as possible.[207]

Are PrEP and/or PEP provided in practice?														
	CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
PrEP	Yes	–	–	–	–	–	–	–	–	–	No	No	–	No
PEP	Yes	–	Yes	–	–	–	–	–	–	No	No	No	–	No

"–" indicates information unavailable.

Similar gaps are reflected in practice. CSC is the only jurisdiction in which PrEP and PEP are confirmed.[208] However, awareness about PrEP and PEP availability remains low among federally incarcerated people.[209] In Alberta and Quebec, stakeholders stated that PrEP is not regularly provided, but would likely be available upon request.[210] In Nova Scotia and Ontario, stakeholders shared that they had heard of some people being able to access PrEP, if they had a prescription from the community.[211] In Alberta, a stakeholder noted that PEP is regularly provided following violent incidents involving blood or other bodily fluids.[212] In other jurisdictions, stakeholders stated that neither PrEP nor PEP is available in prison, or did not know whether they were available.[213]

ENABLING POLICIES

***Guidelines 800-8: Post-Exposure Prophylaxis Protocol for Managing Significant Exposure to Blood and/or Other Body Fluids* (CSC)** aims to provide a prompt and consistent response to protect the health of individuals who have a significant exposure to another person's blood or bodily fluids in prison.[214] A significant exposure refers to certain contacts with bodily fluids capable of transmitting HIV, HBV, or HCV. Prison administrators must ensure that prisons are stocked with PEP, local pharmacies have PEP supplies, and nearby hospitals and clinics can provide PEP to incarcerated individuals and staff when necessary. Incarcerated people and prison staff who experience significant exposures must be immediately transported to a nearby hospital or clinic. Alternatively, for an incarcerated person, a nurse may initiate PEP in prison. Incarcerated people must also receive medical follow-ups from prison physicians and must be offered counselling by the prison psychologist.

6. Opioid Agonist Treatment

Guidance: WHO guidance confirms that OAT is an essential part of healthcare in prison, to prevent STBBI transmission and other harms.[215] For individuals with an OAT prescription from the community, OAT must be continued in prison without delay.[216] For individuals without an OAT prescription from the community, but who have a history of opioid use and wish to access the treatment, OAT must be available as soon as possible. Treatment must be responsive to individual needs and preferences — for instance, people in withdrawal or pregnant people must be prioritized for prompt OAT access. Moreover, treatment must not be altered without consent, or for any non-medical reason. Instead, treatment must be provided consistently throughout imprisonment and upon release.

UNDERSTANDING OPIOID AGONIST THERAPY

OAT is a medication-based treatment that reduces opioid withdrawal symptoms for individuals who are dependent on opioids.[217] Treatment involves taking opioid agonist medications, such as methadone (Methadose), buprenorphine/naloxone (Suboxone), slow-release oral morphine (Kadian), and buprenorphine extended-release (Sublocade). Some OAT medications, such as Suboxone, are taken as tablets or films daily. Others, like Sublocade, are taken as monthly injections. These medications are highly effective in reducing STBBI transmission and overdoses.[218] They are also known to reduce rates of re-incarceration.[219]

Observations: In most jurisdictions, OAT is largely available for individuals with an active prescription from the community, in both policy and practice. Fewer jurisdictions provide for OAT initiation, and alarmingly, OAT is regularly discontinued for security reasons, rather than health reasons.

Is OAT initiated and continued in prison, pursuant to policy?														
	CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Initiated	Yes	Yes	Yes	Yes	No	Yes	–	No	Yes	–	No	Yes	No	No
Continued	Yes	Yes	Yes	Yes	Yes	Yes	–	No	Yes	–	No	Yes	Yes	No

"–" indicates information unavailable.

CSC, British Columbia, the Yukon, and Ontario have the most comprehensive OAT policies.[220] They call for OAT to be both initiated and continued in prison, and to be provided promptly upon admission and continuously throughout imprisonment and upon release. They call for certain people to be prioritized based on need (such as pregnant people and those in active withdrawal). Importantly, CSC and Ontario policies also stress that OAT must not be terminated as a form of punishment. CSC's policy states that, "The physician, in making decisions on involuntary tapering, must come to a decision based on medical reasons and not include any aspect of punishment or deterrence."[221] Similarly, Ontario's policy states that patients must never be terminated from OAT, except with patient consent when clinically appropriate.[222] Conversely, British Columbia's policy states that involuntary termination will only occur "as a last resort," which may allow for harmful interpretation.[223] Similarly, the Yukon allows involuntary discontinuation following "an assessment with the health services team and WCC Physician."[224]

Alberta and Saskatchewan policy call for OAT to be initiated and continued in prison, without delay upon admission and without interruption during incarceration and upon release.[225] These policies fall short, however, as they are silent on whether involuntary discontinuation may occur, and, if so, on what grounds.

Committing to Care

An often-repeated description of what opioid withdrawal feels like is the sensation of dying. Sufferers can experience elevated heart rate and blood pressure, excessive sweating, abdominal pain with vomiting and diarrhea accompanied by dehydration, tremors, a sensation of bone pain, skin agitation, a general inability to stay still, insomnia and heightened anxiety. In the throes of detox, the desire to stop these symptoms is overwhelming. Were the sufferer to restart opioids during their detoxification these symptoms would quickly disappear."

– OmbudsPEI, *Committing to Care: Improving the Treatment of Opioid Use Disorder in the Provincial Correctional System,* April 2023. Available at https://ombudspei.ca/2023/04/23/reports, at p. 6.

The remaining policies contain significant gaps. In Prince Edward Island, for instance, OAT can be continued or initiated in prison, but people can be discontinued if they are found to be distributing their medication in an unauthorized manner.[226] In Nova Scotia, OAT can only be continued, and not initiated.[227] Additionally, incarcerated individuals must sign an agreement to obtain OAT, and any breach of the agreement leads to forced termination of OAT.[228]

Is OAT initiated and continued in prison in practice?														
	CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Initiated	Yes	Yes	Yes	–	No	–	–	–	–	–	Yes	–	No	Yes
Continued	Yes	Yes	Yes	Yes	Yes	Yes	–	–	–	Yes	Yes	Yes	Yes	Yes

"–" indicates information unavailable.

In practice, OAT access has greatly improved throughout the years (see "Advocacy Highlight: Prisoners' Legal Services' Human Rights Complaint," p. 31). Today, many jurisdictions provide OAT with fewer delays and interruptions to an increasing number of people. For instance, CSC now initiates or continues people on Methadose, Suboxone, or Subulocade within days or weeks of their admission, or their request to initiate OAT.[229] In 2023, more than 3,500 people were on OAT in CSC prisons, with significantly fewer people on waitlists than before.[230] Despite the improvements, there remains an urgent need to eliminate waitlists entirely, as treatment delays can be harmful and even life-threatening.[231]

ADVOCACY HIGHLIGHT: PRISONERS' LEGAL SERVICES' HUMAN RIGHTS COMPLAINT

In 2018, Prisoners' Legal Services (PLS), which provides legal services to people in provincial and federal prisons in BC, filed a complaint with the Canadian Human Rights Commission regarding CSC's OAT program. At the time, PLS had received close to 100 calls from incarcerated people who were made to wait months or years to receive OAT or were being involuntarily and inappropriately taken off OAT.[232]

In 2021, PLS and CSC reached a settlement to improve the OAT program.[233] CSC committed to eliminating waitlists and removing unnecessary barriers or delays. In policy, CSC committed to following the *Mandela Rules* and to ensure that involuntary termination only occurs when clinically appropriate or upon request by incarcerated individuals. CSC also included "Good Samaritan" principles in its policies to allow incarcerated individuals to respond to overdoses without fear of punishment.

Similar improvements have been noted in British Columbia, where the ministry of health has made OAT its focus since taking responsibility for healthcare in prison in 2017.[234] Today, incarcerated people can continue or initiate OAT in prison, with access to Methadose, Sublocade, Suboxone, or Kadian,[235] and OAT is broadly accessible,[236] with about 40% of the British Columbia prison population on the OAT program.[237]

Despite the progress, there have been concerning reports that incarcerated people are being pressured by prison authorities to participate in a specific OAT regimen that does not correspond to their needs, in some instances to reduce the risk of overdose or because of concerns regarding its unauthorized distribution (i.e. "diversion"). Stakeholders reported that CSC and British Columbia have forced people onto OAT, during "moments of vulnerability," to prevent "drug seeking behavior."[238] Some people have been pressured onto Sublocade because it is provided by injection and thus cannot be redistributed in an unauthorized manner, despite their needle aversions or fears about changing from a treatment that is working.[239] As one stakeholder described, "security concerns are trumping people's wellbeing when it comes to OAT."[240]

Alberta, New Brunswick, and Newfoundland have also developed practices to consistently initiate and continue OAT in prison.[241] For instance, Alberta and Newfoundland now have OAT teams made up of healthcare providers specializing in OAT, who help to streamline OAT initiation and continuity of care throughout incarceration and upon release.[242] Yet, important concerns remain. For instance, in New Brunswick, people are not initiated on OAT until a community provider has agreed to continue treatment upon release. As there are few providers in the community, many people are forced on long waitlists.[243] In Newfoundland, OAT is not provided at consistent times due to nursing shortages.[244] In Alberta, incarcerated individuals do not consistently receive an OAT supply upon release or are not always linked to community providers on release.[245]

> ***[The guys] find [the OAT team] very supportive and non-judgemental… The guys walk past the OAT office all the time and they will pop their head in… They can have regular contact with people… They can share what they want."***
>
> – Stakeholder, Eastern Health
> (Interview with the HIV Legal Network, May 16, 2023)

Ontario, Quebec, and Saskatchewan initiate and continue OAT in prison, but inconsistently,[246] with access to OAT initiation varying by prison. The gaps are most pronounced in Ontario, as people are not even consistently able to continue OAT prescriptions from the community, due to long waitlists and healthcare provider preferences.[247] For instance, some healthcare providers have allegedly refused to continue OAT in prison based on someone's experience with OAT in the community (e.g. whether they abstained from opioid use or not).[248] In Ontario, the lack of comprehensive release planning also hampers continuity of care, as individuals are often released from prison without health cards, healthcare coverage, or phones. Thus, even people who receive OAT prescriptions upon release are not able to pick up or pay for their medication in the community.[249]

> ***"People know they can get [OAT], but people also know that it's hard to get. People know that if you can get to a doctor and if you can get through the waitlist, then you can get it. I feel like that message is out there... Lots of people get so, so sick from withdrawal, and they are just desperate to get onto treatment and aren't able to. When there is that scarcity, it also means that there is an increased demand for people to divert their medications, and there is an increased illicit market in the jail for that, and there is increased harm where people get muscled for their medications."***
>
> – **Stakeholder, Ontario Healthcare Provider (Interview with the HIV Legal Network, January 31, 2023)**

Manitoba and Nova Scotia only continue OAT — they do not initiate.[250] In Manitoba, an apparent desire from prison authorities to be able to initiate OAT is hampered by a lack of physicians willing to prescribe OAT in prison.[251] A similar concern has been raised in Nova Scotia.[252] Notably, Prince Edward Island and the Yukon used to only continue OAT, but have recently enacted changes to also allow initiation in prison.[253] At present, it is unclear whether those changes will translate to consistent access.

> ***"I think its torturous to do that to someone and put them into a sickness. I don't think they look at [diversion] in a harm reduction way... They just look at it as a charge that they then need to punish."***
>
> – **Elizabeth Fry Society Mainland Nova Scotia (Interview with the HIV Legal Network, March 2, 2023)**

Alarmingly, in most jurisdictions, OAT is being terminated involuntarily.[254] In Alberta, a stakeholder explained that an individual found to be distributing their OAT in an unauthorized manner (i.e. "diverting") will have their prescription reviewed by a prescriber, who will usually decide to terminate on that basis, rather than for strictly clinical reasons.[255] In Manitoba and Saskatchewan, stakeholders shared that an individual found distributing in an unauthorized manner, even once, will usually be taken off their medication.[256] In Nova Scotia, Ontario, Prince Edward Island, and the Yukon, people are also taken off OAT when found distributing in an unauthorized manner, with little recourse to dispute the decision or get a second opinion.[257]

ENABLING POLICIES

***Guidance on Opioid Use Disorder Program* (CSC)** emphasizes patient rights and dignity, holistic care planning, and trauma-informed, person-centred, and culturally safe care.[258] To access OAT, incarcerated people must meet the diagnostic criteria for opioid use disorder. People who enter prison in withdrawal must be initiated on OAT on the day of admission. Other people, such as pregnant people who are using opioids, were previously using opioids, or in opioid withdrawal, must be started on OAT as soon as possible. People who enter prison already on OAT must be seen and assessed by a nurse within 24 hours of admission and be continued on OAT without interruption. Strategies are in place to ensure continuity of care and consistent medication administration practices, and to ensure that healthcare personnel are not involved in carrying out punishment, such as terminating medication without consent.

***Opioid Agonist Treatment and Management of Opioid Withdrawal* (Ontario)** clarifies that individuals who are receiving OAT in the community must be identified upon admission, and have their medication continued without interruption.[259] Moreover, individuals who meet the criteria for opioid use disorder must be identified as soon as possible upon admission, and throughout incarceration. They must be offered OAT according to clinical guidelines. Certain individuals, such as those in withdrawal, must be prioritized. Community providers must be contacted upon initiation to ensure continuity of care. People must "never be subjected to forced detoxification, though they may be withdrawn completely from opioids with their consent when clinically appropriate."

PROMISING PRACTICES

PharmaCare (BC) covers the cost of most OAT medications for BC residents, including people in prisons.[260] To access coverage, incarcerated people need only an OAT prescription and a Personal Health Number (see p. 15, "Promising Practices," for further information on Personal Health Numbers). PharmaCare expanded its coverage to include more types of OAT in 2015, which was associated with increased OAT uptake in BC prisons.[261]

Community Transition Teams (BC) support continuity of care for individuals diagnosed with Opioid Use Disorder (OUD), upon release.[262] Teams include social workers, peer support workers, Indigenous patient navigators, and nurse prescribers. They link individuals to mental health and substance use services in the community, and provide short-term clinical interventions, such as primary care, counselling, and OAT prescriptions.

Ministère de la Santé de des Services sociaux (Quebec) delivers OAT education and training to healthcare providers working in prison, to get more healthcare professionals comfortable prescribing and initiating OAT in prison.[263] The training has led to the development of a Community of Practice for healthcare professionals in prison, keen to improve their practices.

7. Naloxone

Guidance: WHO guidelines emphasize the importance of providing naloxone to all incarcerated people, all prison staff, and any other people in prison who might witness an opioid overdose.[264] Naloxone must be provided with education on how to recognize and respond to opioid overdoses, which should be considered part of first aid training.[265] Education should also include information on drug use, overdose prevention, and harm reduction more broadly.[266] A regular supply of naloxone must be maintained in multiple locations in prison, accessible to incarcerated people and staff.[267] Naloxone must also be offered to incarcerated people upon their release, together with refresher training on how to recognize and respond to opioid overdoses.[268]

UNDERSTANDING NALOXONE

Overdoses linked to a tainted opioid supply, when not promptly detected or treated, can lead to neurological damage or death.[269] In Canada, between January 2016 and March 2024, opioid toxicity was implicated in nearly 47,162 deaths.[270]

Naloxone can prevent fatal opioid overdoses.[271] It is an opioid antagonist that quickly reverses the effects of opioid overdose if administered in time.[272] While naloxone can cause withdrawal symptoms in people who are dependent on opioids, it is not otherwise harmful, even if provided to someone who is not experiencing an opioid overdose.[273] Studies have repeatedly found that broadly accessible naloxone significantly reduces rates of opioid toxicity deaths, particularly as overdoses are often witnessed and naloxone is easy to use.[274] The WHO has stressed that take-home naloxone programs are particularly important when people who use opioids are leaving prison, as they experience high rates of opioid overdoses in the four weeks following their release.[275]

Observations: Despite naloxone's life-saving potential, Canada's jurisdictions do not all require naloxone to be in prisons as a matter of policy. Moreover, no jurisdiction provides naloxone directly to incarcerated people. Promisingly, most jurisdictions offer incarcerated people naloxone upon release.

Is naloxone directly accessible to people in prison, or via prison staff, pursuant to policy?														
	CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Direct	–	–	No	No	No	–	–	No	No	–	No	–	No	No
Staff	Yes	Yes	Yes	Yes	No	Yes	–	Yes	No	–	Yes	Yes	Yes	No

"–" indicates information unavailable.

Nine jurisdictions have policies that require naloxone to be available in prison: CSC, Alberta, British Columbia, Nova Scotia, Nunavut, Saskatchewan, the Yukon, Prince Edward Island, and Newfoundland. Of those jurisdictions, none clearly states that incarcerated people must have direct access to naloxone to respond to an overdose. Instead, most specify that naloxone may only be administered by trained staff, without specifying which staff obtain training, or what training includes.

Alberta, Nova Scotia, Nunavut, Saskatchewan, Newfoundland, and Prince Edward Island all explicitly restrict naloxone access and administration to healthcare staff and other prison staff trained in naloxone administration.[276] In Prince Edward Island, for instance, administration is restricted to nurses. If a nurse is not present, prison staff witnessing an overdose are simply directed to contact emergency services, monitor the individual, and administer CPR if necessary.[277]

CSC, British Columbia, and the Yukon are unclear as to whether incarcerated people have direct access to naloxone. CSC policy states that naloxone is freely available in its prisons, and that it must be held in strategic locations, including "in inmate accessible storage kits in accommodation units where there

are no dedicated staff."[278] However, the policy also states that only healthcare staff and other trained prison staff can administer naloxone. Thus, even though incarcerated people may have access to naloxone, they are seemingly not meant to administer it. British Columbia policy states that naloxone can be found in trauma bags but does not specify who has access to trauma bags.[279] The policy does state that *anyone*, including healthcare and non-healthcare staff, can administer naloxone, stressing that the response must be immediate. In the Yukon, policy states that naloxone must be available throughout prison, and that incarcerated people and prison staff must receive education on naloxone use.[280] Even so, the policy is not clear as to whether naloxone must actually be accessible to incarcerated people.[281]

> ***"The first person to find an overdose is usually the roommate, so if they had access [to naloxone], they could use it. There is no harm in giving it… It would be good to have nasal naloxone and to have people with it. The more access the better."***
>
> – **Stakeholder, Alberta Health Services (Interview with the HIV Legal Network, February 9 and 16, 2023)**

Of the six jurisdictions with policies, Saskatchewan alone specifies that all prison staff must be trained in naloxone administration upon their hiring, and that further naloxone training is available on an online platform.[282] The training is meant to cover opioid overdose prevention, determining when naloxone must be administered and how to administer it, and what to do following administration. While Nova Scotia and the Yukon provide training materials on naloxone administration, those jurisdictions have no clear policy on who must receive the training and when.[283]

Is naloxone directly accessible to people in prison, or via prison/healthcare staff in practice?														
	CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Direct	No	No	No	No	No	No	–	–	No	No	No	No	No	–
Staff	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

"–" indicates information unavailable.

Naloxone is accessible to prison staff, including correctional officers and/or healthcare providers, in all jurisdictions.[284] In many jurisdictions, however, correctional officers do not receive adequate training and are reluctant to respond in emergencies. For instance, in Manitoba, a study revealed that of the correctional officers surveyed, 15% reported encountering fentanyl or carfentanil monthly, but only 4% reported feeling able to recognize fentanyl or carfentanil use, overdose, or withdrawal, and only 8% reported being very comfortable using naloxone.[285] The study confirmed that, broadly, correctional officers do not receive adequate education and training on harm reduction and naloxone administration, and often call healthcare staff to respond to a suspected overdose, rather than acting themselves.[286]

We don't even know where it's kept: exploring perspectives on naloxone administration by provincial correctional workers in Manitoba, Canada

[The correctional officers'] discomfort over potential liability [from administering naloxone incorrectly] stems from a lack of experience administering naloxone beyond training scenarios, and thus they worry that incorrect usage of naloxone during a stressful overdose situation may result in some form of reprisal, whether professional, public or both. These expressed concerns must be couched in the scientific fact that giving people naloxone who are unconscious because of a non-opioid overdose is unlikely to cause them harm, and very rarely will someone experience a life-threatening allergic reaction to naloxone... There is a low-risk outcome when administering naloxone, but this potentiality does not trump the adverse effects or fatalities that will occur if a suspected opioid overdose is not treated immediately."

– R. Ricciardelli et al., "'We don't even know where it's kept': exploring perspectives on naloxone administration by provincial correctional workers in Manitoba, Canada," *International Journal of Prison Health* 20(1) (2024): 30-46, at p. 36.

Similar concerns have been raised in Alberta, New Brunswick, Newfoundland, Nova Scotia, Ontario, Prince Edward Island, and the Yukon.[287] For instance, in Alberta, correctional officers often rely on healthcare staff to provide naloxone. In Newfoundland, there is often only one correctional officer who has been trained in naloxone present at any given moment.[288] In the Yukon, not all correctional officers carry naloxone.[289]

In the jail where I did the most time, there is one button to let somebody know what happened. If someone overdoses on the upper top floor, and the [guard] is sleeping [on the bottom floor], you have to wait until the guards do their rounds every half hour. You would be screwed. But really, we have nasal naloxone now... you could easily hang one of those in each cell or at least on the range, so if there was an overdose you could easily respond to it."

– Matthew Bonn, former Program Manager, Canadian Association of People who Use Drugs (Interview with the HIV Legal Network, March 7, 2023)

Even so, incarcerated people do not have direct access to naloxone in any jurisdiction.[290] At present, when incarcerated people witness an overdose, they must alert staff, causing a delay.[291] Nearly every stakeholder agreed that naloxone should be directly accessible to incarcerated people, as they are more able to respond quickly to an opioid overdose. Many stakeholders also stressed that making naloxone directly accessible to incarcerated people would not pose any safety issue, as naloxone is not harmful if given to individuals who are not experiencing an opioid overdose.[292] Promisingly, in New Brunswick, a plan has been approved to make naloxone directly accessible to incarcerated people.[293] If the plan is enacted, it will provide a promising practice for other jurisdictions.

> ***In all the places I have been housed, we do not have access. The only individuals that have access to naloxone are staff, which is guards. If someone is to overdose, and it has happened, you need to get the attention of guards, they need to bring people in. There is a lot of time that is wasted."***
>
> – **Alicia Gordon, Formerly incarcerated woman (Interview with the HIV Legal Network, March 6, 2023)**

Is take-home naloxone provided pursuant to policy?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
No	Yes	Yes	Yes	No	Yes	–	No	Yes	–	No	No	Yes	No

"–" indicates information unavailable.

Only Alberta, British Columbia, Nova Scotia, Saskatchewan, and the Yukon state in policy that naloxone kits must be provided to people upon release, despite the clear evidence that overdose risks are most acute in the weeks immediately following release.[294] With the exception of Saskatchewan, these jurisdictions also require that education be provided to people receiving kits, including on opioid overdose prevention, assessing signs of opioid overdose, using naloxone, and obtaining more naloxone kits in the community. Ontario's information guide similarly confirms that take-home naloxone kits can be requested from healthcare staff during release.[295]

Is take-home naloxone provided in practice?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Yes	Yes	Yes	–	Yes	Yes	–	Yes	Yes	Yes	Yes	Yes	Yes	Yes

"–" indicates information unavailable.

In practice, most jurisdictions consistently offer naloxone upon release.[296] For instance, in some jurisdictions, people who are receiving OAT, or who have been diagnosed with opioid use disorder, automatically have naloxone placed in their belongings, which they receive on release.[297] Unfortunately, training is not consistently provided when people are released early, such as when they are released directly from a courthouse.[298]

In Manitoba, New Brunswick, PEI, and the Yukon, take-home naloxone is offered, but less consistently. For instance, in Manitoba, only some prisons provide naloxone in release packages.[299] In New Brunswick, recent government data shows that only 34 take-home naloxone kits were distributed by prisons in 2022, compared to over 2,000 distributed by the community organization Ensemble Moncton.[300] In PEI and the Yukon, prison authorities are equipped to distribute naloxone kits, but evidence is lacking on how those programs are running.[301]

ENABLING POLICIES

***Responding to Suspected Opioid Overdose* (BC)** guides the province's response to suspected opioid overdoses, emphasizing broad naloxone accessibility and immediate naloxone administration.[302] In prisons, naloxone must be in trauma bags. In the community, naloxone must be in the Community Transition Teams' first aid kits (see p. 33, "Promising Practices," for further information on Community Transition Teams). In the event of a suspected opioid overdose, in prison or community, anyone who is available is encouraged to administer naloxone. Following administration, people experiencing an overdose must be transferred to hospitals. They must then be referred to substance use counsellors and offered take-home naloxone, as well as naloxone training.

***Guidelines 800-4: Response to Medical Emergencies* (CSC)** provides for easy access to naloxone within CSC prisons and rapid administration of naloxone by CSC staff.[303] Naloxone must be placed in locations where there are dedicated staff, *or* in storage kits accessible to incarcerated people where there are no dedicated staff. In the event of a suspected opioid overdose, prison staff must administer naloxone, regardless of whether they have received training. Prison staff must then immediately call an ambulance. Training on naloxone administration is provided on CSC's internal online platform.

***Take Home Naloxone Kits* (Saskatchewan)** requires consistent naloxone access to people being released from prison.[304] Prison directors must establish procedures to ensure that incarcerated people are aware of the take-home naloxone program and are offered naloxone upon release. Remanded people returning from court to retrieve property are to be offered a naloxone kit when "reasonably practicable." Incarcerated people who express interest in obtaining naloxone kits in the community are to be provided with information on how to do so.

PROMISING PRACTICES

Unlocking the Gates (BC) is a peer-led, non-profit organization that aims to support people reintegrating in the community following their release from prison.[305] The organization meets with people at the prison gate, or in the community, and offers take-home naloxone kits and naloxone training.

Blood Ties Four Directions Centre (Yukon) is a community organization that aims to eliminate health inequities and promote equal access to health and wellness.[306] The organization provides a broad array of harm reduction programming in the community, including safer injection equipment, safer inhalation kits, drug checking programs, and harm reduction education. Notably, Blood Ties focuses on providing take-home naloxone kits and overdose prevention training to people recently released from prison.

8. Sterile Drug-Use Equipment

Guidance: In recognition of the broad use of drugs in prison, since 1993 the WHO has consistently recommended that prisons provide sterile needles and syringes to incarcerated people to prevent STBBI transmission.[307] Several distribution models have been used around the world to provide such equipment in prisons, including distribution via prison healthcare staff, community-based organizations, or trained peers, and distribution via automated dispensing machines. Whichever model is used, access to sterile needles and syringes and other drug-use equipment must be easy, discreet, and confidential, and must be free from the risk of punishment.[308] Moreover, sterile equipment should be provided with education on safer drug use and overdose prevention, as well as other harm reduction programs (such as naloxone and OAT programs).

UNDERSTANDING PRISON-BASED NEEDLE AND SYRINGE PROGRAMS

Studies have consistently found that sterile needle and syringe programs in prisons reduce the risk of STBBI transmission.[309] Moreover, they have confirmed that such programs do not lead to increased drug consumption in prison, the use of needles as weapons against prison staff, or other safety concerns. In fact, needle and syringe programs have been found to facilitate referrals to other healthcare and harm reduction services.

Observations: At present, sterile needles and syringes are only available in eleven CSC prisons, through the Prison Needle Exchange Program (PNEP) initiated in 2018.[310] No programs are available in provincial and territorial prisons. Strong opposition by correctional officers' unions has limited broader uptake.[311] In CSC prisons with PNEP, flaws in policy and practice, including routine breaches of confidentiality that subject participants to increased scrutiny and possible punishment, have prevented the PNEP from being truly accessible.

Are sterile needles and syringes available pursuant to policy?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Yes	No	No	No	No	No	–	No	No	–	No	No	No	No

"–" indicates information unavailable.

PNEP policy does not facilitate easy and discreet access to sterile injection equipment. Instead, it creates barriers that deter and prohibit participation in the program. To participate, individuals must first meet with CSC healthcare services to receive education related to drug use, safer drug-use practices, the harms of drug use, the risks of STBBIs, as well as referrals to other health services.[312] Next, people must undergo a "threat risk assessment," through which prison administrators determine whether an person's participation will pose a security concern.[313] The process has been criticized for scrutinizing security concerns rather than clinical need. Data from 2022 revealed that 23% of PNEP applications were rejected based on the risk assessment.[314]

Individuals who are accepted in the program are provided with one PNEP kit at a time, which contains one syringe, one cooker, three water bottles, one vitamin C sachet, and filters.[315] These supplies are known to be insufficient, and do not reflect actual need based on drug use patterns. For instance, disinfectant swabs are not included in the kits because of their alcohol content.[316] Participants are also required to keep their kits, and all their contents, visible in their cells when not in use, and to show the kits to correctional officers during daily visual inspections. This makes them easy targets for other incarcerated people, who may themselves need sterile injection equipment, and prison staff, who continue to punish and otherwise stigmatize drug use.[317] If drugs are found in the kit — that is, the kit has been used — individuals can receive institutional charges.[318]

Interestingly, in April 2024, the Yukon published a policy that suggests that a needle exchange program may be initiated in prison, if the territory considers it necessary.[319] The policy states that prison staff, including correctional officers and healthcare providers, play a role in instituting harm reduction strategies, which includes making available "needle exchange (if this becomes an issue within the facility)."[320] To date, there is no evidence to suggest that such a program has been initiated.

A Risk of Weaponization?

In terms of the weaponization of injection equipment, interviewees stressed that people who inject drugs would much prefer to keep needles for their personal use and that the threat of needles being used as weapons was a scapegoat, noting: 'They're [using] that as an excuse to not do it… If a man wanted to do that, he does not need a needle to do that… Most guys, if they have a needle, they're going to use it for whatever they do and… that's it, they'll throw it away.' (Interview #30, Indigenous man, AB)."

– S. Chu et al., *Points of Perspective: Research Report on the Federal Prison Needle Exchange Program in Canada,* HIV Legal Network & Toronto Metropolitan University, November 2022. Available at www.hivlegalnetwork.ca/site/points-of-perspective-research-report-on-the-federal-prison-needle-exchange-program-in-canada/?lang=en.

Are sterile needles and syringes available in practice?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Yes	No	No	No	No	No	No	No	No	No	No	No	No	No

"–" indicates information unavailable.

In practice, access to the program is further hampered by application delays, lack of program information, inconsistencies in eligibility criteria, limited operating hours, and limited supplies.[321] In some prisons with PNEP, some correctional officers are not even aware of the program's existence. Moreover, correctional officers' hostility towards the program and to drug use in prison more broadly, together with the lack of confidential access, has led to the scrutiny and punishment of program participants.

Unsurprisingly, PNEP participation rates are low. Between 2018 and 2020, only 42 participants were enrolled in PNEP.[322] As of 2022, only 53 participants were enrolled in PNEP. As of August 2024, 451 people were approved for the program, but only 47 were participating.[323] Meanwhile, among people who reported injecting drugs in federal prison in the 2022 National Health Survey, 47% of those reported injecting with a previously used needle and 53% reported sharing their used needle with someone else.[324] As the OCI noted in its 2021-2022 report, "the program has failed to generate much interest, trust, or confidence from either prisoners or front-line staff. It remains a program largely in name only."[325]

> *We know that people are using in our facilities. We also know that people are not using safely. We know that people are getting infections and having adverse intravenous drug use from not clean needles, from shared needles usage or syringe usage, or they are injecting with things that are not meant to be needles or syringes... [We have seen people inject with] pens ... We also have gaming systems, and there are pieces within the controller that people can use.... We know that people go on medical [temporary absences] because they have an abscess or infection that clearly came from intravenous use."*
>
> – Case Management and Social Work Services Manager, Nova Scotia Department of Justice (Interview with the HIV Legal Network, January 27, 2023)

Across the country, stakeholders marked an urgent need for meaningfully accessible sterile injection equipment, due to pervasive drug use in prison. They stressed the need to move away from the PNEP model, and instead provide incarcerated individuals with broad and easy access to sterile equipment based on clinical need, without security screenings or the need to advertise possession of sterile equipment.[326]

ADVOCACY HIGHLIGHT: POINTS OF PERSPECTIVE

In November 2022, the Legal Network and Toronto Metropolitan University published *Points of Perspective: Research Report on the Federal Prison Needle Exchange Program in Canada*.[327] The report details findings from 30 interviews with people from across Canada about their knowledge of or/and experience with PNEP. The interviewees highlighted the following program needs: anonymity and confidentiality, ease of access to equipment, and trust in providers administering the program — reflecting WHO guidance. The report concludes with six recommendations:

1. Remove administrative and other barriers to enrollment, including by eliminating the "Threat Risk Assessment," and disseminate sterile injection equipment in secure kits to all people in prison upon request;
2. Enhance confidentiality for participants by ceasing daily visual inspections of PNEP kits, and ensure that program participation is not recorded in the files of incarcerated people;
3. Diversify the distribution of sterile injection equipment, including via peer distribution and automatic dispensing machines installed in locations without surveillance;
4. Provide other harm reduction materials and services for people who use drugs in prison, including smoking and snorting equipment, naloxone, safer tattooing supplies, and overdose prevention services;
5. Implement mandatory training for prison authorities, correctional officers, and healthcare staff about the benefits of PNEP and the impacts of drug-use stigma; and
6. Engage in meaningful consultation and regular engagement with people in prison about how to improve the program design, which may be adjusted based on the specifics of each prison, as PNEP continues to rollout nationally.

9. Bleach

Guidance: The WHO recommends that bleach be provided in prison only as a "second line strategy" to sterile needle and syringe programs.[328] While bleach is a useful disinfectant for blood spills, it is not entirely effective in preventing HIV or HCV transmission.[329] Where bleach programs are implemented, full-strength bleach must be made easily and discreetly available in multiple locations in prisons. Bleach programs must include information about the most effective ways to use bleach to clean drug-use equipment, and on the limited effectiveness of bleach for preventing STBBI transmission.

> *I understand the hesitancy in the community to talk about bleach to clean needles and syringes simply because it's not 'the most effective' approach. However, harm reduction is harm reduction. It's not an absolute risk reduction. It's not possible to absolutely eliminate risk, that's why it's called 'harm reduction'... I get that [people] don't want to recommend it because it's not perfect, but in prisons you don't have access to anything else."*
>
> – Sofia Bartlett, Interim Scientific Director for Clinical Prevention Services, BC Centre for Disease Control, and Adjunct Professor, School of Population and Public Health, University of British Columbia (Interview with the HIV Legal Network, February 2, 2023)

Observations: Bleach is not prioritized in policy or practice in most jurisdictions.

Is bleach available pursuant to policy?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Yes	Yes	No	No	No	No	–	No	No	–	No	No	No	No

"–" indicates information unavailable.

CSC and British Columbia alone provide for bleach in policy. Both jurisdictions require bleach kits to be freely available in multiple locations in prison, and accessible in private locations without the need to approach prison staff. Both jurisdictions also require that education be provided alongside bleach, with information on how to use bleach as a disinfectant. Until 2023, Saskatchewan also had a policy requiring bleach in prison, but that requirement has now been removed, for unknown reasons.

> *I would rather we have syringe distribution than bleach. In light of not having that, it would be good to have a [bleach] program at all."*
>
> – Civil Society Organization (Interview with the HIV Legal Network, January 31, 2023)

Is bleach available in practice?													
CSC	BC	AB	SK	MB	YK	NT	NU	ON	QC	NL	PE	NS	NB
Yes	–	No	No	No	No	–	–	No	Yes	Yes	No	No	No

"–" indicates information unavailable.

In practice, bleach is largely unavailable. CSC, Newfoundland, and Quebec appear to provide bleach but do so inconsistently. For instance, some CSC prisons provide bleach free through vending machines.[330] The vending machines, however, only provide a small amount of bleach, malfunction regularly, and frequently run out of stock. In other CSC prisons, bleach bottles and distributors are attached to walls outside healthcare offices or correctional officers' offices, where discreet access is not possible.[331] In Newfoundland, there is no official bleach program, but incarcerated individuals can request bleach to "clean the showers."[332] Bleach is thus not discreetly accessible and is not provided with information on use or effectiveness. Finally, in Quebec, bleach availability differs from prison to prison.[333] A 2017 study found that bleach was available to 69% of surveyed incarcerated people there.[334]

ENABLING POLICY

***Bleach* (British Columbia)** clarifies that bleach must be freely and readily available in living units and in healthcare units, as well as checked daily and restocked when necessary. Access must also be anonymous, without the need to approach prison staff. To minimize risk of injury, bleach must be appropriately labelled, and individuals must have access to rubber gloves to protect their skin. Education must also be provided by healthcare staff, and on printed materials, on how to use bleach as a disinfectant.

***Bleach Distribution* (CSC)** explicitly recognizes that bleach is a harm reduction measure meant to prevent STBBI transmission. Upon admission, everyone is given a bleach kit, information on how to obtain more, and is instructed on how to use bleach as a harm reduction and first aid measure. Bleach is to be placed in at least three locations in each prison, which offer as much privacy as possible and do not require staff interaction. Printed instructions about how to use bleach, including how to clean needles and syringes, are available throughout prisons. Possession of one bleach bottle is not considered evidence of "drug usage, or any other activity constituting a disciplinary offence."

PROMISING PRACTICES

"Instructions on the proper use of the bleach kit" (CSC) is a poster that simply lays out how to use bleach to clean tattooing machines, tattooing and piercing needles, cookers, and syringes.[335] For each item, the instructions specify how much water and bleach should be used, and how long the item should be soaked. The poster also states in large, red font that "Cleaning with bleach may not kill hepatitis C."

10. Safer Tattooing and Skin-Piercing Measures

Guidance: Safer tattooing and piercing programs are central to the WHO's package of interventions for STBBI prevention in prisons.[336] Such programs must include discreetly accessible sterile equipment as well as safer tattooing and piercing training. Programs must also include education on risks associated with sharing tattooing and piercing equipment, and any other skin-penetrating equipment, such as razors.

Observations: Safer tattooing and piercing programs are largely ignored in policy and practice. Instead, incarcerated people are punished for engaging in such activities.[337]

Is safer tattooing and piercing programming provided for in policy?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
No	No	No	No	No	No	–	No	No	–	No	No	No	No

"–" indicates information unavailable.

Is safer tattooing and piercing programming available in practice?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
No	No	No	–	No	No	–	–	No	No	No	No	No	No

"–" indicates information unavailable.

Manitoba is the only jurisdiction in which there is a strong emphasis on education regarding the risks of STBBI transmission associated with tattooing and piercing.[338] The jurisdiction does not, however, offer a more comprehensive program, and largely punishes tattooing and piercing, as in other jurisdictions. Stakeholders from across the country noted that safer tattooing and piercing programs were necessary, as tattooing and piercing are pervasive in prisons, despite the practices being punished.[339] Stakeholders noted that there would be great interest from people in prison to participate in safer tattooing and piercing programs, but that there is little appetite to implement these programs among prison administrators.[340]

> *People were willing to MacGyver by whatever means necessary to get [tattoos]. I saw a lot of infections... I would see girls using smuggled staples and trying to file them. I saw people making their own ink... in really unsterile situations. I also saw people sharing the same needle to do several tattoos. That is super concerning. But again, there was no access to anything that was sterile. The reality is that people are going to do them regardless."*
>
> – Alicia Gordon, Formerly incarcerated woman
> (Interview with the HIV Legal Network, March 6, 2023)

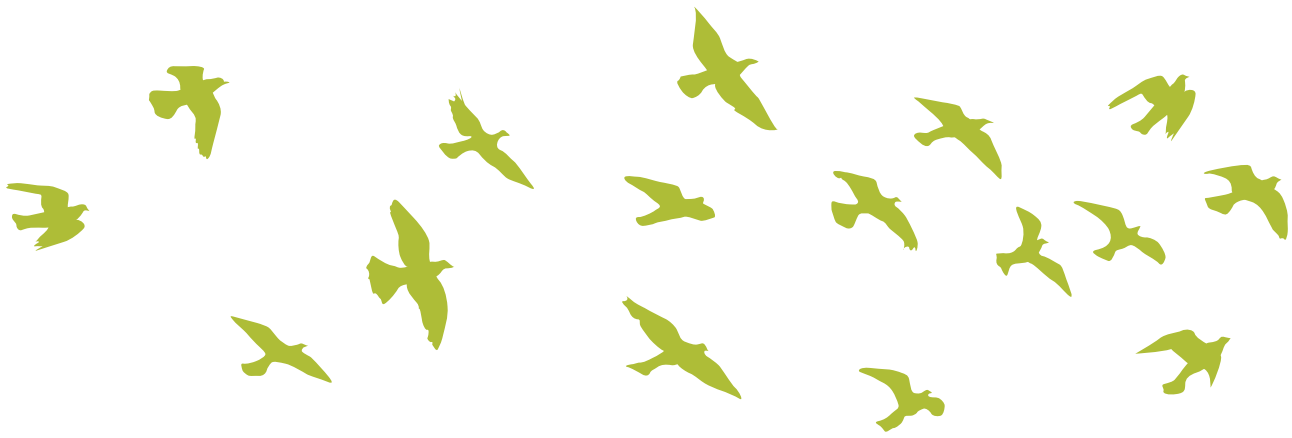
> *We understand that a lot of people are getting HCV inside through tattooing and piercing. 100% the equipment should be available. … All my clients have gotten prison tattoos. A lot of them are beautiful tattoos."*
>
> – Olivia Gemma, former Provincial Hepatitis C Coordinator, PASAN (Interview with the HIV Legal Network, March 10, 2023)

In federal prisons, and prisons in BC, Newfoundland, and Ontario, stakeholders noted that slashing and cutting are broadly punished in the same manner as tattooing and piercing. In many instances, people who are caught slashing or cutting are sent to segregation.[341] As one stakeholder described, it is "punishment on top of punishment."[342]

PROMISING PRACTICES

Safer Tattooing Practices Initiative (CSC) was a safer tattooing pilot program that ran between 2005 and 2006, and was repeatedly cited by stakeholders as a promising model.[343] The initiative involved the establishment of "tattoo rooms" in six prisons, and the provision of education on safer tattooing practices. An evaluation conducted following the pilot found that the initiative led to enhanced knowledge among prison staff and incarcerated people around STBBIs, reduced risk of harms (such as STBBI transmission), increased safety for prison staff and incarcerated people, and increased employment opportunities for incarcerated people. The evaluation critiqued the limited numbers of trained tattoo artists and sporadic hours of operation but found that otherwise the cost of the program was low compared to its benefits. The program was forced to shut down in 2006, by a newly elected federal government unsupportive of harm reduction programs.

People Living with Experience (Newfoundland) is a program developed in 2023 at Her Majesty's Penitentiary, in partnership with a community organization that runs a suicide support group. The program trains incarcerated people to support others who are struggling with mental health issues and/or slashing and cutting. The program's goal is to keep individuals with mental health conditions out of segregation through peer supports.



11. Population-Specific Needs

Guidance: The WHO has long stressed the need to address health inequities in prison, including for Indigenous people, racialized people, women, and trans people.[344] They must have access to care that is responsive to their needs — that is, culturally sensitive and appropriate, as well as gender sensitive and appropriate. Accordingly, prison staff and healthcare providers must be trained to provide that sensitive and appropriate care.

Observations: Across Canada, the needs of Indigenous people, racialized people, women, and trans people are not being met. Their needs are regularly ignored or overtaken by ill-defined security concerns. The discrete cases in which their needs are being met are often the result of efforts by individual staff, incarcerated people, or community organizations, rather than system-wide policies or practices.

I. INDIGENOUS PEOPLE

Guidance: Prison authorities must develop and implement policies that institute trauma-informed, culturally appropriate, and culturally sensitive services, including in healthcare, and prohibit and prevent discrimination against Indigenous staff and incarcerated people.[345] Policies must enact practices that are responsive to the rights and needs of Indigenous people, including access to traditional medicines and healing practices. Prison authorities must work with Indigenous communities to make use of alternatives to imprisonment, such as Indigenous-run healing lodges.[346]

Observations: In policy and practice, most jurisdictions are failing to provide culturally sensitive and appropriate programming, supports, and services to Indigenous people.

In policy, Nunavut appears to have the most comprehensive programming for Indigenous people. For instance, Aaqqigiarvik Correctional Healing Facility policy explains that incarcerated people have access to counseling by Elders; an Inuit Cultural Skills Program, to learn about "the land, hunting, and gathering, and the diverse cultures of the north"; and carving and other arts and crafts programs.[347] At least in policy, these programs do not appear to be vulnerable to ill-defined security concerns.

CSC, New Brunswick, Nova Scotia, Ontario, and Saskatchewan require Indigenous programming in policy. Each jurisdiction, however, allows ambiguous security issues to override Indigenous rights and needs. For instance, CSC policy establishes a Pathways Initiative, an Elder-driven intensive healing program, but strictly limits participation to people with low-security classifications.[348] New Brunswick allows incarcerated people to retain sacred articles, but only if they "do not compromise safety and security."[349] New Brunswick also allows people to have spiritual medicines, but only upon approval by prison administrators (without specifying what warrants approval). Additionally, the province allows smudging, but only during times of "personal crisis" or when "operationally feasible." Similarly, Nova Scotia allows for incarcerated people to access daily smudging, with the approval of correctional staff, who are to consider "any serious behaviour issues" or "other identified security issues."[350] People must be escorted to and from the smudging area and frisked before they can return to their living unit after a smudge. Moreover, smudging ceremonies can be postponed in the case of "serious security concerns," without explanation of what those concerns may encompass. Nova Scotia policy also allows incarcerated people to participate in sweats led by Elders, in traditional sweat lodges available in all their prisons.[351] Again, however, correctional staff have control over who can participate and how frequently sweats occur, based on undefined "security concerns." In Ontario, incarcerated people are allowed access to Elders, Spiritual Leaders, or Healers, but "subject to superintendent's normal control of visits."[352] Moreover, essential medicines requested must be kept in bags "that meet security standards." In Saskatchewan, spiritual items are allowed only "when and where appropriate" and if "not contraband."[353]

> *There are so many native people that are so smart. Maybe they have a criminal record. Look at me: I have a university degree and a brand-new car. But none of that matters because I'm a native person. People need people with lived experience advocating and working for them."*
>
> – Elizabeth Fry Society Mainland Nova Scotia
> (Interview with the HIV Legal Network, March 2, 2023)

Notably, Saskatchewan and British Columbia are the only jurisdictions to require comprehensive staff training in policy.[354] British Columbia's policy applies to all healthcare staff in the province, and thus all healthcare staff working in prison; there does not appear to be a policy that applies to correctional officers. Other jurisdictions limit training to only staff working with Indigenous people,[355] make such training optional,[356] or leave training requirements unclear and ambiguous.[357]

The inadequate policy is reflected in practice. Indigenous-specific programming and services are somewhat accessible at the federal level where there is *some* access to Elders, smudging, and sweat lodges.[358] Yet, even CSC programs are extremely inadequate.[359] For instance, the Pathways Initiative has consistently been criticized for its stringent eligibility criteria, and for overburdening and undervaluing its Elders. Other programs at the federal level adopt "one-size-fits-all" approaches, oversimplifying Indigenous diversity. Notably, alternatives to traditional imprisonment exist at the federal level, including Indigenous-run initiatives. However, they are insufficient in number, inadequately funded, and under-used.[360] A stakeholder also reported that Indigenous people who choose not to engage in these programs can also be considered "not compliant with their rehabilitation," which can have negative implications for their parole.[361]

> *I know they have [sweat lodges] in federal, so why not provincial? Two years less a day is the maximum sentence in [provincial]. I know if I haven't had a sweat since the winter. I have missed a spring sweat, a summer sweat, and now we are moving into the fall. That is three seasons that I miss. I am feeling it."*
>
> – Stakeholder, Native Council of Prince Edward Island
> (Interview with the HIV Legal Network, September 27, 2023)

At the provincial and territorial level, programs vary greatly, with some jurisdictions engaging in promising practices. In the Yukon, Indigenous programs are prioritized. First Nations governments ensure that incarcerated people have regular access to Elders and healing programs.[362] In many other jurisdictions, programming falls well short.[363] For instance, in Nova Scotia, incarcerated people do not have consistent access to smudging or sacred medicines, despite policy that entitles them to such.[364] Moreover, people have their sacred medicine confiscated, or inappropriately treated by staff and other incarcerated people (for instance, by blending medicines together or discarding them on the ground). In most other jurisdictions, similar limitations are reported, which prison staff, incarcerated individuals, and community organizations are consistently working against.[365]

ENABLING POLICIES

Inuit Cultural Skills Program **(Nunavut)** recognizes the importance of Inuit-specific programming for the overall health and well-being of Inuit people.[366] The policy calls for programming to teach clients about "the land, hunting and gathering, and the diverse cultures of the north" and to "enhance self-esteem." Individuals obtain classroom instruction and on the land instruction, including culturally and traditionally relevant hunting and survival techniques.

Commissioner's Directive 702: "Indigenous Offenders" **(CSC)** aims to establish interventions to meet the unique needs of Indigenous incarcerated people.[367] Indeed, the policy calls for the development of the Pathways Initiative, as well as other programs that prioritize access to Elders and Spiritual Advisors, to provide counselling, teaching, and ceremonial services (which can include, smudging, sweat lodge ceremonies, traditional pow-wows, etc.). Traditional foods can be used in ceremonies and celebrations. Critically, Indigenous people must be consulted and collaborated in the development and monitoring of Indigenous programming.

First Nations and Metis Cultural Programs and Services **(Saskatchewan)** recognizes that over 75% of the people in prison in Saskatchewan are First Nations and Métis, even though they represent only about 15% of the jurisdiction's population.[368] All prison staff are required to develop cultural competency, with assistance from Elders and Cultural Advisors, "to foster an effective and respectful environment." All new staff are required to receive a day of cultural awareness training before they start working. Additionally, staff who directly supervise incarcerated people are required to attend additional cultural training to enhance their cultural competence.

PROMISING PRACTICES

Whitehorse Correctional Centre (WCC) Inspection 2018 (Yukon) outlines the steps that have been taken in the prison to address the needs of Indigenous people. In the report, prison authorities describe incorporating "First Nation culture into the fabric of operations and programming at the WCC."[369] Prison staff are required to participate in culturally relevant training. Prison authorities have also established a First Nations Liaison Officer to provide culturally relevant supports, as well as a Sweat Lodge Program Facilitator to ensure consistent sweat lodge operation. Prison authorities now ensure Elders are consulted on cultural matters, maintain a roster of available Elders to provide services (including traditional teachings, ceremonies, and healing circles), facilitate solstice gatherings and feats for incarcerated individuals and their families (where traditional food is available), make smudging kits available in every unit upon request, incorporate traditional foods into their menus, run a library of Yukon First Nations books, and schedule storytelling circles. Additionally, prison authorities have been referring incarcerated individuals to community-based healing programs.

Indigenous Court Workers (Prince Edward Island) work with Indigenous individuals who are involved in the criminal legal system, focusing on restorative justice and lowering recidivism.[370] Indigenous court workers meet with incarcerated individuals, prepare Gladue reports and recommendations, and conduct pre- and post-report counselling. They work with prison authorities to ensure that Gladue recommendations are incorporated in release plans, and to establish referrals to healthcare and other services in the community. They also facilitate smudging, drumming, and other cultural services that incarcerated people may want or need.

II. RACIALIZED PEOPLE

Guidance: Prison authorities must develop and implement non-discriminatory policies and services that are trauma-informed, culturally appropriate, sensitive, and responsive to the rights and needs of racialized people, including access to cultural and/or religious practices and interpretation services where necessary, and in the context of healthcare.[371] Prison authorities must also work with racialized communities to develop and implement strategies that address the overrepresentation of racialized people in prisons.[372]

Observations: The needs of racialized people are largely overlooked. Few jurisdictions have policies devoted to the needs of racialized people in prison. No jurisdiction has consistent culturally responsive practices.

CSC is alone in clearly laying out a policy to meet the needs of racialized people.[373] The CSC policy requires that services and programs be designed and monitored to meet the needs of "ethnocultural offenders, using an intersectional lens."[374] The policy thus provides for special diets, interpreters, and more comprehensive programs centred on meeting the needs of racialized people. Yet, the policy does not meaningfully prioritize those needs and rights. For instance, incarcerated people may form associations to promote their cultural needs or interests, but only if approved by prison authorities — and the criteria for approval is not available. Racialized people from the community can come into prisons to provide services, but they are not compensated for their work. Cultural sensitivity training is required, but only of staff who work directly with racialized people.

Several other jurisdictions have policies that provide for interpreters and special diets in prison; others treat the needs of racialized people as an "add-on" to the needs of Indigenous people.[375]

> *In 2020, after being there for three years, they put a piece of paper on the unit saying they were having an Emancipation Day celebration. I was up in arms. I have already been here for three years, like why now? At the dinner time, they said something special would be coming, and it was chicken with jerk dressing. I said I am going to be here a few more years, let's see if I am still emancipated next year. And next year, there was nothing..."*
>
> – George Flowers, detained at Toronto South Detention Centre from 2017 to 2022 (Interview with the HIV Legal Network, February 22, 2023)

In practice, there is little to no consistent programming to meet the needs of racialized people, despite repeated reports of egregious racial discrimination in prison. For instance, in 2022, the OCI found that "discrimination, stereotyping, racial bias and labeling of Black prisoners, remain as pervasive and persistent as before."[376] The OCI concluded that there had been no progress in the past decade. In 2023, the East Coast Prison Justice Society also raised concerns that racialized people in Nova Scotia prisons were being treated worse than other prisoners.[377] That same year, Ontario's Chief Coroner marked an urgent need to advance "anti-racism, cultural and gender considerations in all facilities, including attention to zero-tolerance policies; sensitivity training for correctional staff; collection, reporting and use of race-based data; culturally specific product availability within canteens and facilities."[378] The Chief Coroner explained that the overemphasis on security and safety in Ontario jails was, in fact, contributing to a less safe environment.

ENABLING POLICIES

***Commissioner's Directive 767: "Ethnocultural Offenders"* (CSC)** is meant to ensure that the specific needs and cultural interests of racialized individuals are met through effective services and interventions.[379] Prison administrators must foster an environment in which activities and services for racialized people can take place. Thus, staff are required to report any discriminatory and disrespectful behaviour witnessed. Prison administrators must also ensure that racialized people have access to any specific diet, religious accommodation, or interpretations services they may require. Incarcerated people may also form associations and/or committees to meet their specific needs and interests. Racialized people are to be involved in the development and implementation of programs and services. Notably, concerns have been raised that the policy has taken the place of action, rather than empowering action.[380]

PROMISING PRACTICES

African Heritage Month (Nova Scotia) was celebrated for the first time in the jurisdiction's prisons in 2023. The celebration involved education materials, conversations, and workshops. Prison authorities are also developing an African-Nova Scotian experiences program, which has been welcomed by those who have had the opportunity to participate to date.[381]

III. WOMEN

Guidance: Prison authorities must develop and implement policies that are sensitive and responsive to women's unique healthcare needs and vulnerabilities.[382] Specifically, policies must ensure that women are protected from gender-based discrimination, including violence, by staff and other incarcerated people. Women must also have access to specialized healthcare, such as gynecological and breast cancer screenings, pregnancy care (including abortion care), and parenting supports.[383]

Observations: In some jurisdictions, the safety needs of women in prison are addressed in policy, insofar as it relates to the segregation of male and female prisoners and the conduct of strip searches. For instance, Nova Scotia states that women are to be separated from men and supervised by women.[384] New Brunswick states that, if for operational reasons, women need to be held in the same prison as men, women will be held in separate areas from men and will be transferred to a women's prison as soon as possible.[385] Newfoundland states that women's prisons are to be administered by people with the experience, skill, and education necessary to understand the unique challenges and needs of incarcerated women.[386] Additionally, most jurisdiction's policy states that strip searches are to be conducted by a staff member of the same gender.[387] However, in those jurisdictions, strip searches may be conducted by someone of another gender if a delay would pose a risk to safety — which means that women's needs can be dismissed for unspecified safety concerns.[388]

Only Prince Edward Island has a policy mandating comprehensive gender-specific healthcare. This including cancer screenings (e.g. regular Pap screenings and breast examinations, health education and relevant follow-up care),[389] abortion services, including counselling and follow-up care,[390] pregnancy care, and parenting support[391] (e.g. ensuring the expectant mother's health needs are met, and developing plans for delivery, the care of the child following delivery, and follow-up care for the mother after delivery).[392]

Other jurisdictions only make vague promises to respond to women's needs. For instance, CSC policy regarding women's prisons simply states that "physical and mental health professionals will be deployed consistent with community healthcare standards and may intervene according to their professional function, regardless of their sex."[393] CSC also describes a mother-child program in policy but does not detail healthcare to be provided to parent or child in prison.[394] In Nova Scotia, the health ministry states that incarcerated people can request "women's health" care, but also notes that such care is not guaranteed.[395] Saskatchewan's Ministry of Justice has claimed that it has a policy that provides for pregnancy care, including pregnancy tests on admission and pre- and post-natal care. [396] Despite their apparent publication of all their prison policies, we have been unable to locate such a policy.

> ***In my work, it is obvious that there are almost no policies to support prevention of pregnancy and pregnancy termination, which are both very important in the context of STBBIs […]. These are very important, but they are invisible to prison services at both the provincial and federal level."***
>
> – **Martha Paynter, Director of Nursing Research, Contraception and Abortion Research Team, University of British Columbia, and Assistant Professor, Faculty of Nursing, University of New Brunswick (Interview with HIV Legal Network, February 23, 2023)**

In practice, gender-based violence in prisons is pervasive, despite policies meant to prevent it.[397] For instance, in 2023, staff at the Edmonton Institution for Women, a CSC facility, was charged with sexual assault, unlawful confinement, and breach of trust for their forcible detention and sexual abuse of an incarcerated woman.[398] That same year, a staff member at the Vanier Centre for Women in Ontario was convicted of breach of trust and sexual assault in an incident there.[399] At present, Quebec's Leclerc Detention Centre is the target of a class-action lawsuit, led by a formerly incarcerated woman, denouncing the "cruel and unusual treatment" and "civil wrongs causing serious harm." The lawsuit points to abusive strip searches and lack of basic healthcare.[400]

Unsurprisingly, women's healthcare services are limited in most jurisdictions. For instance, CSC has been described as providing the "bare minimum" to pregnant women — failing to provide gynecological exams, healthcare for children, or family planning.[401] One stakeholder explained that, in federal institutions, women can go years without obtaining Pap tests, and many women are reluctant to approach healthcare providers because they see those providers as correctional staff first and foremost.[402] Moreover, CSC's mother-child program has been described as traumatizing — increasing women's vulnerability to child protection services, providing inadequate perinatal healthcare services, and arbitrarily prohibiting many from participating.[403] In Alberta, a women's health program was recently cut, due to lack of funding. It had been providing gynecological exams, pregnancy care, and family planning.[404] In New Brunswick, some women are advised to seek gynecological support once they return to their communities.[405] In Ontario, birth control is not consistently available.[406] In Nova Scotia, women do not have access to birth control or sexual and reproductive health screenings. They face difficulties accessing basic products, including menstrual products and clean underwear.[407]

ENABLING POLICIES

Women's Clinic and Pap Screening **(Prince Edward Island)** confirms that women are offered regular Pap smears and breast exams, and are referred to physicians for follow-up when necessary.[408] The tests are to be provided by female nurses, who are also to provide health education and opportunities to discuss any other health issues.

Pregnancy Termination **(Prince Edward Island)** explains that incarcerated women have access to abortion.[409] Women considering abortion are provided with information to inform their decision and are offered counselling through the Women's Wellness Program. When a woman decides to terminate a pregnancy, healthcare staff notify the Women's Wellness Program to arrange an appointment. Following the procedure, women are offered follow-up care, including counselling.

"Offender" Pregnancy **(Prince Edward Island)** confirms that healthcare staff work with pregnant women to make sure they are meeting their nutritional and medical needs.[410] A case plan is to be developed to make sure that the specific healthcare needs of both the mother and unborn child are met. If the mother will be incarcerated at the expected delivery date, a plan will be developed for hospital admission, subsequent care of the child, and follow-up care for the mother. Healthcare staff are to ensure that referrals are made for any required specialized care.

PROMISING PRACTICES

Mother-Child Program (British Columbia) allows children to live with mothers in special units in prison for up to two years.[411] Mothers and infants are given time to bond, breastfeed, and develop healthy familial attachments. The program is complemented by several services and supports, including pre- and post-natal care, parenting programs, and links to community providers. In 2013, the Supreme Court of British Columbia confirmed that cancelling such programs is contrary to *Charter* rights, including the right to life, liberty, and security of the person.[412]

Wellness Within (CSC and Nova Scotia) is a non-profit organization based in Nova Scotia that provides support to women, gender-diverse, and trans people, as well as pregnant or parenting people.[413] Volunteers, including trained and certified doulas, provide pregnancy support, abortion, breastfeeding, and newborn care supports in prisons across Nova Scotia.

IV. GENDER-DIVERSE PEOPLE

Guidance: Prison authorities must develop and implement policies that are sensitive and responsive to trans people's unique healthcare needs and vulnerabilities.[414] Policies must ensure that trans people are protected from discrimination based on gender and/or sexuality.[415] Accordingly, prison authorities must allow trans people to self-identify and be placed in the appropriate prison for their identity and preference.[416] Trans people must also have access to specialized care, including hormone therapy, gender-affirmative care, and targeted mental health care.[417]

Observations: An increasing number of jurisdictions have policies to recognize the needs of trans people. Unfortunately, most policies allow vague security concerns to override individual needs. In practice, trans people regularly have their needs overlooked, contributing to significant harms.

Eight jurisdictions — CSC, British Columbia, New Brunswick, Nova Scotia, Ontario, Saskatchewan, the Yukon, and Prince Edward Island — have policies in place to protect the rights of trans people, with provisions on where to place them, how to protect them from discrimination and violence, and what gender-affirming care is available.[418] Specifically, they allow people to self-identify, and to be placed in the prison that corresponds to their gender identity or expression.[419] However, many also state that people may be placed in a prison that does not align with their gender identity or expression if "overriding health and safety concerns cannot be resolved."[420] Thus, trans people may have their rights infringed based on undefined safety concerns.

In policy, each of these jurisdictions also aims to address trans people's other needs. For instance, BC offers private shower and toilet access to trans people.[421] CSC also provides such upon request.[422] British Columbia and CSC require staff to receive education on the rights of trans people.[423] In New Brunswick, staff are simply given guidelines on how to treat trans people respectfully.[424] Similarly, in Prince Edward Island, prison staff are instructed to be clear that "transphobic language, bias, and bullying is not to be tolerated."[425] In Prince Edward Island, as well as Saskatchewan, New Brunswick, Nova Scotia, Ontario, and the Yukon, policy also states that trans people can choose the gender of the staff that will perform their strip search.

Access to gender-affirming care is very limited in each policy. In most cases, gender-affirming care is limited to personal items and clothing that reflect expressed identity.[426] CSC and Saskatchewan come closest to meeting human rights obligations. CSC policy states that healthcare providers will ensure that gender-diverse people are provided with essential physical and mental health care, including gender-affirming surgery, and healthcare providers are directed to follow World Professional Association for Transgender *Health Standards of Care*.[427] In Saskatchewan, policy states that people will be provided clothing appropriate to their self-identified gender, may retain items needed to express their gender identity, and will have gender-affirming healthcare needs, such as hormone therapy, accommodated.[428]

> ***Trans women are told, 'Well, you don't look woman-ish enough to be in this facility. You should dress more feminine. You should be more feminine.' But on the other hand, the uniform is a baggy, horrible sweatsuit, so what are you expecting? And lipstick is contraband. You just can't win."***
>
> – **Martha Paynter, Director of Nursing Research, Contraception and Abortion Research Team, University of British Columbia, and Assistant Professor, Faculty of Nursing, University of New Brunswick (Interview with HIV Legal Network, February 23, 2023)**

In practice, the needs and rights of trans people are not being met.[429] In jurisdictions with trans-specific policies, the needs of trans people continue to be regularly dismissed. In federal prisons, a stakeholder explained that waitlists to access gender-affirming care are extremely long, especially for gender-affirming surgery, and that CSC prison staff will sometimes disregard people's preferred names and pronouns.[430] Often the needs of trans people are disregarded due to "security concerns" informed by biological determinism.[431] Between December 2017 and March 2020, 67% of trans women were housed in men's prisons, and 95% of trans men were housed in women's institutions.[432] PLS has reported that, of 47 requests by gender-diverse people for transfers to women's prisons, 72% were denied.[433] Similarly, information obtained from CSC by the Queen's Prison Law Clinic shows that between December 2017 and March 2022, 83% of trans women who requested a transfer to a women's prison were denied.[434] "Safety concerns" were the basis for many of the refusals.[435]

Despite trans-specific policies, gaps in services and programs are clearly linked to a lack of knowledge about gender diversity. There have been reports of trans people being denied hormone therapy medication, placed under mental health watch, and subject to derogatory language.[436] There have also been regular reports of trans people being exposed to violence. At the federal level, studies have confirmed that trans people face exceptionally elevated risks of sexual violence and other forms of harm by incarcerated people *and* prison staff.[437] CSC's management system increases the risks, as it effectively outs people by only updating their gender in the system following bottom surgeries.[438] Similar findings have been made at the provincial and territorial level.[439]

The concerns are even more pronounced in jurisdictions without trans-specific policies. People are systematically placed in prisons that are not appropriate to their gender, which causes significant distress to trans people.[440] For instance, in Quebec, a study found that anatomy is the main factor in determining where people are placed. Moreover, in that province, trans people are often placed in infirmaries and subject to segregation, with limited access to programs and services.[441]

ENABLING POLICIES

***"Transgender Offenders"* (Saskatchewan)** recognizes that appropriate placement is central to respecting and protecting the rights of trans people.[442] Trans people are to be placed in prisons that correspond to their self-identified gender or preference, unless there are overriding concerns that cannot be resolved without undue hardship. Trans people are to be provided with clothing, including undergarments, that correspond to their self-identified gender, during incarceration and for court appearances. They may also retain items required to express their gender unless they pose legitimate health and safety concerns. If trans people must be separated from the general population because of health and safety concerns, they must be offered the same social and programming opportunities as others. Notably, transition-related healthcare needs (e.g. hormone therapy, surgery, mental health care) are to be assessed by healthcare staff and accommodated up to the point of undue hardship.

***Commissioner's Directive 100: "Gender Diverse Offenders"* (CSC)** aims to meet the needs of gender-diverse people in prison "in ways that respect their human rights and ensure their safety and dignity."[443] Among its provisions, all staff are required to obtain training that is current on gender identity and expression. Training materials must be developed and updated in collaboration with external stakeholders, such as gender diversity advocacy groups.

The Principle of Equivalence: Overdose Prevention, Drug Testing, and Safer Supply

Guidance: The WHO has not yet released guidelines that address overdose prevention, drug testing, and safer supply in prison. Such services are, however, necessary pursuant to the principle of equivalence, which requires that healthcare in prison be at least equivalent to that available in the community.[444] Given the documented frequency of drug use in prison, and the known toxicity of the unregulated drug supply, such measures must thus also be available in prison. Indeed, the WHO describes screening and treating for hazardous drug use as an essential health intervention.[445] The WHO has also long emphasized health protection as a part of its strategy, which includes reducing health hazards.[446]

UNDERSTANDING OVERDOSE PREVENTION SERVICES, DRUG TESTING, AND SAFER SUPPLY

Overdose Prevention Services (OPS) are health services that provide a safe, hygienic environment where people can use drugs under the supervision of trained staff or volunteers. OPS may offer a range of other harm reduction services, such as drug testing and referrals to other healthcare services.

Drug testing refers to the verification of the contents of unregulated drugs to help people make more informed decisions about their drug use. For instance, fentanyl test strips help to identify whether there is fentanyl in a tested drug.[447]

Safer supply refers to the provision of pharmaceutical-grade alternatives to the unregulated, illegal drug supply to prevent toxic drug death. Safer supply can be distinguished from OAT by the ways in which it is offered, including the flexibility of the program, the goals of care, and the environment in which services are delivered.

Observations: No jurisdiction offers adequate overdose prevention, drug testing, or safer supply programs in policy or practice. CSC and Nova Scotia offer some programs at a limited number of institutions.

Are overdose prevention, drug screening, and/or safer supply available pursuant to policy?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Yes	No	No	No	No	No	–	No	No	–	No	No	No	No

"–" indicates information unavailable.

In 2019, CSC began operating its first OPS at the Drumheller Institution in Alberta. Since then, CSC has established OPS at the Springhill Institution in Nova Scotia and the Collins Bay Institution in Ontario,[448] and is currently in the process of opening additional sites.[449] The stated aims of these OPS are to limit overdoses, needle sharing, STBBI transmission, and facilitate referrals to other healthcare services.[450]

CSC is reported to have guidelines for the operation of OPS. However, those guidelines remain publicly inaccessible.[451] Publicly available information indicates that OPS are consumption rooms in healthcare units, where healthcare staff are available to provide health-related education, counselling, and emergency response in the event of an overdose. Incarcerated people can bring their own drugs to the OPS, which are open from 7:00 a.m. to 7:00 p.m. seven days a week.[452] A review of the OPS further reveals that incarcerated people are provided with various needles and syringes, tourniquets, alcohol swabs, adhesive bandages, mixing cups, fentanyl testing strips, sterile water, cotton filters, vitamin C sachets, and an ignition source (such as a lighter).[453]

To participate, people must meet with healthcare services to discuss the process.[454] People are not required to undergo the threat risk assessment (required for the PNEP). Instead, they must have the drugs they intend to consume (which are not considered contraband en route to the OPS), be able to self-administer their drugs, provide informed consent to participate in the program, and sign an *Overdose Prevention Service Patient Information and Contract*.[455] People who have a history of overdose, and/or who are living with HIV and/or HCV, are prioritized for participation.

Are overdose prevention, drug screening, and/or safer supply available in practice?													
CSC	**BC**	**AB**	**SK**	**MB**	**YK**	**NT**	**NU**	**ON**	**QC**	**NL**	**PE**	**NS**	**NB**
Yes	No	No	No	No	No	–	–	No	No	No	No	Yes	No

"–" indicates information unavailable.

In practice, the OPS provide some promise as they give incarcerated people access to sterile needles and syringes and drug testing.[456] However, there are significant barriers to accessing the program, which mirror the barriers to the PNEP: as drug use continues to be punished, people are reluctant to engage in the program for fear of being targeted by prison staff and other incarcerated people. A stakeholder described accounts of people having their cells searched after going to an OPS, despite apparent guidelines that prohibit increased searches or drug testing based on OPS participation.[457] Limited operational hours further deter engagement.

Unsurprisingly, OPS have low participation rates. As of August 2024, only 106 people were approved to participate in OPS, with about 2,275 visits across all OPS since their introduction in June 2019.[458] In fact, as of February 2024, not a single person had used the Collins Bay site, which opened in November 2023.[459]

> ***"It would be great to have [drug testing] in prison. The drugs are coming in, we all know that — especially in federal prisons, but even in provincial prisons. In BC, most drugs have fentanyl in them, especially in the opiates. It is very rare to see just heroin, there is often fentanyl in it."***
>
> – **Pam Young, Program Manager, Unlocking the Gates (Interview with the HIV Legal Network, March 9, 2023)**

Remarkably, in Nova Scotia, people on safer supply in the community have been able to maintain their safer supply prescriptions in prisons. Safer supply prescribers in the community have corresponded with healthcare providers in prison confirming a person's eligibility for safer supply and stressing the need to continue a patient on safer supply to reduce the risk of overdose and other adverse health outcomes. Healthcare providers in prison have been receptive and have allowed the community healthcare providers to continue their patients' prescriptions in prison.

> ***"We are 20 years behind. Fentanyl is just starting to hit here. And crystal, too. Crystal is in all the coke. Fentanyl is in everything. People may bring stuff in or have things thrown over the wall … You really don't know what you are getting… It would be helpful for them just to have [drug checking strips] just to be sure that they are safe. But that would never fly, not here…. Because of stigma."***
>
> – **Stakeholder, Eastern Health (Interview with the HIV Legal Network, May 16, 2023)**

No other jurisdiction has meaningful overdose prevention, drug testing, or safer supply programs. Incarcerated people who were regularly accessing these programs in the community are prevented from doing so in prison.[460] Stakeholders broadly agreed that there was a need to ensure access to such programs in prison.[461] Many prioritized the provisions of safer supply in prison, given the likelihood that people will knowingly use tainted supply due to the difficulty of accessing drugs in prison and the harshness of withdrawal symptoms.[462]

PROMISING PRACTICES

Mobile Outreach Street Health (Nova Scotia) provides primary healthcare services to people who are homeless, insecurely housed, street involved, or otherwise underserved.[463] They provide safer supply prescriptions to eligible people in the community, which can be continued in prison. Healthcare professionals from the community write to prison healthcare staff to confirm the incarcerated person's prescriptions, the importance of continuing prescriptions to avoid overdose or other adverse health impacts, the concerned person's consent to safer supply, and the details of the prescriptions that should be provided. To date, many individuals on safer supply prescriptions in the community have been able to continue their prescription in prison.

Moving Forward

Over the past several decades, advocates and others have pushed to make timely information about healthcare and harm reduction in prisons publicly accessible. The information — including on healthcare services, service uptakes, and health outcomes — is necessary to keep governments accountable to their human rights promises. Even so, information about health and healthcare in prison remains largely inaccessible today. **To meaningfully move towards a rights-based system of healthcare and harm reduction in prison, all jurisdictions in Canada must commit to making healthcare and harm reduction information accessible in a timely manner.**

The information that has been gathered for this report confirms that Canada is not meeting human rights standards. There is a distinct lack of policy around the provision of healthcare in prison. Most jurisdictions focus primarily on safety and security in policy and pay insufficient attention to fundamental health services. Some jurisdictions, predominantly those with well-established whole-of-government structures, have more comprehensive healthcare policies. However, even those policies fail to meet international guidance. **It is crucial that each jurisdiction establish a comprehensive set of policies that reflect international guidance. Only then will each jurisdiction be able to engage in consistent health promoting and protecting practices to which it can be held accountable.**

The two charts below outline the lags across the country, in policy and practice. They highlight the barriers that must be overcome for Canada to meet its human rights obligations to people in prison, including to respect, protect, and promote the right to health without discrimination. In practice, no jurisdiction is meeting the minimum standards. Some jurisdictions are engaging in promising practices that should serve as models across the country. **Every jurisdiction must promote transparency to improve accountability and move towards more comprehensive and consistent care across the country.**

POLICY	CSC	BC	AB	SK	MB	YK	NT	NU	ON	QC	NL	PE	NS	NB
Ministry of health (p. 10)	No	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	No	Yes	No
STBBI testing and treatment (p. 15)	No	No	No	No	N	No	–	No	No	–	No	No	No	No
STBBI education (p. 20)	–	Yes	No	Yes	No	Yes	–	No	No	–	Yes	No	No	No
Safer sex supplies (p. 24)	Yes	Yes	No	No	No	No	–	No	No	–	No	No	No	No
PrEP (p. 27)	–	No	No	No	No	No	–	No	No	–	No	No	No	No
PEP (p. 27)	Yes	No	No	–	No	–	–	No	No	–	No	No	No	No
OAT initiated (p. 29)	Yes	Yes	Yes	Yes	No	Yes	–	No	Yes	–	No	Yes	No	No
OAT continued (p. 29)	Yes	Yes	Yes	Yes	Yes	Yes	–	No	Yes	–	No	Yes	Yes	No
Direct access to naloxone (p. 34)	–	–	No	No	No	–	–	No	No	–	No	–	No	No
Staff access to naloxone (p. 34)	Yes	Yes	Yes	Yes	No	Yes	–	Yes	No	–	Yes	No	Yes	No
Take-home naloxone (p. 37)	No	Yes	Yes	Yes	No	Yes	–	No	Yes	–	No	No	Yes	No
Drug-use equipment (p. 39)	Yes	No	No	No	No	No	–	No	N	–	No	No	No	No
Bleach (p. 42)	Yes	Yes	No	No	No	No	–	No	No	–	No	No	No	No
Tattooing and piercing (p. 44)	No	No	No	No	No	No	–	No	No	–	No	No	No	No
Overdose prevention (p. 56)	Yes	No	No	No	No	No	–	No	No	–	No	No	No	No

"–" indicates information unavailable.

PRACTICE	CSC	BC	AB	SK	MB	YK	NT	NU	ON	QC	NL	PE	NS	NB
Ministry of health (p. 10)	No	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	No	Yes	No
STBBI testing (p. 15)	Yes	Yes	Yes	No	No	No	–	–	No	No	Yes	Yes	No	No
Counselling (p. 15)	No	Yes	No	–	Yes	Yes	–	–	No	–	No	No	No	Yes
HIV treatment (p. 16)	Yes	Yes	Yes	Yes	Yes	Yes	–	–	Yes	–	Yes	Yes	Yes	Yes
HCV treatment (p. 16)	Yes	Yes	No	No	No	No	–	–	No	No	No	Yes	Yes	No
STBBI education (p. 20)	No	No	No	–	Yes	No	–	–	No	Yes	No	No	No	No
Safer sex supplies (p. 24)	No	No	No	–	Yes	No	–	–	No	Yes	No	No	No	No
PrEP (p. 27)	Yes	–	–	–	–	–	–	–	–	–	No	No	–	No
PEP (p. 27)	Yes	–	Yes	–	–	–	–	–	–	No	No	No	–	No
OAT initiated (p. 29)	Yes	Yes	Yes	–	No	–	–	–	–	–	Yes	–	No	Yes
OAT continued (p. 29)	Yes	Yes	Yes	Yes	Yes	Yes	–	–	–	Yes	Yes	Yes	Yes	Yes
Direct access to naloxone (p. 34)	No	No	No	No	No	No	–	–	No	No	No	No	No	–
Staff access to naloxone (p. 34)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Take-home naloxone (p. 37)	Yes	Yes	Yes	–	Yes	Yes	–	No	Yes	Yes	Yes	Yes	Yes	Yes
Drug-use equipment (p. 39)	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No
Bleach (p. 42)	Yes	–	No	No	No	No	–	–	No	Yes	Yes	No	No	No
Tattooing and piercing (p. 44)	No	No	No	–	No	No	–	–	No	No	No	No	No	No
Overdose prevention (p. 56)	Yes	No	No	No	No	No	–	–	No	No	No	No	Yes	No

"–" indicates information unavailable.

The status quo is untenable — people in prison are forced to witness their own health deteriorate, without recourse, and in clear violation of Canada's human rights obligations. The following recommendations stem from a review of the literature and from the Legal Network's interviews with stakeholders, and will help Canada to meet its obligation to promote the right to health of people in prison:

- In each jurisdiction, the health ministry must be responsible for the provision of healthcare in prison, ensuring that healthcare in prison is equivalent to that in the community. Each health ministry must work with their respective ministry responsible for prisons to ensure that health is promoted throughout the prison system, and not only in the provision of healthcare services.
- Universal STBBI testing and treatment must be available in all prisons. Testing and treatment must be offered upon admission and regularly throughout imprisonment. Testing and treatment must be confidential, and only carried out with express informed consent. Pre- and post-test counselling must be available, particularly for testing and treatment related to HIV and HCV.
- Comprehensive STBBI education must be available in prison, for corrections officers, healthcare staff, and incarcerated people. Education must include information on STBBI prevention, including safer drug use, safer tattooing, and safer sex, and must be responsive to the needs of different populations. Education should also be provided by qualified peers and community organizations.
- Safer sex supplies, including condoms, dental dams, and water-based lubricant, must be available and accessible free in multiple locations and discreetly, without request.
- PrEP and PEP must be available in prison. PrEP must be accessible to people with prescriptions from the community and to people at risk of acquiring HIV. PEP must be accessible to people in prison and prison staff following possible exposures to HIV.
- OAT must be available, without delay, to people who wish to continue or initiate the treatment in prison. OAT must be provided consistently throughout imprisonment and following release. OAT must never be involuntarily altered or terminated for any non-medical reason.
- Naloxone must be accessible to all people in prison, corrections officers, and healthcare staff. All people in prison, including staff, must be trained in recognizing the signs of an opioid overdose and how to use naloxone in response. Take-home naloxone kits must be offered to all people released from prison, together with a refresher course on when and how to use naloxone.
- Sterile drug-use equipment must be easily and discreetly accessible in prisons via multiple distribution points, without the threat of punishment for drug use. Sterile equipment should be provided with education on safer drug use and overdose prevention.
- Bleach must be accessible in all prisons, particularly where there are no accessible needle and syringe programs, with clear instructions on use and information on its effectiveness.
- Health inequities must be addressed in prisons. Indigenous people, racialized people, women, and trans people must have access to healthcare that is responsive to their unique needs, including programs and services that are sensitive and responsive to their culture and gender.
- Overdose prevention services, drug testing, and safer supply must be available and accessible in prisons and reflect promising practices in the community.

Endnotes

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11 See, e.g., Public Safety Canada, *2022 Annual Report: Corrections and Conditional Release: Statistical Overview*, March 2024, available at www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ccrso-2022/index-en.aspx [*2022 Annual Report*]; Department of Justice Canada, *Sentencing in Canada*, March 2023, available at https://www.justice.gc.ca/eng/rp-pr/jr/jf-pf/2023/pdf/RSD_JF2023_Sentencing-in-Canada-EN.pdf.

12 *2022 Annual Report, ibid*. "Indeterminate sentences" are terms of imprisonment that do not have end dates; the Parole Board of Canada reviews these case after seven years and every two years thereafter.

13 See, e.g., A. Owusu-Bempah et al., "Race and Incarceration : The Representation and Characteristics of Black People in Provincial Correctional Facilities in Ontario, Canada," *Race and Justice* 13(4) (2023): 530-542; Justice Canada, *Overrepresentation of Indigenous People in the Canadian Criminal Justice System: Causes and Responses*, January 20, 2023, available at www.justice.gc.ca/eng/rp-pr/jr/oip-cjs/p3.html.

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15 See, e.g., *2022 Annual Report, supra* note 11.

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