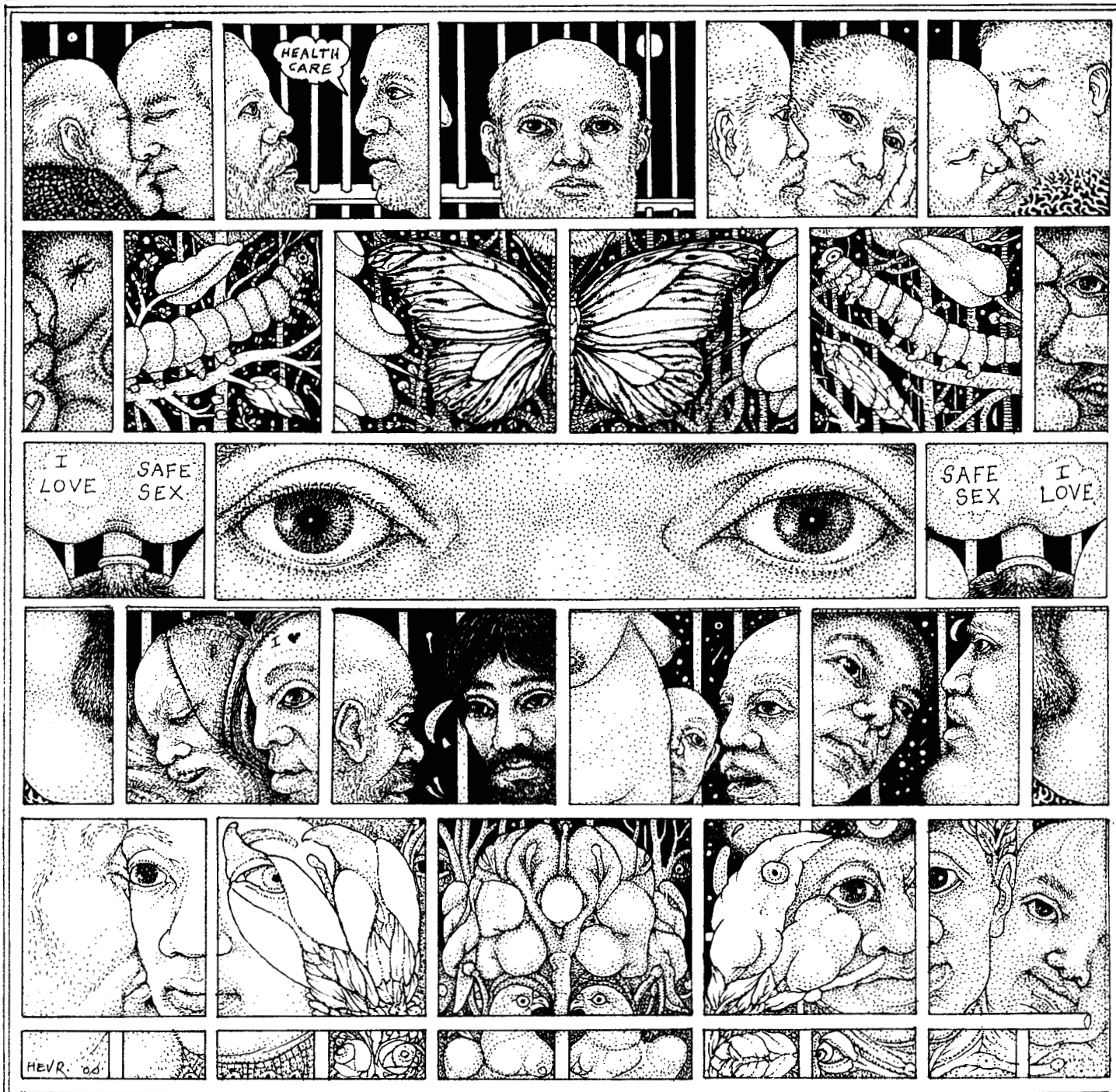
Pros & Cons

A Guide to Creating Successful Community-Based HIV/AIDS Programs for Prisoners



By Rick Lines

Prisoners' HIV/AIDS Support Action Network (PASAN)

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PROS & CONS:
A Guide to Creating Successful Community-Based
HIV/AIDS Programs for Prisoners

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We are interested in your feedback.

DEDICATION

I would like to dedicate this book to five people who died fighting, and one who continues to fight for the living.

To Michael Smith – anarchist, radical fairy, AIDS activist, and co-founder of PASAN, whose vision and compassion helped lay the foundation.

To Billy Bell – who died alone of AIDS in federal prison in 1996, "like a dog in a back kennel," nineteen days after being denied parole.

To Laurence Stocking – father, friend, and tireless activist for health care rights for prisoners, killed by the system in November 1998.

To Katie Baird – activist and survivor, whose body left us, but whose spirit walks beside us.

To Rodney Bobiwash – Wacoquaakmik, Bear Clan of the Mississagi Nation, Klanbuster, whose leadership, courage, and humor taught me by example. Rodney passed into the spirit world just as this manual was completed. I wish he were here to see it.

and

To Shannonbrooke Murphy – my partner and comrade, who first brought me into the prisoners' rights struggle, and without whose support and inspiration this book could not have been written.

ABOUT THE AUTHOR

Rick Lines has been a prisoners' rights advocate since 1990. From 1993-2000, he was employed at PASAN, initially as Prison Outreach Coordinator, and later as National Programs Coordinator.

Rick has published regularly on HIV/AIDS and prisons. In 1999 Rick co-authored the PASAN policy document *HIV/AIDS in the Male-to-Female Transsexual and Transgendered Prison Population: A Comprehensive Strategy*. In 2002, he authored a major policy document on HIV/AIDS and Hepatitis C in Irish prisons, published by the Irish Penal Reform Trust and Merchants Quay Ireland.

Rick has spoken on HIV/AIDS and prison issues before many audiences, including the *Parliamentary Subcommittee on AIDS* (Ottawa), the *XI International Conference on AIDS* (Vancouver), and members of the *Presidential Advisory Council on HIV/AIDS* (Washington, DC).

Rick is currently employed as a Drug Strategy Coordinator in the Republic of Ireland, where he continues to be involved in HIV/AIDS and prison work. He plans to return to Canada.

Rick holds a Masters Degree in Sociology from York University, Toronto.

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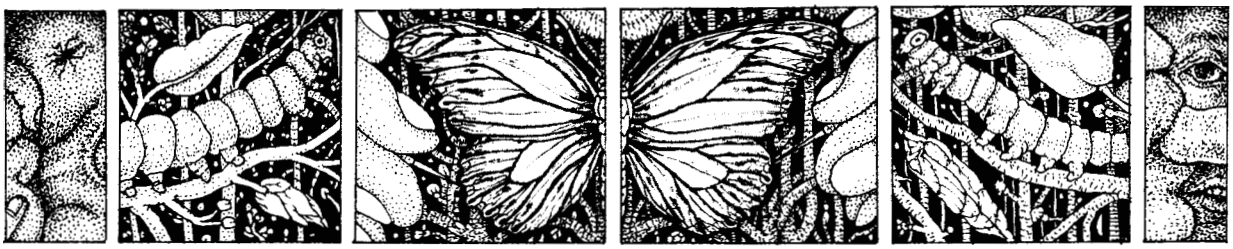

Preface

IN THE SPRING OF 1992, I was approached to do an interview on my radio program. At the time, I was a volunteer news programmer with CKLN-FM, a progressive, community-based radio station in Toronto, where I was known for my interest in prisoners' rights issues. The interview was about a new organization called "PASAN", which had just released a document called *HIV/AIDS in Prison Systems: A Comprehensive Strategy*. Via telephone, I interviewed a woman named Julia Barnett, who was one of the founders of PASAN and a co-author of the document.

I did not know it then, but that ten-minute interview would change my life forever, and would culminate in the manual that you now hold in your hands. Who would have guessed that that short interview would start a chain of events that would determine the direction of my work for the next decade?

HIV/AIDS in Prison Systems: A Comprehensive Strategy, or the "PASAN Brief", as we call it, was the first document of its kind in Canada. Written by a coalition of AIDS activists and organizations, prisoners' rights groups, ex-prisoners, and people living with HIV/AIDS, the brief outlined a series of 40 recommendations to establish a comprehensive and compassionate response to HIV/AIDS in the Canadian prison system. It is a visionary work. When it was released in June 1992, it helped push the federal government to empanel the *Expert Committee on AIDS and Prisons* (ECAP) to study the issues. When ECAP's final report was published in March 1994, it drew heavily on the PASAN Brief. The PASAN Brief is in fact the single most cited source in the ECAP Report, referenced on over fifty separate occasions.

Although not as widely recognized today as are some later publications, the PASAN Brief still serves as the foundation of all subsequent documents on HIV and prison issues published in Canada – not a bad accomplishment for a small group working without government funding.

What are my thoughts in reviewing the PASAN Brief ten years later?

That such an innovative, comprehensive, and prescient document could be produced by a volunteer coalition of dedicated people is a testament to the strength and vibrancy of the community-based AIDS movement in this country.

That the document is still so relevant today is testament to the failure of the federal and provincial governments to act decisively to address one of the greatest community health crises in Canada this past decade.

While successive governments have ducked the issues raised by the PASAN Brief, community-based organizations have not. PASAN itself opened an office in the summer of 1993 (when I was hired), and began providing direct AIDS services to prisoners across Ontario. Similar initiatives emerged in AIDS service organizations in other parts of Ontario and Canada, as HIV-positive prisoners and ex-prisoners challenged the AIDS movement to embrace their needs. Dedicated workers and prisoners involved in various John Howard and Elizabeth Fry branches also began to press their organizations to include the needs of people living with HIV/AIDS within their mandates. Aboriginal communities – already disproportionately affected by both incarceration and HIV infection – began to develop their own AIDS projects and strategies, challenging the broader AIDS movement to hear and respect the voices and experiences of Aboriginal peoples in all aspects of our work. Prisoners in institutions across Canada began to organize their own peer health programs, struggling to provide for themselves the educational and support services denied them by the correctional system.

Emerging from this diversity of effort is some of the most innovative and inspirational HIV/AIDS work of the past ten years. This manual is an attempt to synthesize the experience PASAN has gained as part of that process, and the lessons we've learned since 1993 in trying to develop and implement our vision of comprehensive community-based HIV/AIDS services for prisoners.

Over the twelve years I have been involved in prisoners' rights work – nine of them specifically in HIV/AIDS – I have had the ongoing privilege of working with brilliant and inspirational people, both inside and outside prison walls. I am proud to have been able to learn from some of the most dedicated, articulate, compassionate, and creative human rights activists in Canada today. Some of them have honoured me in contributing to the writing and reviewing of this book. All of them have honoured me with their friendship.

I would like to thank the members of the National Review Committee – Joanne Daniels, Monique Fong, Mike Gatner, Tom Howe, Michael Linhart, LaVerne Monette, Jim Motherall, Viviane Namaste, Thierry Pinet, Pat Tait, and Holly Wiggins – for volunteering their time and expertise to help make this publication stronger and wiser.

I would like to thank the members of PASAN's Review Committee – Eveline Allen, Giselle Dias, Anne Marie DiCenso, Richard Elliott, Koshala Nallanayagam, Trish Noordstra, Rhonda Roffey, and Perry Schatz – for their dedication to our organization and to our cause. I would particularly like to thank Giselle Dias and Cheryl Proc for their assistance with the post-production work of this manual.

Thanks also to all those who helped by focus testing and reviewing the final draft.

I would like to thank the people who contributed written submissions and personal stories for this book – Ruth Carey, "Charlie", Willie Danks, Anne Marie DiCenso, Lyndon George, Trevor Gray, Michael Linhart, John MacTavish, Patti McGuirk, James Motherall, Jeff Piker, Thierry Pinet, Rhonda, Tina, Victor, and Holly Wiggins – for sharing their knowledge and experience.

I would like to thank Health Canada for funding this publication as part of the Canadian Strategy on HIV/AIDS, and particularly Angela Favretto and Jeff Dodds for their ongoing assistance and support of the project.

I would like to thank Jean Dussault and Garry Bowers for the translation, Eric Mills for the design, and Hernan Valencia for the cover art.

I would like to thank Shannonbrooke Murphy for all her work editing this manual, and for her patience in dealing with a sometimes impatient author.

And I would particularly like to thank those colleagues, comrades, teachers, and friends not named above, whose work and passion have inspired me in this struggle – Raffi Balian, Julia Barnett, John Bellosillo, Jim Campbell, Georgia Davis, Rick Foster, Ralf Jürgens, Kenny Hunter, Raymond Luc Levasseur, Zoltan Lugosi, Tom Manning, Alys Murphy, Monte O'Toole, Tracy Ribble, Michael Sobota, Kevin Thomas, Diana Walker, Richard Williams, Cheryl White, Tasha Yovetich, Arlo Yuzicapi Fayant, and Art Zoccole.

Rick Lines

January 13, 2002

SECTION A

Preparation

CHAPTER ONE

"Pros" and "Cons"

THE PHONE RINGS. You answer. You hear a computerized voice.

"*This is Bell Canada. You have a collect call from….*" followed by a short snippet of a name.

It's a name you don't know. The person on the other end of the line is calling from prison, and is a person living with HIV/AIDS (PHA).[1] This prisoner needs your support.

If you've never worked with people living with HIV/AIDS who are incarcerated, you probably want to help, but don't know where to begin. You may have no idea how the prison system works, or may not be aware of what healthcare rights prisoners have.

For those of you with no experience in prison work, this manual will give you enough background information, service/program ideas, and strategies to allow you to get the work done.

If you already work with prisoners, this manual may reinforce some of your own conclusions, but it should also give you some new ideas to incorporate into your work. It provides detailed information and strategies to enable you to better defend the rights of prisoners, and further expand the availability and accessibility of HIV/AIDS services.

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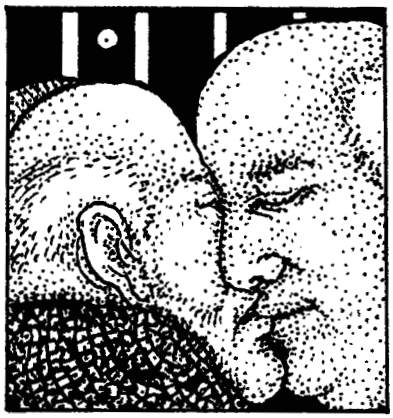
[1] *HIV* stands for *Human Immunodeficiency Virus*. HIV is the virus linked to AIDS. *AIDS* stands for *Acquired Immune Deficiency Syndrome*. HIV attacks the body's immune system, its defense against disease, and weakens it over time. HIV attacks the immune system chiefly by damaging the CD4 (also known as T4 or T-helper) cells that help the body fight off diseases. A person who has HIV gradually loses the protection of his or her immune system, and begins to experience health problems. The amount of time that it takes HIV to begin to affect a person's health varies widely from one individual to another. When a person is diagnosed with one of the serious illnesses or cancers that are "AIDS-defining", the person is then said to have developed AIDS. Definition provided by the AIDS Committee of Toronto, www.actoronto.org.

CHAPTER ONE

"Pros" and "Cons"



I. How Is Working with Prisoners Different?

For HIV/AIDS workers, working with prisoners and ex-prisoners can pose a unique challenge. Unlike working with some other populations, where testing HIV positive is often a defining moment in a person's life, for many prisoners and ex-prisoners their HIV status is not their biggest concern. For people worried about where their next meal, next bed, or next fix is coming from, it is understandable that HIV infection may fall low on their list of priorities. For those struggling to address a legacy of family violence, sexual abuse, or the scars of residential schools or foster care, it's understandable that the complex emotions that accompany a positive HIV test can be subsumed by other, deeper personal pains.

This is not a barrier to doing HIV/AIDS work. However, it is an essential context to understand. Just because *your* main concern is HIV/AIDS does not mean that *your imprisoned client's* main concern is HIV/AIDS. In order to be effective, you need to be willing and able to work with prisoners and ex-prisoners on their own terms.

But this is not the only reason why working with prisoners living with HIV/AIDS can be a very different experience. Most clients who access AIDS services in the "outside" community do so *specifically* for HIV/AIDS related support. Precisely because those people live in the outside community, they have the opportunity to seek out a variety of profes-

MOST PRISONERS AND EX-PRISONERS struggle with multiple and complex survival issues in their daily lives. Many share common life experiences that may include –

- poverty
- racism
- surviving family violence, neglect, and/or sexual abuse
- surviving foster care or residential school
- mental health problems
- literacy problems
- drug use
- homelessness
- institutionalization
- other medical concerns (Hepatitis, TB, Diabetes)

sionals and agencies for other services, and may also enjoy safe and confidential access to friends and family for emotional support. Prisoners do not enjoy the same kind of multi-level supports that are available in the general community. Therefore, HIV/AIDS workers often find themselves filling many different counselling or support roles.

For many prisoners living with HIV/AIDS, you may be the only worker they see, or the only worker with whom they have any level of trust. You may become *the* person with whom they will need to discuss a complex variety of personal issues and concerns. AIDS counsellors and support workers working with prisoners should therefore expect that often little or no time in a given session will be devoted to specific discussions of HIV issues. A client may instead need to discuss sexual abuse issues, drug use issues, institutional frustrations, or just have a friendly face or voice to talk to about everyday mundane things.

Prisoners do not enjoy the same kind of multi-level supports that are available in the general community.

Similarly, HIV prevention educators should anticipate spending much of their time in a prison workshop facilitating discussions of issues ranging from drug use to Hepatitis C[2] to general frustrations about prison health care.

Rather than being off-topic, all of these interactions are positive and constructive contributions to prisoner health promotion, and therefore relevant to your work. All discussions with prisoners are of value in expanding your understanding of the specific nuances of the prison environment. More importantly, they are crucial for building trust with your client or clients. Trusting relationships between yourself and the prisoner/s, and a detailed understanding of the complexities of prison life, are two of the necessary foundations of innovative, responsive, and effective community-based prison programs.

[2] *Hepatitis C (Hep C, HCV)* is a blood-borne virus that infects and can seriously damage the liver. Many of those infected do not get sick, or feel ill only for a brief time, but 80% will develop *chronic Hepatitis C*. Chronic Hepatitis C can lead to liver disease, including cirrhosis (scarring of the liver) and liver cancer. An estimated 20% of people with chronic Hepatitis will develop cirrhosis. While treatment options exist for people living with Hepatitis C, as yet there is no cure. Definition from the Hepatitis C Society of Canada, www.hepatitiscsociety.com.

II. Building Relationships – The Foundation of Prison Work

At a most basic level, doing HIV/AIDS work in prisons is about building relationships: between yourself and the prisoner/s; between your agency and the institution; and between prisoners themselves.

Building Relationships Between Yourself and the Prisoners

Your relationships with prisoners need trust to survive. Your goal as a community worker, therefore, is to cultivate and develop trust with the prisoners with whom you work. However, people in prison do not give their trust easily. This is often because prisoners have had trust violated in their lives - in the family, in school, in church, in the judicial system. Therefore, it's understandable that trust is not given freely, but must be earned by community workers.

In prison, you are also working within a social context where trust is held in the highest regard. The notion of being "solid" is central to prison life. Prisoners divide one another into two general categories – those who are solid, and those who are not. Being considered a "solid con" is the highest mark of respect within the prison culture, and something that is admired by both friends and enemies.

In this context, the rules and codes of conduct for community-based workers are very clear if you hope to win trust. You must abide by those same principles in order to be successful.
In those areas where you cannot do so because of professional ethics or protocols (instances of suicide risk, for example), you must make those boundaries and limitations clear to prisoners at the outset. This also applies to any personal boundaries you yourself may observe, or topics you may be uncomfortable discussing. If you feel compromised by hearing about a client's criminal history, or

- **Relationships between yourself and the prisoners**
  - individual relationship/s between yourself as a worker and the prisoner/s for whom you provide services
  - are based on trust
- **Relationships between your agency and the institution**
  - a professional relationship between the agency or organization you represent and the institution
  - are based on mutual convenience
- **Relationships between prisoners themselves**
  - you play a facilitation role in these relationships, encouraging community development within the prison
  - are based on common interests

Who is "solid"?

Someone who is solid is trustworthy:

- a person who keeps a confidence
- a person who won't collaborate with the staff, or betray *any* information about another prisoner to the institution
- a person who won't give information against another con to the police to save their own skin
- a person who won't back down on those principles, even when tempted with rewards or threatened with punishment

being told of illegal activities such as drug trafficking within the prison, be up front about it. In defining your boundaries from the outset, you are giving the prisoners themselves the choice of how much to confide in you, and about what issues. You do not want to find yourself in a circumstance later on where you feel you must violate trust. Being clear about boundaries is something most prisoners will respect.

If you *are* fortunate enough to earn trust, it is crucial that you not violate it. To do so destroys your usefulness as a community worker, destroys the credibility of your agency within the prisoner population at that institution, and potentially damages the ability of other individuals or agencies to do AIDS work. Always remember, while a community worker can rarely expect to be considered solid in the same manner as a prisoner, *you can definitely be judged to be not solid*. If you are judged to be not solid, you might as well give up the prison portfolio in your agency to someone else.

Building a Relationship Between Your Agency and the Institution/s

Agency/institutional relationships, on the other hand, are not built upon trust. As a community worker, you should never find yourself trusting the institution, as this is considered a mark of complacency. At the same time, the institution will never completely trust you, as you are an outsider. Still, that does not mean that a constructive, cooperative relationship cannot develop between your agency and the institution, based upon some common goals.

The relationship between your agency and the institution is essentially one based on mutual convenience. Your agency is mandated to provide AIDS services to people who are living in the prison, so you need to get in. The prison is mandated to provide health services to prisoners, and your agency can help them do that without increased burden on their staff.

As an AIDS service provider, you are able to render a quality service to prisoners at no cost to the institution. This is a powerful incentive for correctional facilities. Your presence in the institution will therefore be a sup-

port to both prisoners and prison staff alike. This is your unique strength, and one that you should emphasize every time you approach a prison about starting a program. Thus, while initially a relationship of convenience, hopefully your agency can earn the respect of the institution through the development of strong and effective programs and services. If you achieve this, it can open doors for expanding services within that institution and others in the region.

While you are attempting to build a relationship between your agency and the institution, it is crucial to define the boundaries and limitations of that relationship. Never lose sight of the fact that you are there to work for the prisoners, and that becoming too comfortable with the prison staff can jeopardize that work. Remember that one of the marks of being "solid" is a refusal to collaborate with prison staff. While you obviously cannot meet that extreme expectation in your role as a community-based professional, you *can* maintain clear rules and boundaries that govern your interactions with staff.

Never lose sight of the fact that you are there to work for the prisoners, and that becoming too comfortable with the prison staff can jeopardize that work.

Working with prison staff is necessary, because you have to go through the staff in order to get access to the prisoners. Having friendly relationships with the staff can sometimes help facilitate that access. While one should not underestimate the importance and utility of cultivating supportive contacts within any institution, cultivating these contacts is a tactic, not a goal unto itself. Your goal is to reach the prisoners.

Relationships with prison staff must be predicated on this understanding. Remember that the prison staff are not your co-workers or colleagues. They are professionals with whom you try to build strategic cooperation to assist you in your work. This is not to say that you should not work towards cooperation with correctional staff around specific individuals or specific issues. Effectiveness may require cooperation, whether in longer term relationships with key staff members, or in transitory alliances in certain specific situations.

Whatever the case may be, you must approach these relationships with a clear understanding of your respective agendas. Periodically those agendas may be in direct conflict. At other times you can work together more easily, based upon limited common ground. In
all cases, your job is to get things done for your clients, and to minimize institutional hindrance, by whatever approach delivers results.

Do not underestimate the real risk that being perceived as "too friendly" with prison staff poses to your credibility with the prisoners. Why should the prisoners trust you if you are chummy with their keepers? This goes to questions of funding as well. If your agency accepts funding from correc-

tional services, your credibility with prisoners is lost. Why should they trust you if you are seen to be working for "the man"? Do not assume that this issue will not be raised. The question of *"who pays you?"* is often one of the first questions prisoners ask in any workshop.

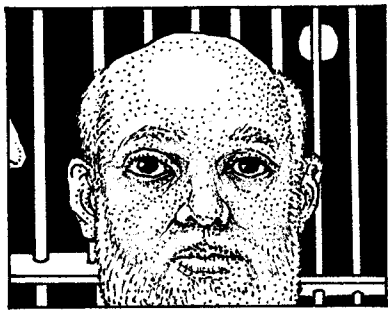
Building Relationships Between the Prisoners Themselves

If well done, your work can also foster constructive relationships between prisoners themselves.

HIV/AIDS cuts across racial, ethnic, and other divisions within the prison. Health programs therefore provide the opportunity to bring prisoners together on common issues. This can be an important exercise in community development within the prison population, and can serve as a basis for prisoners to continue to work together on common concerns.

This can also be a way to begin to tackle AIDS-phobia and other related discrimination issues that erect barriers between prisoners, and that undermine prisoner health, regardless of HIV status.

III. Advocacy – The Engine of Change



For both "pros" and "cons", the prison context has another, critical effect on AIDS work. It magnifies the urgency of creating change.

Prisoners live under conditions that are strictly controlled by the institution. As imprisoned people living with HIV/AIDS have enhanced needs, *any* existing systemic barriers to care and services can potentially threaten their health.

Prisoners living with HIV/AIDS live in an environment that is generally stressful, hostile, and isolating. High levels of AIDS-phobia and misinformation about HIV transmission mean that PHAs are often feared and ostracized by prisoners and staff members alike.

Prison is also an environment where adequate and consistent access to specialized health care is difficult, and where maintaining confidentiality about one's HIV status is a daily struggle.

Under these conditions, the risk of unnecessary or accelerated health decline – or death – is ever-present. This is a reality that you can help change.

This manual is based upon a fundamental principle – that people in prison have the right to the same programs and health services as do people in the community. Prisoners living with HIV/AIDS have a right to medical care comparable to that available in the community, and all prisoners have the right to access the knowledge and materials necessary to protect themselves from HIV infection. Prisoners' rights to adequate levels of health care are explicitly laid out in government legislation and prison policy across the country. Despite commitments on paper, however, in reality prisoners must often fight to receive adequate standards of care. For prisoners living with HIV/AIDS, this struggle is intensified.

Prisoners are in a uniquely vulnerable situation regarding their rights. Stripped of their independence – and thus artificially limited in their ability to act on their own behalf – prisoners, more than most people, require the assistance of outside advocates to ensure that their rights are safeguarded. Thus, in choosing to do HIV/AIDS work with people in prison, you are inherently choosing to be an advocate.

Advocacy is the process through which you as a community-based worker intervene in a situation to try to create a positive change. The police, the courts, the prisons, the parole/probation offices – all of these branches of the criminal justice system have the ability to affect the life and health of your client in negative ways. Therefore, there may be times when you are

compelled to intervene with these various levels of bureaucracy on behalf of your client or clients. As an AIDS worker in prison, advocating on behalf of your clients will be an integral part of your job description.

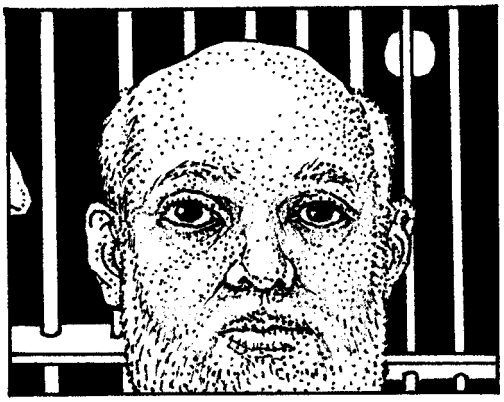
Within the prison environment, there is also an important relationship between advocacy and effective programs and services.

As a community-based organization hoping to conduct a prison program, you will most likely have to be an advocate for yourself. While some prisons are quite open to community groups, many others are not. In these instances, just getting your foot inside the building requires an advocacy plan. You may need to fight to get into the institution, to get space for your program, and to get access to prisoners. Depending upon the culture of the particular institution, advocating the necessity and importance of your work may be an ongoing concern.

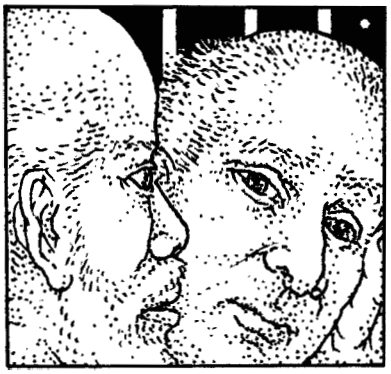
In choosing to do HIV/AIDS work with people in prison, you are inherently choosing to be an advocate.

The very process of engaging in advocacy also produces positive symbiotic effects. When advocating on behalf of your imprisoned client/s, you demonstrate to the prisoner population that you are willing to "go to bat" for them against the system. This will immediately enhance your credibility amongst prisoners, and will clearly show that your agency is working for their benefit, and not just that of correctional services. As trust in your agency grows, you will find more PHAs accessing your services, and greater prisoner participation in your outreach and education programs.

At the same time, as your programs and services expand, and you become recognized by the institution as providing important HIV/AIDS services, you will gain greater credibility with the institution, which will in turn make you a more effective advocate.



IV. CONCLUSION: *Moving Forward Together*



Exploring the relationship between advocacy and effective client services/ programs is the goal of this manual. The ensuing chapters provide the background and structural information necessary to identify common problems, and some tested approaches to help resolve them as quickly as possible. While the information is given with some level of detail, the chapters and Table of Contents are structured to allow you to locate answers to specific questions as easily as possible. You will also find *"inside information"*: stories, ideas, and experiences from prisoners and ex-prisoners living with HIV/AIDS and their advocates, illustrating from their own perspectives many of the issues raised in this manual.

The community-based AIDS movement in Canada has been doing innovative and effective HIV prevention and health promotion work for fifteen years or more. We know what programs work to reduce transmission of HIV, and improve the health of people living with HIV/AIDS. The efficacy of such programs is beyond debate. These same programs *can and must* be adapted to meet the needs of people in prison. Anything less is a fundamental denial of their rights to a proper standard of health care.

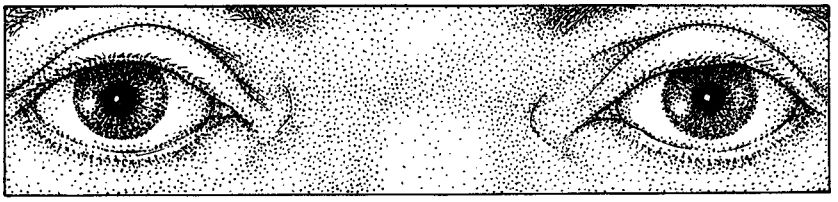
Programs that work to reduce transmission of HIV, and improve the health of people living with HIV/AIDS *can and must* be adapted to meet the needs of people in prison.

While prisoners are often a forgotten population in Canada, community-based organizations must not ignore their duties to provide them with services and to advocate for the improvement of their living conditions. People in prison are *part* of our communities. They are our fathers and mothers, brothers and sisters, lovers, friends, and children. The fact that they have been removed from the "outside" community for a period of time does not change this fact, nor reduce the health care rights to which they are entitled.

"Silence = Death" was an early and compelling rallying cry for the community-based AIDS movement. Unfortunately, this cry is still relevant today, and nowhere more so than in the prisons. Giving voice to people living with HIV/AIDS, and fighting for recognition of their human rights and health care needs, have always been the cornerstones of our movement. We must continue to expand our vision to embrace people living with HIV/AIDS in prison – to create services that address their needs, and to advocate for institutional changes that respect their rights. History has shown us that unless the community-based AIDS movement takes leadership in this struggle, change will not come.

So the phone rings. *Here's what you need to know.*

"INSIDE" INFORMATION



Rhonda's Story

MY NAME IS RHONDA. At 19 years of age, I came to Toronto from a small island in the West Indies called Grenada. I finished high school at 15 and a half, and decided I wanted to come here to pursue my dancing career.

I became a mother not too long after coming to Toronto, which put my career on hold. Things started to get really hard for me because I did not have family in Canada. I had immigration issues to deal with, and depression – missing home and my family – but I decided to stay here because I am very strong-minded and stubborn. I wanted to stay in Canada because I still had my dreams of becoming a professional dancer, and doing something good with my life so that my mom could be proud of me.

I had my three kids fairly close in age, so I had to be a full-time mom. After having my last daughter in 1993, I started getting really sick and did not know what was going on with me, because I have always been very healthy. Then, in 1994 there was a rumour going around that my baby's daddy had slept with some girl who had AIDS. In June of 1994 I got so sick that I could not get up and do anything for my kids. I was finally taken to the hospital after being in bed for four days. I was diagnosed with PCP pneumonia, put on antibiotics, and sent home.

After being home for a couple of days a police officer came to my door, because I did not have a phone at the time and there was no one home at the number I left with the hospital. The policeman came to say that I needed to get in touch with the hospital because my antibiotics were not strong enough. I think at that time they were figuring out that PCP pneumonia was a symptom of HIV/AIDS.

I was advised to see my family doctor to make sure the pneumonia was gone, which I did. She started talking to me about getting tested for HIV/AIDS, and explained to me about changes in my cells, and other things she was observing that were different with me, because she had been my doctor for many years. I told my doctor I needed to speak to my kids' dad first, because we were together for a long time. I did, but he tried to discourage me from getting tested. I finally went for testing without letting him know I was going, after sending my two oldest daughters to Grenada to my mom, because I was really tired, and getting sick all the time. That's when I found out, in August of 1994, that I was HIV positive.

I did not know anything about AIDS/HIV. Where I came from in the West Indies, AIDS was not discussed – nor for that matter, any other sexually transmitted diseases. Without telling her father about

my diagnosis, I brought my last daughter in and got her tested. Her results were negative. I finally told the father, and he got tested, and his results were positive too. By the advice of my doctor, I brought my oldest two kids back from Grenada to be tested. I found out in January of 1995 that my oldest daughter was HIV positive as well.

I finally got rid of my kids' dad in 1996, when I found out he was still cheating on me even after we were diagnosed with HIV. I got really depressed again. Nothing seemed to be going right. I was alone with three kids, on welfare. I had immigration problems, my family was far away, and I was really sick. I tried committing suicide a couple of times. That did not work, thank GOD.

In June of 1997 I decided to put my kids into the temporary custody of the Catholic Children's Aid Society because I could not handle much more at that time. I also wanted to see if I could get my life back on track, because I had been using alcohol to stop myself from dealing with everyday life. But that's when I got in trouble with the law. Because my kids were gone, I was free. I took off for Jamaica for two weeks, brought back 6 lb. of marijuana, and got busted at the airport. I spent a week in the (Toronto) West Detention Centre before getting bail.

I went to court to set a trial date but was rearrested because the person who bailed me pulled my bail. I spent a full three weeks in jail before getting out again. In that three weeks I started to think, and miss my kids, and decided that I was not going to let him – meaning my kids' dad – ruin my life and my kids' lives anymore.

Being in jail was really hard for me because I could not eat a lot of the food. I also could not get my medication, which was really hard on me because I was on the cocktail. Not being able to take my meds was screwing my immune system. I was also very stressed out not being able to talk to my kids, and see them as I wanted to.

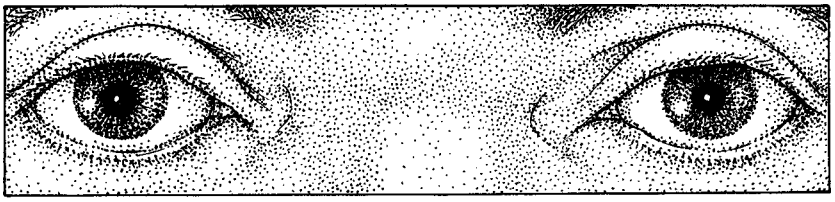
When I revealed my HIV status I did get the support of a couple of women in jail, which made the last part of my time in there easier. I was also able to make them feel like they weren't alone.

I fought my case, and I would call it a victory – even though I got probation. I did not do any more time on the inside. I used the grounds of my being HIV positive, the fact that some people were fighting at the time to legalize marijuana for medical purposes, and the fact that I was doing AIDS education for a few organizations in Toronto.

Now I am happy, quite contented. I have my girls back with me. It seems like my immigration stuff will be cleared up soon. I have a man and I cannot complain. And I am still active educating people and kids, especially on AIDS/HIV. I will not stop until we get through to most of the people out there.

PEACE.

"INSIDE" INFORMATION



Tina's Story

MY NAME IS TINA. I'm 35 years old. I grew up in Calgary. I've been HIV positive for 8 years, and Hep C positive for 14 years. I've been transgendered all my life.

I started working the street as a transgendered prostitute at 10 years old. At that age I already knew the 'girls' and all about the stroll and I really wanted the money. I started working the weekends on the stroll while in school, but I quit school at 15. I was 16 the first time I went to jail for a week.

At 19 I went to Vancouver and did drugs for the first time. It was also the first time I injected drugs. My second arrest happened that same year.

I went back and forth between Calgary and Edmonton with my boyfriend Steve until I was arrested for prostitution at 21. After leaving jail, I was kidnapped by Steve because he liked the money I brought in as a prostitute. This went on for about a year, until I finally hooked up with Dave, a really nice guy I met while serving my 30 days. I knew Steve was looking for me so I went into hiding for about a month until he left. Two weeks later, friends came looking for me to tell me Steve had died. This really screwed me up and I got heavy into injecting drugs like cocaine, heroin, speed, T's & R's, and MDA, and taking mescaline, which I swallowed. I didn't care who I shared with, I was just so messed up. That same year I found out I was Hep C positive.

Six years later, in 1993, I found out I was HIV positive.

That year I moved to Toronto and lived with Tom, who got me into using crack cocaine. It seems that all my men were very controlling and abusive. I worked the streets 24-7. I ended up in jail a lot in Toronto.

The guards in jail treat you rough when you are transgendered. The other guys in jail treat you rough too, unless they want sex from you or want you to be a mule (to bring drugs in for them). A lot of transgendered prisoners are asked to be mules because we are in and out of jail a lot, and usually on small charges like prostitution. This also means that if you are transgendered you can end up in segregation for a long time, being 'dry celled' until the jail believes you're not carrying drugs.

Even if you live like a woman, when you still have a dick you still go to a guy's jail. No one cares if you take hormones or have tits. A lot of rape happens to transgendered girls in jail. It's good to hook up with someone in jail so you can have a protector while you're there.

In 1994 I met Mike in jail. He was a really nice guy and we became good friends. In 1995 I broke up with Tom and

started going out with Mike while in jail, and we have been together ever since. Mike helps me to cope with my medications and all the other stuff that comes with being HIV positive, Hep C positive, and transgendered too.

I came from a good home and my family was always supportive of me being transgendered. In 1999 my mom and her husband asked me to move back home so I did. I've been living in Calgary since then and I'm doing fine. I'm glad I came home.

CHAPTER TWO

Prisons 101

ENSURING THAT THE RIGHTS of prisoners living with HIV/AIDS are respected is a daily struggle waged primarily by the prisoners themselves.

AIDS service organizations and community-based agencies can also play a positive and pro-active role, and your efforts can help make concrete improvements to the conditions faced by imprisoned people living with HIV/AIDS (PHAs).

Before you begin that work, however, it is essential to understand the social terrain of incarceration in Canada, and the basic structures of the Canadian prison system. This knowledge will assist you to work more effectively.

This chapter will review the correctional mandate and the basic structure of the Canadian prison system as a whole, as well as the common structural realities of prisons themselves, their staff structures, and services.

This chapter will also explode common myths about prisoners. It will look at the structures of the prison population: who goes to prison and why; the social responses of prisoners to their environment; and the special needs of certain segments of the diverse prison population.

Those with experience providing services in prisons may be familiar with much of the information in this chapter, and may therefore want to skip ahead to Chapter Three. However, you may also find some of the specific facts and arguments presented in this chapter beneficial to your work.

If you are just starting out in prisons, this chapter will provide the insights you need to orient yourself to the prison environment.

CHAPTER TWO

Prisons 101

Average Canadians know little about what goes on within our prison system, and often care even less. This creates a climate where common myths about prisons and prisoners come to replace facts about incarceration.

When allowed to stand unchallenged, these myths negatively affect both our incarcerated clients, and the provision of community-based HIV/AIDS programs as a whole.

Myths about prisons and prisoners can fuel "law and order" political agendas calling for more police and longer prison sentences, but fewer social services.

Myths about prisons and prisoners are used to justify the neglect of prison health issues by provincial and federal governments.

These myths can influence the moral and financial support our programs can expect from the broader community.

These myths can even negatively affect the way prison work is viewed by our colleagues in the AIDS movement, and sometimes co-workers within our own agencies.

To best serve and advocate for your imprisoned clients, therefore, you need to identify the common myths, and know how to counter them with the facts about incarceration.

Providing you with the tools to do so is the intention of this chapter. After exploding the basic mythology about prisoners' rights and healthcare, it will review essential facts about the Canadian prison system, and essential facts about the Canadian prison population.

I. Common Myths and Facts About Prisoners' Rights and Healthcare

As an AIDS service provider and community health worker serving prisoners, you need to know the myths and facts about the rights of Canadian prisoners. You also need to know basic myths and facts about prisoners and healthcare.

MYTH: People forfeit their rights when they go to jail.

This is probably the single biggest misconception about prison. It is often assumed that once a person enters prison, they leave their rights on the sidewalk outside.

FACT: This could not be further from the truth. People retain their rights under the *Canadian Charter of Rights and Freedoms* when they go to prison.

As established in the case of Raymond v. Honey, *"a prisoner retains all civil rights which are not taken away expressly or by necessary implication."*[1] Therefore, prisoners have the same rights as people in the outside community, save those that are specifically restricted by virtue of their incarceration – such as freedom of movement and assembly, for example.

Given the *Charter* guarantees, any such restrictions on prisoners' rights must be *explicitly set out* under various forms of legislation.

Any violations of prisoners' rights retained under the *Charter* are potentially actionable through the courts.

MYTH: Prisoners should expect substandard healthcare.

Particularly in a climate where all Canadian citizens fear cutbacks in health services, people often assume that adequate healthcare is a luxury that prisoners do not deserve. Not only do many lay people believe this, but some prison staff may also try to convince you that it is true.

FACT: This misconception – closely related to the myth about prisoners' rights in general – is clearly at odds with the guarantees outlined in Canadian legislation and prison policy.

Both the federal and provincial correctional systems are mandated to provide standards of health care comparable to the standard available in the community. For example, all federal prisons are mandated to provide

[1] *Raymond v. Honey* , [1982] 1 All ER 756 at 759 (HL), cited in Richard Elliott, "Prisoners' Constitutional Right to Sterile Needles and Bleach," in Ralf Jürgens, *HIV/AIDS in Prisons: Final Report,* Canadian HIV/AIDS Legal Network and Canadian AIDS Society (Montreal: 1996).

health care services that *"shall conform to professionally accepted standards."*[2] Similar policy also exists under the legislation of the provinces.

This is a crucial fact for all community-based health providers working with prisoners, and is of particular importance when advocating on behalf of prisoners living with HIV/AIDS.

MYTH: Prisoners don't care about their health.

There is often an assumption that people end up in prison because they are self-destructive.

This stereotype is strengthened by the fact that many people in prison are drug users, an activity generally viewed as unhealthy and self-destructive within Canada's prohibitionist social and legal framework. This prejudice can also exist among the social workers and medical professionals who provide services for people in prison.

FACT: Prisoners are often extremely interested in health care issues – possibly more so than most other audiences encountered by a community health worker.[3]

In PASAN's experience, there are several explanations for this.

Prisoners usually recognize that their living conditions enhance their vulnerability to infectious diseases (although awareness about HIV infection itself may not be a primary concern).

Given the high rates of HIV, Hepatitis C, and Tuberculosis (TB) infection[4] in Canadian prisons, prisoners are more likely to have friends or peers living with one or more of these diseases, or to be living with such an illness themselves.

Finally, most prisoners have experienced direct or indirect barriers to accessing health services in prisons.

These factors together create an environment that heightens everyday fears about illness. However, these factors also create an environment where people are not only aware of health issues, but are often motivated to learn options for maintaining or improving their health. This increased awareness of general risk presents a valuable opportunity for community workers to engage in programs that promote health and prevent disease within prisons.

However, do not confuse this increased *awareness* of infectious disease with increased *knowledge* of accurate information on disease prevention and treatment. People in prison generally struggle with the same phobias and misinformation about HIV/AIDS as do those of us in the general Canadian population.

[2] *Corrections and Conditional Release Act*, section 86 (2),www.canada.justice.gc.ca/en/laws/C-44.6/text.html.6

[3] The success of prisoner-initiated Peer Health and Peer Counselling Programs in many institutions provides an example of this motivation and interest.

[4] *Tuberculosis (TB)* is a disease caused by an organism called *Mycobacterium tuberculosis*. When a person with active TB disease coughs or sneezes, tiny particles containing M. tuberculosis may be expelled into the air. If another person inhales air that contains these particles, transmission from one person to another may occur. However, not everyone infected with TB becomes sick, and as a result two TB-related conditions exist – *active TB* and *inactive TB* — both of which are treatable and curable. Definition provided by the Centres for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of Tuberculosis Elimination, www.cdc.gov.

MYTH: Prison health is not related to community health.

The assumption that we need not act on prison health crises because they can be contained behind the prison walls is a common subtext in discussions about prison health policies. It is also wishful thinking.

FACT: The opposite is true. The vast majority of people in prison will eventually be released back into the community.

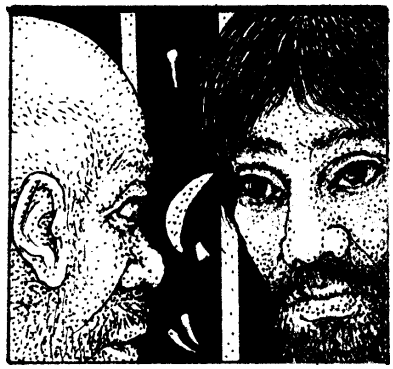
Only the smallest fraction of individuals will spend the rest of their lives behind bars. The overwhelming majority of prisoners in Canada are incarcerated for less than two years.[5]

Given this high degree of mobility between prison and community, any illnesses or health conditions developed in prison do not stay there. When individuals are released from jail, prison health issues necessarily become community health issues. This is why the implementation of comprehensive HIV/AIDS and Hepatitis prevention and treatment programs in Canadian prisons is an urgent public health concern – one that demands immediate attention from the federal and provincial governments.

HAVING DEBUNKED some of the mythology surrounding prisoners' rights and prison health, we will now examine some of the realities of incarceration in Canada, starting with a review of the systems and structures of Canadian prisons, and concluding with an examination of the population of Canadian prisons – the prisoners themselves.

[5] Of the approximately 33,000 people incarcerated in Canada at any time, between 19,000-20,000 are in provincial custody. Of those in federal custody, almost half are serving sentences of six years or less, meaning they will be on full release, or eligible for parole, within two years. Correctional Service of Canada, "Basic Facts About Federal Corrections," http://www.csc-scc.gc.ca/text/faits/facts07-05_e.shtml, and Correctional Service of Canada, *Offender Management System*, March 31, 1997.

II. Canadian Prisons: Systems and Structures



The Canadian prison system is only one component of a much larger criminal justice system.

The larger criminal justice system is comprised of several separate and distinct parts. The legislative branch – provincial and federal parliaments – determines the law: that is, definitions of and penalties for "criminality". The other component parts of the criminal justice system regulate aspects of law *enforcement*. The police make arrests. The judiciary tries, prosecutes, and imposes sentences. The prison or "correctional" system incarcerates.

Thus, the prison itself is merely the endpoint of a larger political and administrative process. It is the location where individuals who have been found guilty of law breaking are housed for a defined period of time.

The prison system has no control over who goes to jail. These decisions are made at the legislative level (by elected officials who shape Canadian laws) and at the judicial level (where judges and juries rule on guilt or innocence and decide sentencing).

This may seem an obvious point, but it is crucial for understanding how community-based agencies can interact productively with the prison, and thus make a role for themselves in providing programs and services to prisoners. This fact also determines when and where community-based health professionals can most effectively advocate on behalf of imprisoned persons living with HIV/AIDS.

For example, there is no use in advocating with prison staff for a sentence reduction, because judges make these decisions. There is no use in advocating for the reform of Canadian drug laws to correctional services, because those laws are determined by elected legislators.

On the other hand, interventions related to the *correctional mandate* are entirely valid. For this reason, it is important to familiarize yourself with it.

The Correctional Mandate: A Mandate of Care

The correctional (prison) system has a much different mandate than the other arms of the criminal justice system.

The correctional system is *custodial*, that is, it is charged with providing care and services to people in their custody while they are incarcerated.

TIP:

The Correctional Service of Canada's website is an excellent resource. Not only does it include up-to-date contact information for all federal institutions and parole offices, but also the Commissioner's Directives and a link to the Corrections and Conditional Release Act, which together govern the majority of federal prison policy. www.csc-scc.gc.ca.

As outlined above, correctional systems are mandated to provide health care services to professionally accepted standards.

The "correction" part of the mandate further stipulates that prisons provide programs for people during the period of their incarceration, in an effort to reduce their risk of re-offending upon their release. For example, all federal prisons are mandated to *"provide a range of programs designed to address the needs of offenders and contribute to their successful reintegration into the community."*[6]

Both aspects of the correctional mandate allow for community involvement in delivering programs and services to people in prison. In fact, *facilitating access for community-based organizations to the prison is arguably part of the correctional mandate*.

Allowing prisoners to access services and supports from the community – such as health education, literacy services, emotional or spiritual counselling, ethno-cultural support groups, etc. – contributes to building healthy and positive relationships between prisoners and the community. Once established, such relationships can improve a prisoner's chances of successful reintegration upon release, as they can provide increased community support. Across the country, numerous correctional officials and staff already recognize and encourage this supportive potential.

In fact, existing prison healthcare structures and community access structures reflect this "mandate of care" – at least to some degree. (See *Other Common Structures of the Canadian Prison Environment: Staff Structures* and *Programs and Services*, below.)

Canada's Prisons: Two Systems, Multiple Challenges

While a mandate of care is consistent throughout the entire Canadian prison system as a whole, the structure of adult incarceration in Canada is divided into two separate and distinct systems – the federal system and the provincial systems.[7]

The length of sentence determines whether an individual is housed in a federal or provincial prison.[8]

The Federal System

The federal government has the responsibility for housing people with sentences greater than two years. These "federally sentenced" individuals are incarcerated in institutions commonly called *penitentiaries*.

[6] *Corrections and Conditional Release Act*, section 76.

[7] Hereafter the term "provincial prison" may be used to refer to institutions under both provincial and territorial government jurisdiction.

[8] This is true in virtually all cases. However, in *some* instances and *some* regions, people sentenced to *more* than two years may be housed in provincial institutions. This is often so for women, given the limited number of federal women's prisons. Likewise, under some circumstances, it is also possible for a person with *less* than a two-year sentence to be housed in a federal facility. Such cases are the exception rather than the rule, however.

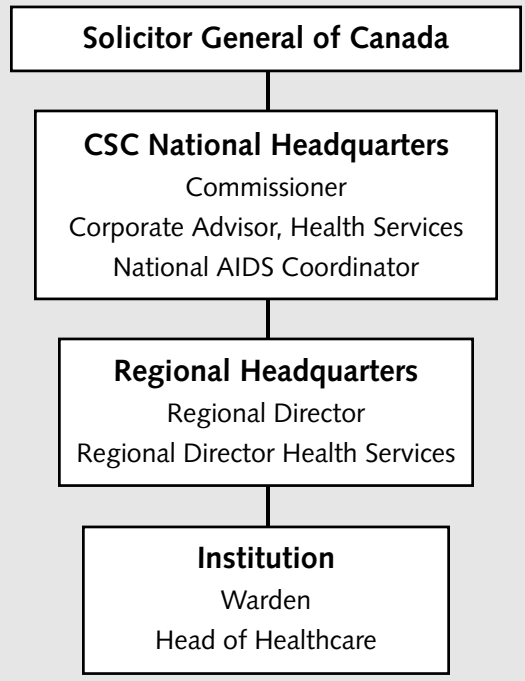
The federal prison system is administered by the *Correctional Service of Canada (CSC)*, which is accountable to the Solicitor General of Canada.

CSC's *National Headquarters* is in Ottawa but administration from province to province is coordinated on a regional basis, under various *Regional Headquarters*:

- *Atlantic Region* (Newfoundland, Nova Scotia, Prince Edward Island, New Brunswick)
- *Québec Region*
- *Ontario Region*
- *Prairie Region* (Manitoba, Saskatchewan, Alberta)
- *Pacific Region* (British Columbia)

While administered regionally, the entire federal prison system is governed by the same set of regulations – the *Corrections and Conditional Release Act (CCRA)* and various *Commissioner's Directives* (CDs), which together outline prison structures, rules, and practices. Therefore, federal prisoners in Alberta are entitled to the same programs, medical care, etc., as are federal prisoners in Québec and federal prisoners in New Brunswick. In theory, this ensures a consistent level of access to programs and services across the country.

CSC Bureaucracy Map



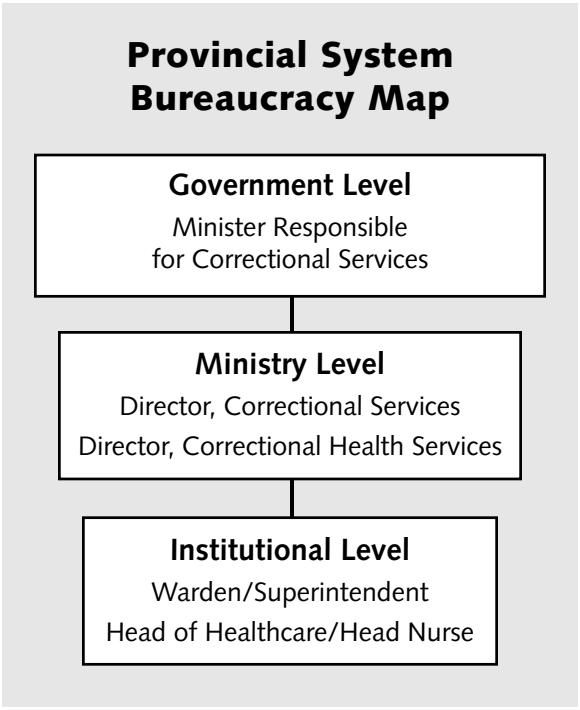
The Provincial/Territorial Systems

Individuals sentenced to less than two years (often referred to as *"two-years-less-a-day"* or *"a deuce less")* are the responsibility of the provincial and territorial governments.

The provincial and territorial prison systems are usually administered by the provincial or territorial Ministry of Correctional Services. Few provinces or territories have a separate Minister of Corrections, however. Rather, correctional services often fall under the jurisdiction of one of the larger justice-related ministries, such as the Solicitor General, Attorney General, or Minister of Public Security. Check with your own provincial or territorial government to determine your regional structure.

The provincial systems incarcerate prisoners in two different types of institutions.

Correctional centres (établissements de détention in Québec) house prisoners who are serving their sentences. That is, they have already gone through the court system, been convicted, and sentenced to a term of less than two years.



Remand centres (also known as *detention centres, pretrial centres, and local jails*) primarily house persons awaiting trial (who are legally *innocent* because they have not yet been convicted of the crime for which they stand accused), those recently arrested and awaiting bail, or those recently convicted and awaiting sentencing or transfer to a longer term facility.[9]

Since each provincial or territorial system is the responsibility of a different government, the level of access to programs and services for "provincially sentenced" prisoners varies from one end of the country to another. While provincial/territorial laws and correctional directives theoretically ensure a consistent level of access for prisoners *within* a single province or territory, in practice there is no consistency from one jurisdiction to another. For example, some provinces provide condoms to prisoners, while others do not.

Young Offender Facilities

Provincial governments also have the responsibility to house young offenders – even though the *Young Offender's Act* governing youth crime and punishment is under federal jurisdiction.

Please note that the issues and regulations for young offenders and young offender facilities completely differ from those pertaining to adult prisoners and institutions. Such discussions are therefore beyond the scope of this manual.

For more information on young offenders see *HIV/AIDS in Youth Custody Settings: A Comprehensive Strategy*, listed in the *Resources* section under *Useful Publications*.

Community Residential Facilities/Halfway Houses

The federal government and most provincial governments operate *Community Residential Facilities (CRFs)*, also known as *"halfway houses"* for prisoners. Halfway houses are another form of detention. Most often, these facilities house people during the final stage of their sentence, as part of a transition back into the community.

People living at halfway houses are generally allowed go into the community unescorted during the day, but must be back in the facility by a set curfew, where they are subject to supervision.

[9] People held in remand centres who are convicted may end up in either the federal or provincial system, depending upon the length of their sentence. In some cases, persons who have been convicted and assigned very short sentences (i.e., less than thirty days) will actually serve their time in the remand centre.

Other Common Structures of the Canadian Prison Environment

Gender Segregation

Male and female prisoners are gender segregated. As a general rule, men and women are housed in separate institutions. However, it is not uncommon to find both men and women housed in a single institution.

There are two situations in which this is most often the case. Detention/remand centres, particularly in smaller communities, will often house both men and women in separate sections of the institution. Also, maximum security federal women prisoners are housed in separate sections of men's penitentiaries.

Transsexual and transgendered prisoners are housed based upon their biological sex, rather than their gender identity. (See *Close-Up on Prisoner Populations with Special Needs: Transsexual and Transgendered Prisoners*, below.)

Security Levels

Federal and provincial prisons are classified according to security rating. These ratings are most easily understood as *maximum, medium,* and *minimum*, although in practice you will find that institutions are often defined as a variation on these degrees (*low medium* institutions, for example, or *super maximums*).

An institution's security classification will have implications for the type of access that community-based groups can expect to enjoy.

The security rating of the prison has two main implications.

- It indicates the security classifications of the prisoners within them, which is often – but not necessarily – related to the nature of their conviction and length of sentence.
- It also indicates the degree to which prisoners are able to move around the prison and associate with one another. For example, super maximum security generally indicates 23 hour a day lock-up with no unescorted movement inside the institution. Minimum security generally indicates "open" institutions, with no fences or bars, in which prisoners have freedom of movement and association.

Detention/remand centres are always run as maximum security institutions.

An institution's security classification will have implications for the type of access that community-based groups can expect to enjoy.

Physical Structures

The basic unit in any prison's physical structure is *the range* (or "cell block"). The range is a self-contained living unit on which prisoners are housed. Ranges are comprised of a group of cells (usually between twenty and forty) and a common living area (that will usually have tables, benches, a television, and showering/toilet facilities).

Depending on the size of the institution, there may be only a few ranges, or several dozen.

Every prison will have at least one range that is designated *protective custody*, or *"PC"*. The protective custody section houses prisoners who are thought to be unsafe in the "general population". In some cases, when a person fears for her/his own safety, they may "check themselves in" voluntarily to PC. In other cases, the administration places them there because of the nature of their conviction. Rapists and child molesters, for example, are generally housed in protective custody. People who are testifying against others prisoners ("rats") are also usually held in PC, as are people who have developed large drug debts within the prison. In other cases, people may be designated PC simply because of who they are. Transsexual and transgendered prisoners are often housed in PC. Openly gay men may be placed in PC. Openly HIV positive prisoners are sometimes placed in PC as well.

Note that PC ranges have no additional security measures, and differ from other ranges only in the nature of their population, and in the serious stigma attached to being housed there. (See *Canadian Prisoner Populations – Prisoners' Social Responses: Prisoner Norms and Codes*, and *Close-Up on Prisoner Populations with Special Needs: Transsexual and Transgendered Prisoners*, below.)

Prisoners are locked in their cells at certain times of the day and night, and are allowed to congregate in the common living areas during other times (although still locked within the confines of the individual range). The security rating of the institution will determine how much freedom of movement people are allowed both within and outside their ranges during the day (to socialize, go to the yard or gym, go to programs, etc.). In higher security institutions, a guard must escort prisoners at all times outside the range. In others, people are able to leave their ranges as they please to attend classes and programs, work out, meet with friends, etc.

Other common basic physical structures of most prisons include the medical unit, chapel, reception area, visiting room/s, program room/s, kitchen, canteen (where snack foods, cigarettes, and other goods may be purchased), segregation/isolation unit, and administrative offices. Some

prisons may also have prison industries where prisoners are sent to work during the day.

Staff Structures

There are various categories of correctional staff, all of whom you may need to work with at certain times.

In general, correctional staff can be divided into the following areas:

1. *SECURITY STAFF* – guards, classification officers (who assess prisoner security levels), Institutional Preventive Security Officers or "IPSOs" (who are in charge of internal prison security)
2. *SUPERVISION/PAROLE STAFF* – case management officers, parole officers
3. *HEALTH CARE STAFF* – nurses, doctors (usually contracted), dentists (usually contracted)
4. *PROGRAM STAFF* – volunteer coordinators, social programs officers, Native liaison officers, social workers, teachers (usually contracted), clergy
5. *ADMINISTRATIVE STAFF* – superintendents/wardens, deputy superintendents, secretaries
6. *BUREAUCRATS* – provincial, regional, and national managers and staff (usually housed in government offices rather than the institutions)

Programs and Services

Programs and services of various types are often available to people in prison. In many cases, participation in these programs is a mandatory part of an individual's *"correctional plan"*, and will be a factor in assessing their eligibility for parole.

Some programs and services are provided by correctional staff, some by community groups and volunteers, and some by prisoners themselves. Some programs and services are provided by all three.

Some prison administrators are very encouraging and supportive of program development, while others are not.

Types of programs run by correctional staff can include: individual and group counselling, drug and alcohol treatment, health education, anger management, life-skills, general education/upgrading, and work training (often as part of prison industry).

Types of programs run by community groups and volunteers can include: literacy programs, cultural programs (for Aboriginal prisoners, or Black

The availability of programs and services will vary widely, depending on the type of institution, its geographic location, its security rating, and its staff culture.

prisoners, for example), spiritual programs, *Alcoholics Anonymous*, *Narcotics Anonymous*, health education (including HIV/AIDS), creative/art/music programs, and social support groups.

Types of programs run by prisoners can include: social support, cultural/spiritual, peer health education and counselling, athletics, and social activities.

The availability of programs and services will vary widely, depending on the type of institution, its geographic location, its security rating, and its staff culture. Detention/remand centres, for example, are notorious for their general lack of programs, while many provincial correctional centres and federal penitentiaries will have a wider variety. Geographically remote institutions often have less access to community programs than do urban prisons. Some prison administrators are very encouraging and supportive of program development, while others are not. Budgetary constraints can also affect the availability of programs and services.

Privileges and Punishments

Prison discipline is based upon a system of earned privilege. The more cooperative and obedient an individual is judged to be, the greater the privileges earned. In some cases, these privileges can be concrete – such as private family visits, lower security classifications, and early parole. In others, they are more informal – such as relaxed surveillance and "less hassle" from staff.

However, just as privileges can be given, they can also be taken away through punitive measures. Again, in some cases punishment for rule infractions can be concrete – such as disciplinary reports, institutional charges, solitary confinement, or movement to higher security institutions. In other cases, they are informal – increased surveillance from guards, more frequent cell searches, more "hassle".

Never underestimate the punitive effects of informal disciplinary actions. While formal disciplinary sanctions are always damaging, particularly towards an individual's application for parole, informal ones can be equally or more detrimental. Since every aspect of a prisoner's day is so tightly controlled by the institution and the staff, being singled out for special attention by guards can have a much bigger impact on one's daily routine and stress levels than does a report in a file.

III. Canadian Prisoner Populations

Canadian prisons are very diverse communities – culturally, linguistically, ethnically, and generationally. Indeed, prisons generally reflect the diversity of the region in which they are situated.

Despite that diversity, you will find that most prisoners share some common history. They often come from poor or working class families, or have lived in poverty at some point in their lives. Many will have a previous history of incarceration. Many will have a history of drug or alcohol use.

Often it is this history that has brought them into conflict with the law.

Who Goes to Prison and Why?

It is perhaps trite to say that there are no rich people in prison. Still, the more time you spend working with prisoners, the harder it will be for you to dismiss that statement out of hand.

An understanding of the social and economic factors influencing which communities are vulnerable to imprisonment in Canada is essential to developing effective and innovative community-based prison programs and services.

Consider the following statistics about the Canadian prison population, and how they could both challenge your preconceptions about prisoners and impact your AIDS service work in prisons.[10]

- *Canada's incarceration rate is 129 people per 100,000. While this is much lower than the United States (649 per 100,000), it is higher than many Western European countries, including England and France.*[11]
- *Approximately 120,000 people pass through the Canadian prison system annually.*[12]
- *There are approximately 33,000 people incarcerated in Canada at any one time: 19,000-20,000 in provincial custody and 13,000 in federal custody.*[13]
- *On any given day, there are approximately 157,000 people in prison or on some form of community supervision.*[14]
- *In the overall provincial/territorial prison system, approximately 91% of prisoners are men and 9% are women. In the federal prison system, 95% of Canadian federal prisoners are men, and 5% are women.*[15]

[10] Please note that the locations for the following on-line citations were accurate at the time of writing. Websites are frequently changed and updated, however. By the time you read this, some of these statistics may be found at different locations on the website/s, or may have been removed from the website/s altogether. If you have trouble locating a specific citation, please contact the website's administrator/s.

[11] Correctional Service of Canada (Public Education), "Myths and Realities: How Federal Corrections Contributes to Public Safety," http://www.csc-scc.gc.ca/text/pubed/mr/mr21_e.shtml.

[12] Canadian Centre for Justice Statistics, *Adult Correctional Services in Canada*, (1995-96).

[13] Correctional Service of Canada, "Basic Facts About Federal Corrections."

[14] Statistics Canada, "Prison Population and Costs 1997/98," *Juristat*, vol. 19, no. 4, (April 6, 1999), www.statcan.ca/english/indepth/85-002/feature/jurl1999004006sda.htm.

[15] Ibid.

- *Although Aboriginal people comprise 2% of the population in Canada, they make up 17% of the federal prison population, and 15% of the provincial/territorial prison population.*[16]
- *Aboriginal people in Canada are incarcerated at a rate of more than 1,600 per 100,000, compared to 48 per 100,000 for non-Aboriginals.*[17]
- *The rate of Aboriginal incarceration in Canada is double the rate of African-American incarceration in the United States.*[18]
- *Rates of Aboriginal incarceration are highest in the provinces of Saskatchewan, Manitoba, and Alberta. More than 50% of the prison population is Aboriginal in Saskatchewan and Manitoba.*[19]
- *Although they comprise only 2% of Canada's population,*[20] *Black people make up 6% of the Canadian federal prison population.*[21]
- *68% of federal prisoners test below Grade 8 levels in language and math.*[22]
- *According to the Correctional Service of Canada, "almost 7 out of 10 offenders admit to having a substance abuse problem that would warrant treatment while in prison."*[23]
- *While the public and the media are primarily concerned about violent crime, violent offenses comprised only 12% of all reported crimes in Canada in the year 2000.*[24]
- *Most people sentenced to provincial prison terms are convicted for property offences or other non-violent crimes. Statistics Canada figures published in 1996 reveal that approximately 25% of provincial prisoners during 1995-96 were serving sentences related to non-payment of fines.*[25]
- *The average cost of incarcerating a person for one year in a provincial/territorial institution is $43,734. The average cost of incarcerating a person for one year in a federal institution is $51,202.*[26]

Prisoners' Social Responses

As do all socially and economically marginalized populations, prisoners respond to the realities of their environment in a variety of ways. They evolve and adhere to their own norms and codes of conduct. They develop their own social organizations. They develop their own economies. In some cases, they succumb to life-patterns that reflect the negative impact of their situation.

Most of these social responses are positive. Knowledge of them can enhance the provision of prison programs and services.

[16] Ibid.

[17] Correctional Service of Canada, "Fact Sheet: Aboriginal Offenders," http://www.csc-scc.gc.ca/text/pubed/feuilles/off-ab_e.shtml.

[18] According to 1997 statistics from the United States Department of Justice, African-Americans were incarcerated at a rate of 725 per 100,000. U.S. Department of Justice, *Bureau of Justice Statistics Correctional Surveys*, www.ojp.osdoj.gov/bjs/glance/jailrair.htm.

[19] Statistics Canada, "Sentenced Offenders Admitted to Custody who are Aboriginal Peoples by Jurisdiction, 1996-97," http://www.statcan.ca/english/kits/justic/justic.htm.

[20] Statistics Canada, "Population by Aboriginal Group: 1996 Census," http://www.statcan.ca/english/Pgdb/People/Population/demo39a.htm.

[21] Correctional Service of Canada, *Offender Management System* (March 31, 1997).

[22] Correctional Service of Canada, "Basic Facts About Federal Corrections."

[23] Correctional Service of Canada, "Fact Sheet: Substance Abuse Programs," http://www.csc-scc.gc.ca/text/pubed/feuilles/subsabprog_e.shtml.

[24] Statistics Canada, "Crimes by Type of Offence," http://www.statcan.ca/english/Pgdb/State/Justice/legal02.htm

[25] Statistics Canada, Canadian Centre for Justice Statistics (CCJS), "Adult Correctional Services in Canada: Highlights for 1994-95," *Juristat*, vol. 16, no. 7 (June 1996), p. 4; and Statistics Canada, CCJS, "Justice Data Factfinder," *Juristat*, vol. 16, no. 9, p. 13.

[26] Statistics Canada, "Prison Population and Costs 1997/98."

Prisoner Norms and Codes

Prisoners have long had their own subculture ("the convict code") that dictates acceptable and unacceptable behaviour among and between themselves.

The subculture is strictly hierarchical. Status is achieved through demonstrating qualities such as leadership ability, trustworthiness, and strength. Control over aspects of the underground economy, such as drugs, can also be a source of status and/or power.

Status is lost through weakness, dishonesty, collaborating with prison staff, "ratting" on other cons, going into protective custody, and being convicted of crimes against women or children (particularly true in, but not limited to, male institutions).

In developing prison programs, it is important that you seek out the support of *"solid" cons* (see *Building Relationships – The Foundation of Prison Work: Building Relationships Between Yourself and the Prisoners* and *Who is "Solid"?* in Chapter One) and respected prisoner organizations (see below), as their endorsement of your programs will play an important role in legitimizing your work with the broader prisoner population.

Prisoners' Organizations

Prisoners form organizations for the same reasons that people on the outside form organizations: to collectively accomplish tasks; to provide each other with social support; and/or to create social changes related to their environment.

In developing prison programs, it is important that you seek out the support of *"solid" cons*.

Prisoner-run groups are facilitated by prisoners themselves, sometimes with support from community volunteers. These organizations fall into five general categories:

1. ELECTED/ADMINISTRATIVE BODIES

These can include *Inmate Committees*, *Range Reps*, *Peer Health Groups*.

These groups are usually authorized by the prison population to represent their needs and opinions before other organizations, and with correctional services.

Elected and administrative bodies are important contacts for community workers, as they are often highly respected among both prisoners and staff.

2. LENGTH-OF-SENTENCE-BASED ORGANIZATIONS

These can include *Lifers' Groups*, *Ten Plus Groups*, *Five Plus Groups*, etc.

These groups are usually more social in nature. However, as individuals who will be living in the institution for prolonged periods of time (particularly in the case of lifers), long-term prisoners are often the most motivated to change prison conditions for the better.

Long-term prisoners also tend to command a great deal of respect from other prisoners, which can be an important boost for your program if you can solicit their support. Such groups are therefore important contacts.

3. IDENTITY/AFFINITY-BASED ORGANIZATIONS

These can include *Native Brotherhoods/Sisterhoods*, *Francophone groups*, *Black/African groups*, *Asian groups*, *Seniors' Groups*, etc.

These groups provide a forum for prisoners of common cultural, ethnic, or generational backgrounds to meet together for mutual support and socializing.

Building links with identity or affinity-based prisoners' organizations offers an opportunity to reach prisoners who – particularly if they are a minority group within the institution – may or may not feel comfortable taking part in other programs.

Such groups also provide an important forum to conduct specific ethnocultural based educational and outreach programs, and can be particularly useful for agencies working with those communities on the outside.

4. FAITH-BASED GROUPS

These can include *Native Brotherhoods/Sisterhoods*, *Muslim Brotherhoods*, *Christian Groups*, *Jewish Groups*, etc.

Each of these groups provides a forum for prisoners of shared beliefs to meet together for support and study.

The mandates and approaches of these groups can vary. Some will be more welcoming of HIV/AIDS and harm reduction information than others.

5. INSIDE/OUTSIDE PARTNERSHIPS

These can include *John Howard Society Groups*, *Elizabeth Fry Society Groups*, *Alcoholics Anonymous*, *Narcotics Anonymous*, etc.

The *John Howard* and *Elizabeth Fry Societies* are support organizations for male and female prisoners/ex-prisoners respectively, with chapters across Canada. They are useful organizations to contact when thinking about starting to work in prisons.

Alcoholics Anonymous (AA) and *Narcotics Anonymous (NA)* are abstinence and religious based support groups that also have chapters across the country. Working with these groups is potentially problematic (see *Making Your Program Proposal: "Piggy-backing" on Existing Programs* in Chapter

Four), but they do provide an opportunity to reach prisoners. You will find that interest in HIV/AIDS varies in accordance with the personalities of the individuals involved.

Together, these organizations will constitute your prison community partners, and working with them will significantly enhance your prison programming and service provision. (For more on working with prisoner organizations see Chapters Four and Five.)

Prisoner Economies and Commodities

Prisoners are not allowed to carry money inside institutions. It is considered contraband. Instead, each prisoner has a "bank" account with the institution, into which money from home, wages from prison employment, etc. can be deposited. Prisoners may draw on this account to purchase goods through the canteen (cigarettes, snack foods, periodicals, etc.) or to send money out to their families.

Although there is no cash in prison, economic transactions obviously take place. Instead of cash, a system of trading and barter is used. In this system, anything and everything is a commodity of exchange, from cigarettes to sex. Likewise, some types of services are provided by prisoners to other prisoners for a "fee". Monetary exchanges do take place, particularly for drugs, however these transactions usually take place through intermediaries outside the prison.

If your organization provides financial assistance to people living with HIV/AIDS, such funds will have to be deposited in the prisoner's institutional account, rather than given to the person directly. Call the institution involved for details on this process.

Institutionalization

When released, one of the most difficult struggles for prisoners to overcome is the effects of *institutionalization*.

For many people, particularly those who have been incarcerated on a regular basis from a young age or who have served long sentences as adults, it becomes almost easier to live inside prison than out. After many years on the inside, the prison environment is the one in which they feel most comfortable. It is the culture and society in which they feel most secure. It is where their friends are, and where they may enjoy a level of respect and recognition. For many, leaving this environment for the relatively unknown and chaotic world on the outside is not only a source of stress and anxiety, it is a source of real fear.

Institutionalization reduces a person's ability to function in the outside world. Thus, for some people, the effects of institutionalization contribute to cycles of rearrest and reincarceration.

Even for those who succeed in the struggle to stay out of prison, it can take many years before they truly leave the institution behind them. Many never do.

When working with prisoners approaching release, or ex-prisoners living in the community, institutionalization will be an important issue to recognize in providing your support services.

Recidivism and Reincarceration

Many people who are released from prison end up reincarcerated after a period of time. This often happens despite the person's best efforts to stay out, and despite support from family, friends, and/or community-based organizations. Reincarceration can either be the result of a withdrawal of parole or supervised release, or the result of new criminal charges or convictions.

The pattern that leads to reincarceration is commonly known as *recidivism*.

Even for those people most determined to stay out, making the transition from prison to "the street" is never an easy process.

While the issue of recidivism is subject to much media attention, controversy, and speculation, it is really not that difficult to understand.

As discussed above, prison is often the end point of more complex social processes that result in some populations being more vulnerable to conflict with the law. Individuals actually have relatively little control over the effects of these social dynamics and prejudices on their lives. Upon release, many people quickly find themselves back in the same cycles that led to their previous convictions. This is particularly true once the stigma of "ex-con" is added to their load, further limiting their opportunities by closing more doors.

Even for those people most determined to stay out, making the transition from prison to "the street" is never an easy process. The effects of institutionalization can often mean that learning to stay out is a process, one that might take several tries over many years.

As with institutionalization, the potential of re-incarceration for your clients is an important issue to recognize in providing your support services.

IV. Close-up on Prisoner Populations with Special Needs

Prisoners constitute a socially and economically marginalized population in Canadian society. As a group, they have identifiable needs and barriers, particularly with regard to HIV/AIDS.

However, there are also significant *sub-populations* of prisoners that have unique and urgent needs and encounter unique and systematic barriers in the prison environment. If you provide prison programs and/or services, you will inevitably have interactions with some or all of these groups.

The following briefs provide information about some of these prison subpopulations, and tips for making your prison programs and services more accessible and relevant to them.

Drug Using Prisoners (Including Injection Drug Users)

Canada's *prohibitionist, criminalization approach to drug use* has resulted in the incarceration of thousands of drug users.

Drug users do not cease being drug users simply because they are imprisoned, however. Many continue to use drugs on either an occasional or regular basis throughout the course of their sentences.

The percentage of incarcerated people using illicit drugs (which, in the prison context, includes alcohol) is much higher than the percentage in the general population – as much as 70% by CSC's own evidence.[27] Even for those prisoners who might not be regular users, the opportunity to get high can be a welcome relief to the overall boredom of being in prison.

In the prison system, drug use is an issue that cuts across racial, ethnic, gender, geographical, generational, and other boundaries. Those prisoners who are not drug users themselves will have friends who are users. For this reason, drug use is an issue that touches almost every person in the prison environment.

Drugs are an unavoidable reality in Canadian prisons. Despite their illegality, the institutional penalties for their use, and the millions of dollars and thousands of person hours spent by correctional services to stop their entry into prisons, drug use and drug trafficking remain as much a part of prison life as they are part of Canadian society.

[27] Correctional Service of Canada, "Fact Sheet: Substance Abuse Programs."

In many ways, drugs assume an even larger significance in prison than they do in the outside community. There are two reasons for this. First, the issue of securing and using drugs is one that affects a large majority of the prisoner population. Second, given the unusually high level of demand, drug trafficking also assumes a disproportionate role in the convict underground economy.

This additional economic incentive partially explains why and how drugs get into prisons.

Although prisons are "closed environments" (where entry is strictly controlled and monitored) a large volume of human traffic passes through the institutions every day. Prison staff come and go on shifts. Visitors come in to see friends and relatives. Non-correctional workers come in to do contract work (construction, plumbing, telephone repair, etc.), or to make deliveries of food and other necessities. New prisoners come into the institutions after arrest or transfer from other prisons. Lawyers come in to confer with their clients. Clergy come in to conduct religious services. Volunteers come in to run community-based programs. This large number of individuals coming and going every day provides ample opportunity for drugs to be brought into institutions.

The fact remains that drugs get into prisons, and prisoners use them.

For this reason, prisons monitor most outsiders very closely as part of their own *"war on drugs"*. Personal visitors may be searched. Outside volunteers and other professionals entering federal prisons may be *"ion-scanned"* to detect trace residue of illicit drugs on their hands or clothes, and have their briefcases and pockets examined.

It's not only outsiders who are subjected to this type of scrutiny. Prisoners themselves are also monitored. They are subjected to regular cell searches, and to random urine testing in federal institutions. *Random urinalysis* means that prisoners must regularly provide urine samples to staff, to be screened for the presence of illegal drugs. Getting caught using or possessing drugs, or providing a *"dirty piss test"*, can have ramifications for a person's institutional privileges, security classification, and parole plans, as well as make the prisoner subject to generally increased surveillance by the institution.

Despite all these preventive and punitive measures, the fact remains that drugs get into prisons, and prisoners use them. As in the broader Canadian society, drugs get in because there is a market for them, and because there is money to be made by providing them. This simple truth continues to drive drug availability in prisons, and drug availability in Canada overall.

The objective of eradicating drugs from institutions influences prison staff decisions at almost every level. However, correctional services' security-

based, punitive *"zero tolerance"* approach has failed in its mission. So far, attempts to impose even harsher penalties on drug using prisoners, or to tighten the already strict controls on prison visits have only resulted in innovations in trafficking and use. Such measures will continue to fail.

Drug using prisoners urgently need access to *harm reduction* tools and programs proven effective in the community.

In fact, some of the current drug detection practices – such as random urinalysis – have inadvertently created an environment where *injection drug use* has actually become even more commonplace in prisons. Injecting has become the logical choice for imprisoned users who want to avoid detection and punishment, because injection drugs pass through a person's system faster than drugs such as hashish or marijuana. Many non-injection drug users specifically start injecting in prison because of correctional policies regarding urinalysis. [28]

For HIV/AIDS workers in prison, this context is crucial to understand, as it has tremendous impact on our work. It directly affects the types of prevention and support interventions we need to provide, the barriers that impede optimal care for our clients, and the political climate in which we work to advance health care rights for incarcerated people.

Urgent Needs

Given the history of failure of the zero tolerance approach, drug using prisoners urgently need access to *harm reduction* tools and programs proven effective in the community.

Given the prison conditions described above, the persistent inavailability of harm reduction options for prisoners has created a very high risk environment for the transmission of HIV, Hepatitis C, and other blood borne diseases through injection drug use. [29] The epidemic proportions of this public health crisis in Canadian prisons are discussed in further detail in Chapter Three.

To reduce or prevent the spread of disease through shared injection equipment, prisoners need access to effective harm reduction options such as needle exchange and methadone programs. These needed harm reduction and HIV prevention measures are discussed in full detail in Chapter Three.

Many drug using prisoners have other needs as well. Some use drugs as a method of self-medication to suppress physical or emotional pain, and may need additional supports around their deeper issues. Some users may be dependent, which will add another dimension to the types of support they may need. If a person's drug use is having a negative impact on their health, they may have a greater need for general health promotion measures.

[28] Some community groups have therefore advocated that CSC remove cannabis screening from urinalysis testing as a harm reduction measure. This would discourage marijuana and hashish smokers from switching to injection drugs to avoid detection. However, at the time of writing, CSC has declined to move on this issue.

[29] Peter Ford, "HIV and Hep C Seroprevalence and Associated Risk Behaviours in a Canadian Prison," *Canadian HIV/AIDS Policy and Law Bulletin*, vol. 4, no. 2/3 (Spring 1999).

Despite the recent legalization of medical marijuana in some circumstances, its continuing illegality for recreational use and the illegality of other drugs mean that drug users are also at a very high risk for reincarceration. Such prisoners may therefore need extra supports in this area.

Systemic Barriers

The biggest barriers encountered by drug using populations in prison are the rigid policies and prejudices inherent in the zero tolerance approach.

This punitive approach to drug use generally prevents imprisoned drug users from being open and honest with staff in seeking help and support they may need and want.

Prejudice against drug users has also erected general barriers to health care services, and has limited the health care options made available to imprisoned drug users. For more specific information on these barriers, see *HIV/AIDS Care, Treatment, and Support: Pain Management Medication* in Chapter Three, and *"Inside" Information: Supporting Pain Management for HIV Positive Women in Prison.* As indicated above, and as detailed in Chapter Three, prejudice has also severely curtailed the options available to imprisoned drug users to prevent HIV and Hepatitis C infection.

TIP:

Drugs exist and are readily available in Canada, both inside and outside prisons. To realistically assess and act upon community health concerns, therefore, you must use pragmatic rather than ideological thinking in your work. Always remember, as an HIV/AIDS worker, the question you need to address is <u>not</u> "how do we stop drugs getting into prisons?" but rather "how do we prevent the spread of disease through the use of drugs?"

Given these urgent needs and systemic barriers, correctional services must shift their focus from preventing drug use to preventing the spread of disease. To date, however, corrections has indicated both disinterest in and resistance to abandoning zero tolerance in favour of harm reduction.

Impact on Community-based HIV/AIDS Programs for Prisoners

Drug use is an overarching issue that has an impact at all levels of prison work. In order to be effective in prisons, therefore, AIDS workers need to become familiar with drug use issues, become comfortable functioning in a drug using environment, and become comfortable in using and advocating a harm reduction/health promotion approach to drug use in prison programs and services.

For more on the specific needs and barriers of drug-using and injection drug-using prisoners, and on harm reduction in prisons, see Chapter Three, Chapter Five, *"Inside" Information: Charlie's Story, "Inside" Information: Victor's Story, "Inside" Information: My Experience Fighting the HIV Epidemic in Prisons,* and *"Inside" Information: Supporting Pain Management for HIV Positive Women in Prison.*

Aboriginal Prisoners

Aboriginal people (First Nations, Inuit, Metis, status, and non-status) are the single most over-represented community within Canadian prisons. Although Aboriginal people comprise 2% of the general population, they represent approximately 15% of the provincial prison population and 17% of the federal prison population. [30]

Due in large part to systemic racism and the economic exclusion of Aboriginal peoples in general, Aboriginal prisoners are more likely to find themselves stuck in cycles of institutionalization. Aboriginal prisoners are denied parole more often, are granted parole later in the course of their sentences, and have their parole revoked more often than non-Aboriginal prisoners. [31] Therefore, Aboriginal prisoners are also likely to serve more time than non-Aboriginal prisoners, and/or to serve time more often.

Aboriginal people are the single most over-represented community within Canadian prisons.

In addition, dramatic increases in the rates of HIV infection among Aboriginal communities on the "outside" [32] mean that effective HIV prevention and treatment measures have become absolutely crucial for Aboriginal prisoners.

Urgent Needs

Given the above factors, Aboriginal prisoners are a population very much in need of culturally appropriate and effective programs and services of all types.

To this end, Aboriginal people have struggled for many decades to maintain their right to follow their own traditions and spiritual practices while in prison. Aboriginal prisoners have uniquely well-developed organizations as a result of these efforts, and they enjoy the active support of many Aboriginal families, Elders, spiritual leaders, and communities.

Although Aboriginal prisoners have made many gains thusfar, their struggle to assert their cultural and healthcare rights continues.

For more details on the specific needs of Aboriginal prisoners, and of HIV positive Aboriginal prisoners, see *"Inside" Information: Traditional and Cultural Healing for HIV Positive Aboriginal Prisoners*.

Systemic Barriers

Despite the efforts of Aboriginal leaders and communities, and policies already put in place by corrections, Aboriginal prisoners' access to cultur-

[30] Statistics Canada, "Prison Population and Costs 1997/98." See also *Canadian Prisoner Populations: Who Goes to Prison and Why?* above.

[31] Correctional Service of Canada, "Fact Sheet: Aboriginal Offenders."

[32] Canadian Aboriginal AIDS Network and Canadian HIV/AIDS Legal Network, "Aboriginal People and HIV/AIDS: Immediate Action Required,"(Press Release: June 7, 2000) http://www.aidslaw.ca/Media/press-releases/e-release.htm.

ally appropriate programming remains problematic in many parts of the country.

The two prison systems tend to allocate service and program resources based upon population numbers. While Aboriginal people form a significant part of the prisoner population overall, in some regions their numbers are comparatively small. This means that in prisons where the number of Aboriginal prisoners is fewer, these prisoners will have less access to spiritual Elders, and limited access to Aboriginal-specific services and programs, than in institutions with a higher Aboriginal population.

In other cases, what programs are available often do not meet the need for a diversity of interventions respecting different Aboriginal nations and traditions. One consistent critique voiced by Aboriginal organizations is that many of the "Aboriginal" programs available to prisoners are merely "Indianized" versions of standard programs developed for non-Aboriginal prisoners. Given the diversity of Aboriginal cultures, languages, and traditions across Canada, even those programs that *are* developed in cooperation with Aboriginal communities are not necessarily applicable across the country. This service gap is most dramatically evident for Inuit prisoners, whose culture and traditions differ greatly from First Nations prisoners. [33]

Aboriginal prisoners also continue to routinely face barriers in accessing traditional medicines, and in conducting spiritual ceremonies.

In their effort to enforce zero-tolerance drug environments, prisons commonly stop Elders and community volunteers from bringing sage, sweetgrass, and other traditional medicines into the institutions. Smudging ceremonies are often prohibited or disrupted because the burning of traditional medicines such as tobacco, sweet grass, cedar, and/or sage is said to smell like marijuana (which they don't), or that such ceremonies violate the "non-smoking" policies of some institutions. Even in institutions that do not interfere with smudging, other traditional medicines are still frequently treated with suspicion. Aboriginal prisoners, Elders, and community volunteers are often subjected to having their personal medicine bundles searched or otherwise manipulated by staff, thereby desecrating these spiritual items. Despite policies by some prison systems that prohibit such disrespectful practices, instances continue to occur across Canada.

While CSC guidelines state that Aboriginal Elders must be afforded the same respect and privileges as chaplains or other visiting clergy, Elders providing spiritual support and education to prisoners still face instances of discrimination in some institutions. Many Aboriginal organizations also face discrimination in some prisons when trying to bring respected community Elders to participate in Aboriginal prisoner programs.

[33] For example, all federally sentenced prisoners from Nunavut (who are primarily Inuit) are sent to Fenbrook Institution in Gravenhurst, Ontario to serve their time. This causes obvious problems with social isolation and climate adaptation, and such difficulties are exacerbated by the problems Nunavut prisoners encounter accessing services in their own language.

Given these urgent needs and systemic barriers, correctional services must redouble their efforts to ensure that Aboriginal cultures and traditions are respected at all levels. Correctional services must guarantee Aboriginal prisoners access to Aboriginal Elders and other Aboriginal community supports.

Corrections must also work with Aboriginal organizations, Elders, and communities to ensure that HIV/AIDS, Hepatitis C, and other health programs and messages reflect the diversity of Aboriginal cultures, traditions, and experiences.

Impact on Community-based HIV/AIDS Programs for Prisoners

In order to do effective prison work, working in partnership with the Aboriginal community is essential. For non-Aboriginal workers and organizations, building respectful working relationships with Aboriginal organizations and communities is a priority in developing your programs.

For more on the specific needs and barriers of Aboriginal prisoners, see *"Inside" Information: Traditional and Cultural Healing for HIV Positive Aboriginal Prisoners*.

TIP:

Many institutions have Native Liaison Officers who are mandated to assist Aboriginal prisoners, and facilitate Aboriginal-specific programs, in the prison. The specific roles of Native Liaison Officers vary between jurisdictions.

Native Liaison Officers can be very helpful contacts for community organizations wishing to provide HIV/AIDS services for Aboriginal prisoners, and should be on your list of important contacts.

Women Prisoners

Only a tiny fraction of the prisoner population are women. In the overall prison system, incarcerated women represent approximately 5% of the total population. [34]

Like male prisoners, most women in prison have histories of poverty, drug use, and previous incarceration. However, women also generally earn lower wages then men, and are more likely to be single parents. As a result, women are more often incarcerated for economic offences directly related to poverty – shoplifting, fraud, and non-payment of fines, for example. Women are frequently incarcerated for prostitution or soliciting.

Women prisoners are also more likely to be survivors of violence.

In addition, seroprevalence studies conducted in Canadian prisons have consistently revealed higher HIV infection rates among women prisoners than male prisoners. [35]

Female prisoners thus have needs unique from male prisoners, very much related to gender differences in socio-economic status that pertain throughout Canadian society. Since women also constitute such a small

[34] Gisèle Carrière, Ann Finn, Melanie Kowalski, Shelley Trevethan, "Female inmates, Aboriginal inmates, and inmates serving life sentences: a one day snapshot," Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, vol. 19, no. 5 (April 1999).

[35] Canadian HIV/AIDS Legal Network, "HIV/AIDS and Hepatitis C in Prisons: The Facts," *HIV/AIDS in Prisons: Info Sheet 1*, (1999).

percentage of the prison population, however, they also face very specific barriers within the system.

Urgent Needs

Histories of childhood sexual abuse are overwhelming among incarcerated women. Histories of physical and sexual abuse as adults, either by male partners or others, are also common. This history is often inextricable from the reasons why women end up in prison. Family violence and/or sexual abuse lead many young women to leave home, thereby increasing their likelihood of homelessness, poverty, and street-involved lifestyles.

For many, the use of street drugs or alcohol are similarly linked. Drug use is a common survival strategy, essential to numbing the pain of years or even decades of violence. A 1999 survey by CSC concluded that fully 93% of federally incarcerated Aboriginal women were classified as "substance users". [36] *Cutting/slashing*, and other forms of self-injury are also more common among women prisoners, who use it as another form of emotional pain management and stress release. [37]

Separation from children also tends to be an issue that disproportionately affects women in prison. As these women are often the sole caregivers for their children, going to jail can mean that their children will be placed in the care of the state. [38] This creates feelings of guilt and shame for the mothers, who feel that they have abandoned their kids. It can also impede their access to their children both during custody and after release, causing further suffering for both mothers and children.

These common issues create urgent support needs specific to the female prisoner population. Such needs dictate the types of services and programs women prisoners require, but also create barriers to their accessing existing prison services in general.

Systemic Barriers

The numerical disparity between women and men prisoners means that program opportunities for women in prison are generally more limited.

While correctional services may dispute claims that there are fewer available programs for women, and point to budgetary figures which demonstrate that the spending per prisoner is greater for women than men, [39] their assertion of equal access does not match the experiences of many community-based professionals providing services for incarcerated women. This is partially because the available prison programs and services are frequently based upon those initially developed for men, and are thus inappropriate at best, and wholly ineffective at worst. [40]

[36] Craig Dowden and Kelley Blanchette, *An Investigation into the Characteristics of Substance-Abusing Women Offenders: Need and Post-Release Outcome*, Correctional Service of Canada (April 1999), http://www.csc-scc.gc.ca/text/rsrch/reports/r81/r81e.shtml.

[37] See *Creating Accessible HIV Prevention Messages – Risk Behaviours and Prison-Specific Prevention Strategies: Other Risks* in Chapter Five.

[38] To avoid placing their kids with the state, some women opt to leave them with their own parents. However, this can mean that they are leaving their children in the care of the same family member/s who abused them as young girls. This again creates not only to tremendous stress and guilt for the imprisoned mother, but can also cause her to downplay the extent of her own sexual abuse. Such situations can delay the prisoner's healing even further.

[39] Per person spending is indeed higher for women prisoners than men, but this is related to the small percentage of women in the system overall. Since the numbers of incarcerated men are so much higher, and the institutions housing men are so much larger, the actual cost per capita is reduced through economies of scale.

[40] This is particularly true for HIV/AIDS programs and educational materials, where corrections – and indeed most community-based programs – have geared their resources towards a male audience.

Geographic isolation constitutes another barrier to women prisoners accessing adequate services and supports.

The small proportion of women prisoners means that correctional services require only a small number of institutions to house them. Therefore, all the women in any given province are automatically sent to the one or two institutions in their region that house women. However, the institution/s may be hundreds of miles from their home communities. As a result, many women prisoners encounter severe isolation from their families, children, and community supports, who may be unable to travel the distance to meet with them.

During the 1990s, CSC built a series of five women's institutions, one in each of their five geographic regions, to address long-standing community concerns. Prior to the opening of the new regional institutions, the only federal women's institution – the Prison for Women in Kingston, Ontario, now closed – was both antiquated and exacerbated geographic isolation for women prisoners from other parts of Canada. While the opening of the five new regional women's facilities has somewhat improved the problem, geographic isolation remains a significant issue for many incarcerated women.

Issues of violence and sexual abuse directly affect the nature and scope of all services needed by incarcerated women.

In addition, there are barriers specific to women inherent in prison program and service delivery itself. Existing prison medical services in particular fail to address the specific needs of incarcerated women, resulting in barriers to women prisoners' access to adequate healthcare.

For example, the history of physical and sexual violence common among incarcerated women demands sensitivity and respectfulness of sexual abuse issues from prison medical services. Some women who are survivors of sexual abuse are understandably uncomfortable being examined by male doctors. Still, some women's institutions do not provide access to a female doctor. This situation results in some women prisoners refusing needed medical services.

Women prisoners living with HIV/AIDS find that the stressful and negative effects of the prison environment on their health are exacerbated by their more limited options for HIV therapies. Most of the research and development of HIV medications has been informed by the health needs of men (who represent a numerically larger proportion of known HIV infections). Since women's symptoms of HIV infection – and reactions to many HIV drugs – differ from those of men, these treatment options are not always appropriate or successful. This is a problem for women living with HIV/AIDS both inside and outside prison.

Finally, gender-specific social stigma – notions about "acceptable" and "unacceptable" behaviour for women [41] – creates other unique barriers for women prisoners.

Gender-specific stigma has an effect on women prisoners' security classification and the consequent availability or lack of programs and services for these women. Social prejudices about women's roles often results in female prisoners convicted of violent offenses receiving longer sentences and being assessed at higher security levels than male prisoners with similar criminal histories. As discussed above, fewer programs and services are available to prisoners at higher security institutions.

The social stigma attached to imprisonment in general also has a disproportionate impact upon women ex-prisoners, as it is compounded by gender stereotypes. Since the general stereotype of a prisoner is male, women ex-prisoners are assumed to be "extra bad". Therefore women prisoners often have a harder time than men upon release, and this can increase the likelihood of recidivism and institutionalization for women prisoners.

Given these urgent needs and systemic barriers, correctional services must redouble their efforts to ensure that all programs and services are sensitive to the specific needs of women prisoners, and take into account common aspects of their life history, such as physical and sexual abuse.

Correctional services must also ensure that HIV/AIDS, Hepatitis C, and other health programs and services are designed to reflect the specific needs and experiences of women prisoners.

Impact on Community-based HIV/AIDS Programs for Prisoners

Issues of violence and sexual abuse directly affect the nature and scope of all services needed by incarcerated women. This is particularly true in HIV/AIDS work, because it necessarily involves discussions of sex and drug use.

For some women prisoners, discussions of sexuality can trigger memories of much deeper hurt. In order to do effective prison work, therefore, HIV/AIDS workers must understand and respect this pain, and be prepared to provide additional and appropriate support to women prisoners.

Needless to say, all HIV/AIDS programs conducted with women prisoners must be gender sensitive. Many women prisoners will *not* feel comfortable having a male support worker, or having a man conduct educational sessions.

[41] Any behaviour that violates the accepted stereotypes of women as docile and nurturing is generally assessed as more "deviant" than similar behaviours among men. For example, men who are prone to fighting are often seen as just being "tough guys" (and maybe kind of cool), while women who behave similarly are seen as "bad girls" and major social transgressors. Therefore, it is common for women to receive longer prison sentences than men for violent offenses.

For more on the specific needs and barriers of women prisoners, see *Creating Accessible HIV Prevention Messages: Risk Behaviours and Prison-Specific Prevention Strategies – Safer Sex, Women's Institutions* in Chapter Five, *Providing Support During the Release Process: Pre-release Planning* in Chapter Six, and *"Inside" Information: Supporting Pain Management for HIV Positive Women in Prison.*

Transsexual and Transgendered Prisoners

"Transgender" is an umbrella term used to describe those who live outside of normative sex and gender relations. [42] These are people who identify with a core gender identity that society believes is not congruent with their external genitalia. This group includes both self-identified "transgendered" and "transsexual" people.

Transsexual and transgendered (TS/TG) people form a very small but important and distinct part of the prison community. They too have urgent needs, and face systemic barriers to accessing health and social services in prisons.

This group is among the most marginalized and disadvantaged in the prison community.

The discrimination faced by transsexual and transgendered prisoners is related to the discrimination faced by TS/TG people in the outside community.

Young transsexual and transgendered people are often forced to leave home because of family hostility. They usually also face discrimination, harassment, or violence at school, leading them to drop out. These factors increase the likelihood that they will end up living on the streets.

Many TS/TG people also face difficulties in obtaining identity documents that accurately reflect their gender. In some cases, this can be because of institutional red tape. In other cases (such as Québec), TS/TG people are legally prohibited from changing their names unless they have undergone *sex reassignment surgery*, which is not sought by, or accessible to, a significant proportion of the TS/TG community. This lack of identity papers reflecting their gender identity and visual appearance not only leads to psychological stress, but also erects barriers to employment, leaving many TS/TG people few options other than working in the underground economy. [43]

These factors lead many young TS/TG people to work in the sex-trade, placing them at increased risk of coming into conflict with the law. Many

[42] Ki Namaste, *Access Denied: A Report on the Experiences of Transsexuals and Transgenderists with Health Care and Social Services in Ontario*, Project Affirmation (Toronto: 1995). Although "transgender" is considered the umbrella term, the term "transsexual and transgendered" is used throughout this manual in an effort to be as inclusive as possible. Some transsexuals do not consider themselves transgendered, and vice-versa.

[43] Ann Scott and Rick Lines, *HIV/AIDS in the Male-to-Female Transsexual and Transgendered Prison Population: A Comprehensive Strategy*, PASAN (Toronto: May 1998).

TS/TG youth also use drugs – either recreationally or to dull their pain – which again increases their chances of arrest. [44]

For these reasons, incarceration is quite a common experience among TS/TG people. The risk of incarceration tends to be greater among male-to-female TS/TG people, however, as they tend to be more visible, and therefore more socially and economically vulnerable than their female-to-male counterparts.

The conditions of vulnerability in which many TS/TG people live – both in the community and in prisons (see below) – put them at increased risk of HIV infection.

Approximately 10% of PASAN's HIV positive clients identify as transsexual or transgendered – the vast majority of these people being male-to female. Yet the proportion of TS/TG people in the prison population is much below this 10% figure. One could therefore conclude that TS/TG prisoners are over-represented in terms of HIV infection, even against the prison population's generally increased seroprevalence rates.

Transsexual and transgendered people are among the most marginalized and disadvantaged in the prison community.

Urgent Needs

Given existing correctional gender segregation policies, whether a TS/TG individual is incarcerated in a male or female institution is determined exclusively by her/his sex organs. Therefore, male-to-female transgendered prisoners are frequently housed in male prisons. [45]

This creates enormous psychological stress, and also frequently exposes these prisoners to an increased risk of *transphobic* [46] violence and sexual exploitation by other prisoners.

Given this situation, many TS/TG prisoners find it necessary to trade sex for protection. Their very survival can hinge on their willingness to provide sex. This reality means they have much less control over the conditions of sexual contact than they would on the outside, and this often places them at increased risk for HIV infection. [47]

Many transgendered prisoners are also either in the process of initiating or continuing hormone therapy, which assists people in changing their body image. Ensuring continued access to hormones is in the best interests of these prisoners, as it helps to maintain their physical and psychological health.

[44] Ibid.

[45] This is the case unless they have undergone sex reassignment surgery, and had their gender change legally registered.

[46] "*Transphobia*" is an irrational fear or hatred of transsexual and transgendered people.

[47] Scott and Lines.

Systemic Barriers

The legitimacy of TS/TG people's needs as a group is not accepted in society as a whole, and this of course trickles down to the prison environment.

Given the unique and entrenched form of discrimination against them, TS/TG prisoners face unusual barriers to having their needs recognized and respected in prisons. For example, correctional staff routinely insist on calling TS/TG prisoners by legal names that do not reflect their genders, thereby denying their very identities and insulting their basic dignity. Needless to say, very few prison programs and services specifically address TS/TG prisoners' unique needs. In many cases, TS/TG prisoners feel completely excluded from the existing services and programs. The likelihood of experiencing transphobia from staff and prisoners can also prevent them from participating.

Given their unique vulnerability in prisons, many TS/TG prisoners are also routinely held in protective custody, ostensibly for their safety. However, individuals charged with or convicted of sexual offenses are often held in these same units. This is particularly common in jails and detention centres. This creates a situation where TS/TG prisoners – who are especially vulnerable to sexual assault – are placed on the same ranges as men with histories of sexual violence. It also means that TS/TG prisoners are often housed in more restrictive living conditions, with less access to social time and prison programs generally. [48]

Transgendered prisoners also face barriers in accessing hormones in the institutions. Hormone therapy is often reduced or cut off upon incarceration. This has a particularly harmful impact on male-to-female transgendered prisoners. While the hormones used by *female-to-male* transgendered people have a lasting effect, those used by *male-to-female* transgendered people do not. Therefore, losing access to these hormones results in serious physical side effects, and in a reversal of body image – a serious source of stress and anxiety.

In some prison jurisdictions, only a recognized Gender Identity Clinic (GIC) can authorize access to hormones and/or sex reassignment surgery. [49] Although GICs have the mandate to evaluate and assess transgendered prisoners, the system is problematic as GICs routinely discriminate against prostitutes, drug users, and people with criminal records. [50] Therefore, GICs do not serve the needs of the street-involved transgendered community, who are the most at risk of coming into conflict with the law, and spending time in prison. [51]

Given these urgent needs and systemic barriers, correctional services must establish programs and services to meet the specific needs and experiences

[48] Ibid.

[49] This is true in the federal system, whose policies on TS/TG prisoners are outlined in *Commissioner's Directive 800*. Available online at http://www.csc-gcc.gc.ca/test/home_e.shtml.

[50] Viviane K. Namaste, "Évaluation des besoins: Les travesti(e)s et les transsexuel(le)s au Québec à l'égard du VIH/SIDA," *Report submitted to the Centre Québecois de coordination sur le SIDA*, (Montreal: May 1998) Copies of the report are available through CACTUS-Montréal, 1626, rue Saint-Hubert, Montréal, H2L 3Z3.

[51] Viviane K. Namaste, *Invisible Lives: The Erasure of Transsexual and Transgendered People*, University of Chicago Press (Chicago: 2000).

of transsexual and transgendered people. Correctional services must build links with TS/TG organizations in the community, and invite them to provide guidance and support in this effort.

Correctional services must also ensure that HIV/AIDS, Hepatitis C, and other health programs and services are designed to reflect the specific needs and experiences of TS/TG prisoners.

Impact on Community-based HIV/AIDS Programs for Prisoners

Given the hostility of TS/TG prisoners' environment, and the barriers they face in accessing health and social services, the HIV/AIDS worker may be the only person with whom these prisoners will feel comfortable. You must anticipate this dependence for extra support, and be prepared to provide it.

AIDS workers in prisons must make an extra effort to reach out to, and provide relevant services for, transsexual and transgendered prisoners. To advise and assist you in this work, be proactive in developing relationships with TS/TG organizations in your region.

For more on the specific needs and barriers of TS/TG prisoners, see *"Inside" Information: Tina's Story*, and *Creating Accessible HIV Prevention Messages: Risk Behaviour and Prison-Specific Prevention Strategies – Safer Sex, Sexual Assault and Non-consensual Sexual Relationships*, in Chapter Five.

V. Conclusion

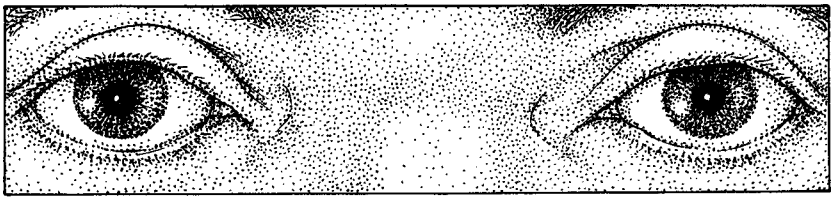
You now have a basic overview of the Canadian prison system and its populations. As with all topics covered in this manual, this chapter should be taken only as an introduction to some issues common to the system as a whole. Individual provinces, regions, and institutions differ in significant ways – both for the better and the worse.

While the information herein can serve as a guide to identifying advocacy issues in your area, it is not a template that applies equally to every institution, or to every situation.

Part of your job will be to apply this basic information to the situation in your own community, and use it to identify the specific needs in your own local prison or prisons. Identifying the key legal, ethical, and human rights issues in your own locality will only come through local work, local consultation, and local investigation.

Having completed an introduction to the Canadian prison system, the next chapter will examine the key issues impacting on HIV/AIDS prevention, care, and treatment in prison. The next chapter will also provide background information on Hepatitis C in prisons, as you will find the two issues integrally linked in the prison environment.

"INSIDE" INFORMATION



Charlie's Story

"Charlie" is an HIV positive Aboriginal ex-prisoner who is a long time injection drug user. He has spent over 20 years of his life in prison, mostly in the federal system. He spoke with PASAN about injection drug use in prison. The following is based on "Charlie's" narrative.

CHARLIE: Needle use in prison is just as common as it is out here on the street. It's every day. There's always somebody bringing in drugs. There's always somebody trying to sell a fit. If you get lucky enough to get a fit, you have to learn how to take care of them, to protect them. It's like your girlfriend. You really have to be very, very careful with them.

There are people who use needles and don't tell people they're HIV positive. Then when people find out there's a mad panic. People have been murdered. People have been killed.

There's a lot of ignorance towards the inmates, especially if they're known to have HIV or AIDS.

And the staff gets paranoid. If a guard came to search my cell, they'd knock on the door and say, *"Hey, we're doing a search in five minutes."* What they're telling me is, *"Grab your needles, take them into the common room, and have a coffee. We don't want to get stuck."*

PASAN: In an institution of 500 guys, how many would you estimate would be injecting?

CHARLIE: Close to 200. Say you have 30-50 guys on a range. Out of those 30-50 guys, there's maybe 20 users, and everybody wants to use your fit.

PASAN: And how many rigs would be going around?

CHARLIE: Five, maybe, or ten. Needles are very hard to get. Usually when you get a needle, it says *"for one use only."* I had a rig that I used every day for 3 months. I was a full-fledged junkie. If you're lucky enough to get a needle, the cost can range anywhere from $20 to a carton of cigarettes. I myself have paid up to $50 just to get a rig. They're very scarce.

I remember in one penitentiary, guys used to line up on payday. There's one guy running the fits, and there's one guy running the bleach. In that situation, if you have HIV or AIDS and don't tell anybody and then get found out, you're probably going to get stabbed or very severely beaten. When you are known to have HIV, it kind of slows down the line because nobody believes the bleach will kill the virus, and no one wants to go after you.

PASAN: I've talked to HIV positive guys who try to keep a rig for only themselves and not share it at all. But then they either end up looking like an asshole for not sharing, or they have to disclose their status to keep the rig from being used by other prisoners.

CHARLIE: Yeah. You're a goof, an asshole. You're *"NG" – no good*. Cop-lover. You get called every name in the book because you won't share, even if you tell them (your status). I myself lied a couple of times and told people I have Hep C. Now Hep C can be transmitted easier than HIV, because it can't be killed by the bleach. But I tell the guy, *"Hey, I'm Hep C,"* and they say, *"Oh, I don't care."*

I'm a hustler. I've always had two or three fits. I've always had people bringing me drugs in. And I've always had clean fits. What I would do is put one or two clean fits away for myself, and then I'd have two or three to sell for drugs or money.

I don't know if I'm supposed to say this, but I've had the odd staff member who'll bring me in a new fit, or a couple of new fits. In exchange I'd buy him some cigarettes, because cigarettes at the time were $7-8 a pack on the street, and we were paying less than $2. So I'd give him a carton of cigarettes and he'd give me five new fits. There are inmates that work in the hospital area, and they sometimes have the opportunity to get fits.

Nothing comes free. You have to pay for it. Even if you pay for it, you don't know if the rig is clean. Most people that I know – junkies – they're more concerned about getting their fix than whether the rig is clean or not. Once they get the hit in them, *then* they get all panicky about whether the rig was clean, and they'll start cleaning it with bleach. But bleach doesn't kill Hep C, as far as we know. So there's a big epidemic of HIV and Hep C in prison.

I've had friends die through trying to keep their AIDS private. Someone finds out they have a needle, and says to them, *"Hey, I'll give you a flap of heroin if I can use your needle."* And then down the road, if they see you getting an *Ensure*, or getting the (HIV drug) cocktail for your disease, the guy suddenly realizes, *"This fucker's got AIDS, and I used his fit."* The next thing you know somebody's trying to kill you or stab you.

PASAN: So what do guys do to get syringes?

CHARLIE: You have to learn how to make your own needles – "fits" or "rigs" we call them. You have to learn how to sharpen your rig on match packs, or on very fine sandpaper. You have to learn to make new plungers. You have to learn how to unplug your rigs. We deal with heroin. We deal with morphine, with cocaine. Morphine is very hard on needles. Heroin is easier but more dangerous. When a rig plugs you have to strip cable wires down to a very, very thin wire and you have to play with the needle to try and unplug it.

When fits break down you can make them from Bic pens, from eyedroppers. A lot of guys use eyedroppers, but you have to learn how to run the eyedropper properly. Other ways we make needles is to use football plugs – that you use to blow a football up with. Break the tip off and grind and grind and grind it until it's sharp. It makes a very thick needle, like the needles for taking blood, and when you put it in it's really hard because you have to shove, shove, shove. If you don't know your veins, you can get really screwed up.

PASAN: So if you're using the needles so many times and keeping them so long, guys must have even more problems with other infections and abscesses.

CHARLIE: I've lost four or five veins myself, because the needles get so dull they won't sharpen anymore. You have to actually hold the fit and drive it through your arm and then try to catch a vein. Some of the garbage we have to use is unreal. I've seen guys cut their arms open just to mix up heroin, and throw it on their arm.

PASAN: Are there a lot of ODs?

CHARLIE: In my own experience, I've seen about fifteen people OD. There's a severe drug problem in prison. And everybody thinks the answer is to take the visits away. But there's guards that'll do it (bring drugs into prison). Some guards charge up to $1000 a flight. What we mean by a "flight" is that I'd send them to you on the street. You would give them the drugs and pay them anywhere from $300-$1000. Then they would bring my drugs in to me.

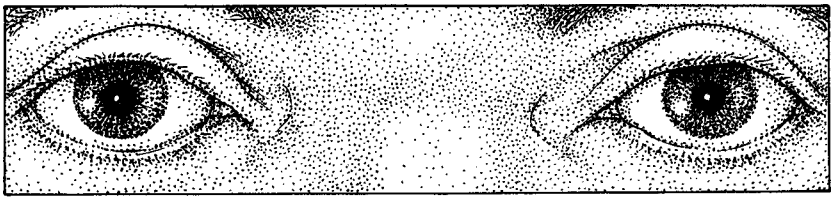
PASAN: Do most people try to use bleach?

CHARLIE: There is bleach in prison, through the laundry. Now they've started to pass out bleach kits, but nobody wants to pick them up because if you pick up a bleach kit, you're showing people you're a user.

Prison is a tough place. A lot of the public is blind to it because they think everybody gets colour TVs, and this and that. A lot of guys come into prison and get depressed. So on the street it's like, *"OK, I'll go have a drink."* Well in prison, instead it's, *"I'll go have a little bit of heroin,"* or *"I'll go do a little bit of crack,"* or *"I'll go smoke a joint."* But they don't realize what they're getting into. I'm not debating the fact that I'm a junkie, and I'm not debating the fact that it's wrong for me to say that for a flap of heroin I would lend somebody my fit. I'd bleach it, in hopes that they wouldn't get Hep C or whatever. But it's almost like a baby crying in the morning, you have to feed it. So when I'm feeling sick, I need a hit. I don't give a fuck, I need the hit.

People are scared to come out and say they're HIV or they're Hep C or they have AIDS because then people just shove them out. And then people get depressed, and this is where you get overdoses, and when people want to end their lives. And it's very, very sad and very, very sick.

If the government would give us our own needles, then we wouldn't have this big epidemic, but that's not the case.



Victor's Story

MY NAME IS VICTOR. I'm a 40 year old inmate incarcerated in Stony Mountain Penitentiary.[1] I got diagnosed with HIV on the street in October 1997.

My initial diagnosis was "by definition" with full-blown AIDS. I also have Hepatitis B, C, and TB. My diagnosis with HIV left me in a shocked and panicked state, not knowing how much time I had to live.

Later, I taught myself on the diseases by reading and getting second opinions from other HIV specialists.

I am also Vice-Chairman of the Health and Wellness Committee here in Stony Mountain Institution (SMI). Being with the committee, I've also gotten a lot of good advice and materials to cope with my diseases inside.

What I find troubling is the improper medical care (i.e., medications) to deal with the side-effects of my HIV cocktails. When I was pen placed in Rockwood Institution (the SMI farm annex) I weighed 167 lbs. In a period of five weeks at Rockwood Institution my weight dropped to 150 lbs.

I asked my specialist for *Nabalone*, which is a THC (synthesized marijuana) pill that stimulates appetite. He also recommended *Tylenol 3s* for my migraine headaches. But the healthcare department refused me these medications due to "policies". I informed the nurse, my parole officer, and my case management team that I would smoke marijuana so that I can eat. That is one of the reasons they increased my security level from minimum to medium.

I have been back in Stony Mountain since October 1999. Again, my weight continues to drop, which is documented in my medical file. At present I weigh 139 lbs. Since I have only ten days left until my statutory release, I've decided that I'll deal with regaining my weight and health on the street, where there are no "policies" against the proper medications I require.

I see a lot of problems with my fellow inmates not getting the proper medications to deal with their diseases. Even when they're given proper meds (i.e., *Interferon* for Hep C) they are not getting medications to deal with the side effects.

One particular inmate indicated to me that he asked the doctor to help him with his side effects from the *Interferon* treatment. The doctor closed his file and simply told the inmate to stop the treatment. This, of course, infuriated the patient, who had nowhere to turn. He came to me and told me the story. As the Health and Wellness Rep, I went to the head nurse and worked it out with her. The pa-

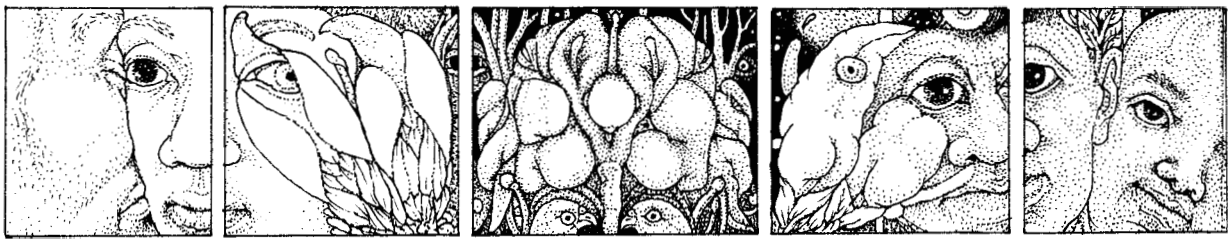
tient got the medications to help him with his side effects.

In the past 19 years I have spent approximately 13 years in SMI, over a period of three sentences. I have seen a lot of needless suffering with medical problems, as I noted with the above examples. Only in the past few years have the epidemic proportions of Hep C and HIV come to light. CSC has this stigma about "medication drug abuse", and do not look beyond that. It has been admitted by both inmates and staff that drugs will always be a part of penitentiary life. There are people inside needlessly getting infected with these deadly diseases. I ask, *what will it take for CSC to do something about the epidemic proportions?* And may I note that staff are also at risk of contracting these diseases.

Overall, CSC must look at their current medication policies and amend them to current (outside) standards, so that imprisoned patients can be properly treated with the appropriate medications.

A needle exchange program would also help to reduce the Hep C epidemic, and other diseases.

[1] At the time of writing. Victor has since been released.



CHAPTER THREE

HIV and Hepatitis C in Prisons

HIV AND HEPATITIS C INFECTION RATES have reached epidemic proportions in Canadian prisons. This public health crisis is the reality that confronts us as HIV/AIDS workers.

For those wishing to create meaningful community-based HIV/AIDS prevention and/or support programs in prisons, a recognition of the scale and seriousness of this crisis is essential, as is a good grasp of the basic prevention and treatment issues for prisoners.

For those hoping to engage in program work, this chapter will inform you about issues related to HIV and Hepatitis C in Canadian prisons. For those hoping to engage in effective advocacy for imprisoned PHAs, this chapter will also provide you with indispensable tools and rationales to shape your own arguments.

The chapter is divided into easy to read briefs, which include detailed background information and analysis on the key national prevention and treatment issues, as well as tips for countering common arguments against expanding care for prisoners.

If you have little or no background in HIV/AIDS work, this chapter will provide a complete briefing on the prevention, care, and treatment issues you need to understand.

If you *do* have a background in HIV/AIDS work, this chapter will explain how essential HIV/AIDS programs and services are applied (or withheld) in Canadian prisons.

CHAPTER THREE

HIV and Hepatitis C in Prisons

In the early 1990s, community-based groups began raising the alarm about the AIDS crisis in Canadian prisons.

Several organizations in particular took leadership, calling on the federal and provincial governments to implement comprehensive HIV/AIDS strategies in the prison system. These groups – *PASAN,* the *Expert Committee on AIDS in Prison*, the *Canadian AIDS Society*, and the *Canadian HIV/AIDS Legal Network* – have all published documents detailing the urgent necessity for government action on this issue.[1] Many of their recommendations are summarized in this chapter.

Since the late 1980s, a number of studies of *seroprevalence rates*[2] among prisoners have illustrated the growing urgency of the problem in every region of Canada.[3] In April 1999, the Correctional Service of Canada (CSC) reported 200 known cases of HIV infection in the federal prison system. This is an infection rate of approximately 1.5%. As this figure only includes HIV infections known to prison health care units, it is reasonable to assume that the actual infection rate is considerably higher.[4]

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[1] See *Further Readings* in the *Resources* section.

[2] "Seroprevalence rates" means "infection rates".

[3] A 1989 study revealed an HIV infection rate of 7.7% in a Quebec women's prison. A 1993 British Columbia study found an HIV infection rate of 1.1% among provincial prisoners. A 1993 study of provincial prisoners in Ontario found HIV infection rates of 1.0% among men and 1.2% among women. A 1998 study revealed an HIV infection rate of 1.7%, *and a Hepatitis C infection rate of 33%* in a federal prison in Ontario. Canadian HIV/AIDS Legal Network, "HIV/AIDS and Hepatitis C in Prisons: The Facts," *HIV/AIDS in Prisons: Info Sheet 1* (1999).

[4] Ibid.

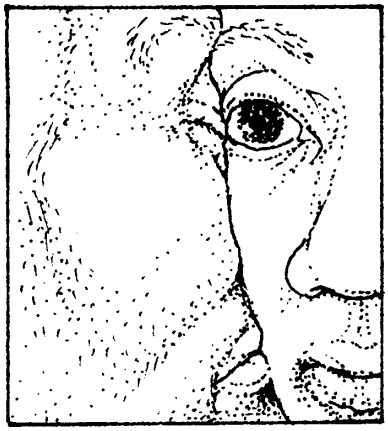
The 1999 study and others like it demonstrate that rates of HIV infection among Canadian prisoners are more than 10 times higher than in the general population. Rates of Hepatitis C infection are 30-40 times higher among prisoners.[5]

Despite their periodic commitments and reassurances, however, the federal and provincial governments have acted neither quickly nor comprehensively to address this escalating public health crisis.

This is the context we enter as community-based HIV/AIDS workers.

[5] Ibid. Despite these explosive Hepatitis C figures, to date much less has been done by community groups or others to address the issue. This is an area ripe for more attention and urgent action.

I. HIV and Hepatitis C Prevention: An Overview of Key Issues



Whether a person lives in prison or in the outside community, the modes of HIV and Hepatitis C transmission are the same.[6]

The definitions of high risk, low risk, and no risk behaviours do not change as you pass from one side of the prison walls to the other. However, within the prison system, various prison policies and practices contribute to the creation of higher risk environments that can make people in prison more vulnerable to HIV or Hepatitis C infection.

Despite the proven high rates of HIV and Hepatitis C seroprevalence among prisoners, in practice correctional systems across Canada continue to limit – or even deny – prisoners access to the tools proven to reduce the risk of transmission of these diseases. As a result, prisoners live in conditions that increase their vulnerability to HIV and Hepatitis C infection.

Below is a summary of the current policies and practices in Canadian prisons that exacerbate the transmission of HIV and Hepatitis C.

Condoms and Lubricants

The traditional tools used to help reduce the spread of HIV through sexual contact – condoms, dental dams, and water-based lubricants – are *not* universally available in Canadian prisons.

While the federal prison system makes condoms available, as do some of the provincial systems, access to condoms is not consistent across the country.[7]

Even in those jurisdictions or institutions where condoms *are* allowed, flawed or shortsighted methods of distribution often mean that access to these effective safer sex tools is limited at best.

In many institutions, prisoners cannot access condoms discreetly or anonymously. It is common for prisoners to have to request condoms from staff members (usually health care staff, but in some cases guards), or pick them up in high-visibility areas. In some Québec prisons, a prisoner must put in a *written request* for a condom, which may then arrive several days later.[8] Given that homophobia is equally prevalent (some would say even more prevalent) within prisons as within general society, these methods of distri-

[6] If you are completely new to HIV/AIDS prevention education, we recommend that you contact your local AIDS service organization to arrange for "AIDS 101" training. *This manual should not be considered a substitute for such training.* Likewise, if you are unaware of Hepatitis C prevention issues, contact your local chapter of the Hepatitis C Society of Canada for more information.

[7] As of this writing, the provincial jurisdictions *not* providing condoms are New Brunswick, Prince Edward Island, and Newfoundland. Canadian HIV/AIDS Legal Network, "Prevention: Condoms," *HIV/AIDS in Prisons: Info Sheet 4* (1999).

[8] Viviane K. Namaste, "Évaluation des besoins: Les travesti(e)s et les transsexuel(le)s au Québec à l'égard du VIH/SIDA," *Report submitted to the Centre Québecois de coordination sur le SIDA*, (Montreal: May 1998).

TIP:

Some correctional officials and guards' unions depend on fairly outrageous claims to justify limiting or denying access to condoms. One of the most common is the accusation that condoms may be used to smuggle drugs inside a person's body cavities (anus or vagina). While this is certainly true in theory, the argument falls apart under scrutiny.

There are any number of items readily available to prisoners (from sandwich baggies to cling wrap to latex gloves) which can fulfil an identical function. Such items are not prohibited. Therefore, this is not a valid argument for limiting access to condoms.

bution create enormous barriers for prisoners wanting to practice safer sex, even in institutions that technically *do* provide condoms.[9]

In addition, many jurisdictions have institutional regulations prohibiting consensual sex. Therefore, many sexually active prisoners will not risk calling attention to themselves by asking staff for condoms. They fear that by doing so they make themselves subject to increased surveillance, and/or having a record made in their institutional file.

Such institutional prohibitions lead to punitive sanctions against safe sex. For instance, in one detention centre where condoms were only available through the guards, it was well known among prisoners that anyone requesting condoms would have their cell partner moved to another range in the prison. This was done on the assumption that the individual asking for the condom was involved in a relationship with their cell partner. Therefore, those prisoners who *were* involved in a regular, consensual sexual relationship – and therefore *most* in need of safer sex materials – were also the *least* likely to access them, due to that institution's distribution policies.

Transsexual and transgendered prisoners experience particular barriers in this regard. In general, staff "expect" TS/TG prisoners to be involved in sexual relationships within the institution. Therefore, TS/TG prisoners tend to experience closer surveillance by staff. Such heightened staff interest in their movements and activities can generate a reluctance to access condoms among some TS/TG prisoners.[10]

It is also common for institutions to limit the number of condoms a prisoner may legally possess. If a prisoner is discovered with more than the number allowed (usually two), the condoms are considered contraband and the individual is subject to disciplinary action. Perhaps most noteworthy is one Ontario institution which insisted that prisoners return all used condoms to staff.

Finally, even where condoms *are* available, this is no guarantee that water-based lubricants or dental dams will also be available.

The above factors create a scenario in Canadian prisons where unsafe sex is pervasive, and safe sex is not only much more rare, but sometimes grounds for punishment.

Leading community-based organizations are demanding that all prisoners have ready and discreet access to safer sex materials, including condoms, water based lubricants, dental dams, and latex gloves. Prohibition of, and punitive disciplinary practices towards, those practicing consensual sex must also end.

[9] For more on barriers to safer sex in prisons, see *"Inside" Information: Breaking "Out" – Same-Sex Relationships, Homophobia, and HIV/AIDS in Prisons*.

[10] For more on the risks specific to TS/TG prisoners, see *Close-Up on Prisoner Populations with Special Needs: Transsexual and Transgendered Prisoners* in Chapter Two.

Needle Exchange

The most effective way to reduce the spread of HIV and Hepatitis C through injection drug use is by using *sterile syringes ("clean needles")*.

In the outside community, therefore, *injection drug users (IDUs)* are encouraged to use a brand new needle for each injection. To encourage this practice, *"needle exchanges"* provide free sterile syringes to IDUs who deposit their used syringes with the service for safe disposal.

While there is easy access to drugs of all varieties in Canadian prisons, there is no access to clean needles in Canadian prisons. Despite advocacy efforts by prominent community-based organizations and respected medical professionals, no jurisdiction in Canada currently provides sterile syringes for IDUs in custody.

This creates a scenario where imprisoned IDUs across Canada regularly share injection equipment (commonly referred to as *"rigs"*, *"fits"*, or *"works"*) by necessity. It is not uncommon for an institution of five hundred prisoners to have only three or four syringes in circulation. This means that all the IDUs in that institution use those same three or four needles. Given their scarcity, prisoners must use and re-use syringes over and over again for months.

Sometimes a syringe is owned by an individual who lends it out, or rents it to others for a fee. Sometimes a syringe may be hidden in a commonly known location such as a washroom, and people will use the rig when they need it.

Typically, a syringe only leaves circulation for one of two reasons – either prison staff seizes it, or it falls apart from repeated use. Until that time, the syringe will be held together with tape and glue: the needle getting duller and duller and shorter and shorter as it breaks off.

The possibility of detection (and the urge to get the fix in as quickly as possible) often precludes any thought of bleaching the needle to sterilize it – even when bleach is available.

The lack of access to sterile syringes is perhaps the most urgent prevention issue in Canadian prisons today. Large injection drug using populations[11] have combined with already high rates of HIV and Hepatitis C infection in prisons to create a public health crisis of frightening proportions.[12]

Federal and provincial governments' failure to act on this issue flies in the face of abundant evidence on the effectiveness of *needle exchange programs (NEPs)* in Canadian community settings. Indeed, studies have consistently

TIP:

As with condoms, some prison staff and guards' unions have adamantly opposed the provision of sterile needles to prisoners. Their opposition is mainly due to fears about needles being used as weapons against staff. However, there are equally convincing counter-arguments that can and should be made.

Creating safe environments in prisons has little to do with the availability of syringes, and much more to do with the prisons' social and grievance structures, living conditions, and staff/prisoner relations. Indeed, multiple objects within prisons can be used as weapons – including very old, very dirty syringes.

The most common workplace risk for guards is the threat of needle stick injuries during searches of cells and individuals. However, if prisoners did not need to hide their syringes, this health and safety risk could be eliminated altogether.

[11] For more on drug using populations in Canadian prisons, see *Close-Up on Prisoner Populations with Special Needs: Drug Using Prisoners* in Chapter Two.

[12] The reuse of syringes has other, more minor, negative health effects. Reusing syringes also increases the risks of other infections, abscesses, and vein damage related to injection drug use.

concluded that needle exchange programs in the outside community are successful in decreasing the transmission of HIV without increasing the number of people using injection drugs.[13] *These results have already been duplicated in European prison environments.*[14]

In spite of this evidence, various levels of government in Canada continue to refuse to initiate needle exchange programs in prisons. As recently as 1999, an expert panel commissioned by the Correctional Service of Canada – comprised of correctional staff, medical experts, and community representatives – called upon the Solicitor General to authorize the pilot testing of one NEP in each of CSC's five regions. To date, the federal government has ignored these recommendations.

Leading community-based organizations are demanding the provision of needle exchange programs in all federal and provincial prisons.

The establishment of needle exchange programs should be done in conjunction with broad consultation with both prisoners and correctional staff. However, this consultation should only consider *how* the programs should be implemented, not *whether* they should be implemented. While the concerns of correctional staff about such programs do need to be addressed through discussion and education, staff *do not* have the right to block access to this life-saving public health program.

Bleach

While never an adequate substitute for needle exchange programs, the use of bleach to sterilize needles before reuse is an important option for harm reduction. In prisons, where sterile syringes are unavailable, the accessibility of bleach takes on additional significance.

Some jurisdictions in Canada have implemented bleach distribution in prisons as a way to address the spread of HIV and Hepatitis C though needle sharing. Like condoms, however, bleach is not consistently available across the country.

In 1992, the provincial prison system in British Colombia was the first to make bleach available as a harm reduction tool. The Québec provincial system also has a similar policy – although actually getting one's hands on the bleach is often easier said than done. Bleach access remains the exception rather than the rule for most provincial jurisdictions.

Correctional Service of Canada implemented a bleach distribution program in all federal penitentiaries in 1996. However, the CSC bleach program is fraught with some of the same internal contradictions that

[13] Canadian HIV/AIDS Legal Network, "Needle Exchange Programs," *Injection Drug Use and HIV/AIDS: Info Sheet 8* (1999).

[14] Some European prisons began providing needle exchange during the 1990s, including institutions in Switzerland, Germany, and Spain. The value of these programs has been proven repeatedly in Switzerland, where NEPs have operated in various prisons since 1992. The Hindelbank institution, for example, has recorded a significant decrease in needle sharing, a decrease in overdoses, and an increase in overall prison health since initiating an NEP in 1994. Most significantly, Hindelbank has recorded *no new HIV or Hepatitis C infections, no increase in drug consumption, and no incidents in which needles were used as weapons*. Canadian HIV/AIDS Legal Network, "Prevention: Sterile Needles," *HIV/AIDS in Prisons: Info Sheet 6* (1999).

undermine the effectiveness of many condom programs. In some institutions, bleach is diluted with water before distribution – further compromising an already sub-optimal harm reduction tool. In other institutions, limited supplies of bleach have meant constant, frustrating shortages.

In reality, bleach-cleaned needles are *not* a proven substitute for sterile syringes. Disinfecting injection equipment with bleach is not 100% effective in preventing HIV transmission, and there is no conclusive evidence that bleach is effective in preventing the transmission of the Hepatitis C virus.[15] Studies done on the effectiveness of bleach are also less convincing when applied to the reality of the prison environment. While bleach may be relatively effective in killing the HIV virus in a syringe used only once, that same bleach may be less effective on a homemade rig, or a six month old syringe held together by glue and scotch tape.

The above factors have created a scenario where only *some* imprisoned IDUs have access – only *some* of the time – to a harm reduction method of questionable efficacy.

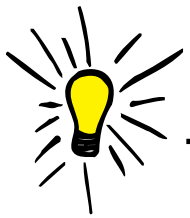
While the availability of bleach does nothing to reduce the necessity of prison needle exchange programs, bleach is still a significant harm reduction tool in those jurisdictions that provide it.

For bleach to be effective, however, the bleach must be full-strength, and access to bleach must be consistent and discreet. This is an area where monitoring and advocacy from the community can positively influence individual institutional practice.

Leading community-based organizations are demanding the provision of 100% full strength bleach (as well as distilled water for rinsing the syringe) in all federal and provincial institutions.

Bleach must be distributed in a non-stigmatizing manner in multiple discreet places throughout the institution. Ideally, all new prisoners entering an institution should be provided a "bleach kit", as this will help protect the identity of IDUs.

Leading community-based organizations also emphasize that the provision of bleach does not negate the necessity of prison needle exchange programs, as bleach is not 100% effective in killing the HIV virus, and is of unknown efficacy in killing the Hep C virus. These groups acknowledge that bleach is an important harm reduction option that must be made available to prisoners, but insist that it is *only one* component of a comprehensive harm reduction strategy that includes needle exchange programs and methadone maintenance therapy.



TIP:

Some institutions and provinces oppose bleach provision on security grounds, arguing that it can be used as a weapon. To counter this, you can point out that this has not been the experience in those Canadian jurisdictions that are currently providing bleach. You can also point out that until a decade ago (when new "hazardous materials in the workplace" standards were enacted) bleach was generally accessible to prisoners in many institutions across Canada as a cleaning agent. This much wider accessibility did not result in undue security risks for staff.

[15] Canadian HIV/AIDS Legal Network, "Prevention: Bleach," *HIV/AIDS in Prisons: Info Sheet 5* (2001/2002).

Methadone Maintenance Therapy

Methadone is a synthetic opiate substitute prescribed by physicians for chronic opiate users. Since its introduction in Canada in the late 1950s, *methadone maintenance therapy (MMT)* has proven successful as a long-term treatment for heroin and morphine users.

Methadone is administered orally, and so MMT reduces the need to use or share injection equipment. MMT therefore offers IDUs another important option for reducing their risk of HIV or Hepatitis C transmission.

For many street-involved IDUs (who have perhaps been out of the health care system for many years) MMT programs also offer an important opportunity for them to develop a relationship with a physician or community health centre, which can lead to an improvement in their overall health.

For these two reasons, many health professionals view MMT as an important harm reduction tool for injection drug users.

Until recently, the federal government regulated methadone prescription access. In the mid-1990s, however, the federal government relinquished control over methadone to the provinces. Since that time several provinces, including Ontario and British Colombia, have greatly improved access to methadone programs in the community, and the numbers of MMT patients have correspondingly increased.

While community methadone access has improved in some regions of Canada, this has not always produced a parallel increase in MMT availability in prisons. A common experience in many parts of the country is that individuals on a methadone program find themselves cut off methadone if they are arrested and incarcerated. This creates a scenario where such prisoners are forced to either endure painful withdrawal symptoms, or go back to injecting drugs purchased through the prison's underground economy.

In recent times, this situation has improved in some provincial systems, due in part to a BC case in which a prisoner took provincial corrections to court for failing to continue her methadone therapy.[16] However, access to methadone remains the exception rather than the rule in provincial prisons.

The federal prison system has also taken some small steps forward on the methadone issue. CSC has recently implemented a policy allowing people receiving methadone prior to incarceration to continue on MMT in the penitentiary.

[16] Canadian HIV/AIDS Legal Network, "Prevention and Treatment: Methadone," *HIV/AIDS in Prisons: Info Sheet 7* (1999).

The other major concern regarding MMT access in prisons is that it is difficult, if not prohibited, for prisoners to initiate a methadone program while incarcerated. This situation creates often insurmountable barriers to those prisoners who wish to utilize MMT to end their heroin dependency.

CSC has begun to implement what it terms an "exceptional circumstances" methadone policy, under which individuals meeting certain selection criteria are allowed to initiate MMT while inside. This policy has frustrated prisoners and community-based organizations in many regions of Canada, however, because the guidelines have been interpreted differently by different CSC Regional Headquarters. Therefore, federal prisoners with identical cases are approved for MMT in some regions but denied it in others. This has resulted in an inconsistent level of methadone access throughout the federal system.

CSC has indicated that its current policy is only an interim measure towards its ultimate objective of offering MMT broadly to opiate-using prisoners within the federal system. This promised expansion of the CSC methadone program is proceeding slowly, however.

The above factors have created a scenario whereby those imprisoned IDUs who wish to use methadone as a harm reduction tool frequently encounter obstacles to doing so, whether in the form of refusal for such programs, or in having their treatments interrupted or discontinued.

As with any harm reduction initiative, unless prison methadone programs are implemented and enforced consistently, their efficacy will be greatly reduced.

Leading community-based organizations are demanding that all prisoners be considered eligible to start MMT, whether or not they have a previous history of involvement in a methadone program.

Prisoners should be assessed for MMT based upon the same criteria as candidates in the general community. In those provinces where MMT access is not available in the community, correctional services should advocate with the provincial Ministry of Health to expand access to methadone within the province.

These organizations also insist that *no prisoner should ever be cut off MMT after being arrested.*

TIP:

Denying a prisoner on MMT access to methadone after arrest and incarceration is a very serious health issue, one of the most urgent you will face. If this occurs, you must vigorously pursue the matter with the institution at all levels, and with the provincial Ministry of Corrections or CSC Regional Headquarters (as appropriate). You might also contact the physician in the community who was administering the individual's MMT program. Do not be shy on this one, and pull no punches.

Tattooing

Tattooing has always been a very popular prison art form.[17] Many talented tattoo artists operate in prisons, and many thousands of prisoners receive tattoos while incarcerated.

Unlike injection drug use, tattooing is a fully legal activity in Canada. It is an art form that is safe for both artist and customer, provided there is access to proper training and sterile equipment.

Despite its legality and broad societal acceptance, tattooing remains a prohibited activity in prisons.

Institutional prohibitions have not reduced the popularity of prison tattooing, but they have succeeded in driving the activity underground. Prison tattoo artists therefore work in secret, and must work quickly to avoid detection. They must often work in unhygienic environments, and usually without adequate tools.

The consequent re-using of scarce tattooing inks and tattooing needles – both of which come into contact with large amounts of blood during the tattooing process – presents a high risk situation for transmission of HIV and Hepatitis C. The lack of access to sterile or clean tattooing environments increases the risk of contracting other infections during tattooing. For these reasons, tattooing in prison presents a significant risk for spread of disease.

Some federal prisons allow prisoners to hire outside tattoo artists to come in and do tattoo work on them. However, given the great expense involved, this is not a realistic option for most prisoners. Also, many prisoners *choose* to have their tattoos done by their peers, whose artwork they may prefer and which they can see before choosing a particular artist. For some there is also added cultural value and esteem attached to having their tattoos done by prison artists.

While CSC has favourably considered the possibility of pilot testing a safe tattooing project in a federal penitentiary, at the time of writing they have yet to move on this issue.

The Québec provincial system has recently denied permission for a safe tattoo project, reasoning that the tattoo artists would not be operating under "professional" supervision.

The above factors have created a scenario whereby thousands of prisoners are getting tattoos under unsafe conditions, and whereby measures to increase safety and reduce harm must not only be improvised by the prison-

TIP:

Many of the materials we call for in other areas of HIV/Hepatitis C prevention may also be used for safer tattooing. Bleach, for example, should be used to clean tattooing equipment. Latex gloves should be worn by tattoo artists when doing work. When advocating for the provision of these materials in your region, make sure your argument does not neglect the importance of these tools for safe tattooing.

[17] Tattooing is particularly important to some Aboriginal prisoners, as it is also considered a rite of passage in some Aboriginal cultures.

ers themselves, but also undertaken surreptitiously and under threat of punishment.

Leading community-based organizations are demanding that all prisons end the prohibition of prison tattooing.

All prisons should provide safe tattoo programs, whereby prison tattoo artists may practice their skill in clean environments, with access to professional equipment, and access to proper sterilization and waste disposal facilities.

For more details on safe tattooing practice in prisons, see *"Inside" Information: Safer Tattooing – A Prisoner's Guide*.

Anonymous HIV Testing

In Canada, the results of HIV testing are managed in two different ways.

The first is *"confidential" testing*, which is the type usually done by general practitioners in the community, and in all prison health care units. When undergoing confidential testing, by law all HIV positive tests must be reported the local Department of Public Health. Therefore, "confidential" testing is not truly confidential. This practice is a barrier to many seeking testing, who do not want their results to be known to others.

The second is *"anonymous" testing*, which is preferred by many people. When undergoing anonymous testing, the person being tested is not required to provide a name. All blood samples are sent to the laboratory with only a numerical identification code. Therefore, when the results are given back, they are known only by the subject of the test. This manner of testing provides much greater confidentiality to the person talking the test. Anonymous testing only takes place as designated sites across Canada.

Access to anonymous HIV testing is another issue where correctional services' policies are generally at odds with accepted community practice.

There is no mandatory HIV testing for prisoners in Canada, nor should there be.

Instead, prisoners in both the federal and provincial systems generally have access to HIV testing services by request, through the institutional health units. However, this testing is *confidential* testing rather than *anonymous* testing, meaning that the results of the prisoner's HIV test are made available to both the prison health unit and to the public health department.

TIP:

Keep yourself up-to-date with the evaluations of those few prison anonymous testing projects currently in operation, as their success can help form the basis for an anonymous testing proposal in your region. Contact the anonymous testing sites in your area and assess their willingness to extend anonymous testing services to prisoners. If they are willing, you should include them in your advocacy efforts.

Given the reasonable concerns that many prisoners have about confidentiality within the institution (see *HIV/AIDS Care, Treatment, and Support: An Overview of the Key Issues – Confidentiality*, below), it is not surprising that many choose not to access HIV testing under these circumstances.

There are a few notable exceptions to this practice. In Prince Albert, Saskatchewan, the local community STD Clinic provides weekly anonymous testing services – including pre- and post-test counselling – to men and women in the two local provincial correctional centres. This initiative was undertaken with the support of the prison health staff, who have no role in the testing process other than providing the clinic space. Hundreds of individuals have accessed anonymous HIV testing through this program since it began in 1994.[18] Following this program's success, in 1998 CSC began a pilot anonymous testing project in Saskatchewan Penitentiary, again in partnership with the Prince Albert STD Clinic. Similarly, prisoners can also access anonymous testing in some Québec provincial prisons (such as Bordeaux and Sherbrooke), where the prison medical services are contracted out to local community health centres, rather than being run by correctional services itself.

These kinds of innovative community-corrections partnerships are, unfortunately, the exception rather than the rule across Canada. However, the fact that such initiatives operate successfully in some institutions should serve to demonstrate their feasibility, and encourage other jurisdictions to move quickly to implement similar projects.

In those prisons where anonymous testing is still not available, this has created a scenario whereby many prisoners who should – and would otherwise want to – get tested decline to do so, thus depriving themselves of the advantages afforded by early detection.

Leading community-based organizations are demanding that all prisoners have access to anonymous testing.

Anonymous testing should be conducted by outside community testing facilities, rather than correctional services, in order to promote confidence in the confidentiality of the results.

[18] Information from Aline Duret, STD nurse, Prince Albert Health Region, Saskatchewan.

II. HIV/AIDS Care, Treatment, and Support: An Overview of Key Issues

Whether a person living with HIV/AIDS (PHA) lives in prison or in the outside community, their care, treatment, and support needs are the same.

However, within the prison system, various prison policies and practices contribute to the creation of environments that can make PHAs in prison more vulnerable to health decline than many PHAs in the community.

Despite its mandate of care, and *Charter* obligations to do so in theory, in practice correctional systems across Canada limit – or even deny – HIV positive prisoners access to a standard of care commensurate with that available in the community. As a result, imprisoned PHAs are generally forced to live in conditions that increase their vulnerability to medical neglect, opportunistic infections, needless suffering, and untimely death.

Below is a summary of the current policies and practices in Canadian prisons that exacerbate these conditions.

Confidentiality

AIDS-phobia is a reality in Canada, both inside and outside of prison.

People living with HIV/AIDS routinely face discrimination and ostracization, and sometimes even violence, as a result of their HIV status. This stigmatization results not only in stress and fear for PHAs, but indeed discourages many people from seeking testing and/or treatment.

In prisons, pervasive misinformation creates unnecessary fears about the risk of HIV transmission via shared living spaces, shared food, shared cigarettes, etc. This creates a prison environment that is often very hostile to people known to be HIV positive.

For these reasons, *confidentiality* is probably the main issue of day-to-day concern for prisoners living with HIV/AIDS.

There are many unique pressures that make confidentiality even more difficult to maintain in prisons than in the outside community. The communal living arrangements, the constant surveillance by staff, and the general AIDS-phobia of prisoners and staff alike, all ensure that protecting the confidentiality of their status is an everyday struggle for imprisoned PHAs.

At the staff level, there is a widespread belief – particularly among guards – that a prisoner's HIV status is a workplace safety issue. In the minds of many correctional officers, they have the right to know who is HIV positive because they believe such knowledge will protect them from HIV infection. While at odds with scientific facts, and contrary to workplace safety guidelines that encourage universal precautions, this attitude is pervasive in prisons across Canada.

This erroneous belief not only has a devastating impact on imprisoned PHAs' ability to maintain confidentiality, it also promotes false notions of workplace "risk" and "safety" among correctional workers. It promotes an institutional atmosphere where security staff often pressure medical staff to identify HIV positive prisoners. It means that when guards discover that a prisoner is HIV positive, they often disclose the prisoner's status to other staff, prisoners, and outside community workers.

Security staff sometimes go to clever lengths to identify HIV positive prisoners without *technically* "disclosing" their status (which might result in some sanction by the institution). For example, many institutions have security stations set up on each range. As a standard security feature, these stations maintain a display of the photos of all prisoners housed in that particular section. This photo gallery is used to keep track of prisoners, and to assist in regular head counts. However, it is not uncommon to see a caption written next to a particular individual's photo, reading *"use universal precautions"*. This is a tip-off that the prisoner is HIV positive. Sometimes HIV positive prisoners notice that their photos have little red dots, or some other kind of indicator, marked on them. Guards will wear latex gloves when escorting certain prisoners, but not others. While unnecessary and unprofessional, this kind of behaviour is still common.

AIDS-phobia frequently causes fellow prisoners to disclose the HIV status of others. Again, some prisoners also feel they have the "right to know", and misguidedly believe that this knowledge will protect them from contracting HIV. Therefore, imprisoned PHAs' confidentiality is also at risk from their fellow prisoners.

There are also subtle or inadvertent ways in which a PHA's confidentiality can be jeopardized or broken, related to the provision of health care or other services in the institutions.

For example, medications are often distributed in open view, thereby risking the chance that other prisoners will recognize the pills that a PHA may be taking. Staff and other prisoners often assume that people receiving nutritional supplement drinks such as *Boost* or *Ensure* are HIV positive. If it is known that an HIV specialist physician visits an institution on a specific day each month, those people called to the health unit on that

day are suspect. If a prisoner is seen talking to the local AIDS support worker, assumptions will be made that s/he must be HIV positive. (To minimize this particular assumption, it is important that HIV/AIDS workers clearly state to prisoners and staff that all people are free to access services regardless of HIV status.)

Most of these examples of potential inadvertent confidentiality breach could be avoided by minor, thoughtful adjustments in service provision on the part of both prison health care staff, and independent community-based service providers.

All of the above factors create a scenario whereby many imprisoned PHAs find that, despite their efforts, their confidentiality is eventually compromised and their status involuntarily disclosed to others in the institution.

Leading community-based organizations are demanding that common prison routines, such as doctors' appointments and the dispensing of medications, be reviewed with the goal of minimizing the risks of inadvertently breaching confidentiality.

Professional codes of conduct governing confidentiality must be implemented and adhered to by all correctional employees, not simply medical staff. Any staff breaching confidentiality should face disciplinary action by the institution.

Furthermore, all correctional staff should have mandatory and ongoing education about the risks and non-risks of workplace transmission of HIV and Hepatitis C, the importance of confidentiality, and the proper use of universal precautions.

Medical Specialists

Having access to doctors who are knowledgeable on HIV disease, and skilled in treating it, is crucial to the health of persons living with HIV/AIDS.

Given the highly specialized and constantly changing nature of HIV treatment information, few correctional physicians fit this category. This necessitates the involvement of outside medical professionals in order to provide a proper standard of care for prisoners living with HIV/AIDS.

Some outside physicians who are personally dedicated to providing health care for prisoners do make an effort to visit institutions to see individual PHAs on a regular basis. In some regions, the federal correctional system contracts community HIV specialists for this purpose. However, this remains the exception.

TIP:

Every breach of confidentiality is serious, and community-based workers should intervene on confidentiality issues whenever they arise – when authorized to do so by the client.

In the case of inadvertent disclosures due to prison routines and practices, you may be able to work constructively with the institution to both identify and resolve problematic procedures.

In the case of deliberate breaches of confidentiality by staff, your client may want you to help them lodge a formal complaint against the staff in question. As most institutions normally impose few or no consequences for such breaches, community-based workers can and should play a role in holding both the staff in question and the institution accountable. A deliberate breach of confidentiality constitutes unprofessional behaviour, whether or not the institution enforces specific regulations against it.

TIP:

Doctors tend to be a breed unto themselves, and usually only take advice from other doctors. Therefore, if you hope to do effective advocacy with the prison physician, your best option is to involve the client's outside doctor, and encourage her/him to contact the prison directly. You, as the community-based AIDS worker, can then intervene to argue the principle that the recommendations of the client's physician of choice should be respected.

Inability to access HIV primary care physicians and specialists is a persistent problem for most incarcerated PHAs.

In many jurisdictions, access to appropriate outside physicians is difficult or impossible. HIV specialists are often in high demand and/or short supply, particularly in rural areas. Even for those institutions located in or near urban centres, providing imprisoned PHAs with the opportunity to see a specialist can be complicated.

If an outside primary care physician is willing to see an HIV positive prisoner, the most common practice is for the prisoner to be transported out of the institution to see the doctor in her/his office. However, many institutions are reluctant to dedicate the financial and staff resources necessary to escort a prisoner to an outside appointment. In addition, since prisoners are usually transported in shackles, many are unwilling to face the humiliation of being escorted through the local hospital in chains, and thus decline to take a scheduled appointment. There is also the issue of confidentiality. The guards escorting the prisoner will obviously know where they are all going, and hence may be able to ascertain the nature of the prisoner's appointment. Since guards escorting a prisoner to an outside medical visit often insist on being present in the examining room, prisoners and doctors alike tend to balk at participating in such escorted visits.

Barriers exist even when the doctor is willing to come into the prison to see individual PHAs. The face and name of the HIV specialist soon get known in the institution, and so prisoners consulting that physician risk compromising their confidentiality to both staff and other prisoners.

Finally, the fact that outside physicians have no prescribing privileges in prisons (all prescriptions must be approved by the institution) means that access to a specialist does not guarantee access to the medications and other treatments that s/he orders.

The above factors create a scenario whereby most imprisoned PHAs end up making do with the ministrations of the non-specialist prison physician. While some prison physicians are willing to seek outside specialist advice and/or assistance on behalf of their patients, many others are not.

Leading community-based organizations are demanding that all PHAs in prison have access to medical professionals experienced and knowledgeable in HIV/AIDS care. This includes access to second opinions.

If the prisoner has an established relationship with an HIV specialist in the community prior to incarceration, the prison doctor should endeavour to consult with that specialist on treatment options. If such a relationship exists, and if geography permits, it is preferable that the prisoner be able to

continue to see their community doctor as their primary care physician to ensure continuity of care.

The procedure for doctors' appointments – whether taking place inside or outside the institution – should be reviewed with the goal of minimizing the risks of inadvertently breaching confidentiality.

Protease Inhibitors and Other Drug Therapies

New and emerging drug therapies such as *protease inhibitor combinations ("drug cocktails")* are offering new hope to many people living with HIV/AIDS. At the same time, these new therapies have created new challenges to the provincial and federal prison systems' ability to provide a proper standard of care to prisoners living with HIV/AIDS.

Drug cocktails (combinations of three or more medications) must be administered in a very rigorous and consistent manner in order for them to be effective.

The proper administration of drug cocktails requires precise timing of dosages, in combination with specific dietary requirements to facilitate the body's absorption of the medications. Failure to meet these requirements significantly reduces the drug therapies' effectiveness. More importantly, improper administration of the cocktails or missed dosages can lead to the development of drug resistance, thereby completely eliminating the effectiveness of that drug therapy for the PHA.

For these reasons, correctional health services must vigorously ensure the proper administration of all new HIV therapies. If they fail to do so, their standard of care will fall dangerously below community standards, and will have a *potentially catastrophic* negative impact on the health and life expectancy of prisoners living with HIV/AIDS.[19] Given the known ramifications on human health, failure in this regard is considered to be medical negligence by many health care professionals and HIV/AIDS workers in the community.

Several barriers commonly impede PHAs' proper access to HIV drug combination therapies in prisons.

The first barrier occurs when the PHA initially enters the prison system. When a person is arrested and tells the health unit that s/he is on a specific combination therapy, the health unit often declines to provide those medications until they have verified the prescription with the person's outside physician. If the person is arrested on a Friday or Saturday night, this delay can amount to two or three days. While this may seem a reasonable

[19] Ann Scott and Rick Lines, *HIV/AIDS in the Male-to-Female Transsexual and Transgendered Prison Population: A Comprehensive Strategy*, PASAN (Toronto: February 1999).

precaution, such delays can be devastating to the health of PHAs for the reasons cited above.

A number of additional barriers emerge after the prisoner is settled in the institution. Some prison doctors require a confirmatory HIV test for their files before allowing the prisoner to access HIV therapies, which again causes delays in treatment. Many prison systems do not allow prisoners to hold and manage their own medications. This compromises the proper administration of the medications, as nurses' rounds and drug dispensing schedules rarely coincide with the prescribed times of dosages, or with mealtimes. In addition, prisoners on remand often miss doses when they are taken to court, because most courthouse holding cells do not have medical staff available to dispense their medications.

TIP:

Interruption in protease inhibitor combination therapies is a very serious health issue. If this occurs, you should vigorously pursue the matter with the institution at all levels, and with the provincial Ministry of Corrections or CSC Regional Headquarters (as appropriate). Also contact the HIV primary care physician in the community who prescribed the treatment, and get her/him on board.

Even leaving the prison can create disruptions in the PHA's treatment. For example, transfers from one institution to another sometimes leave the prisoner without a supply of HIV medications: if the new institution does not have the medications in stock, the prisoner must wait – and miss doses – while the institutional pharmacy orders them in. Similarly, PHAs are often released from prison into the community without a supply of HIV medications, and without money to purchase them. Unless the PHA has previously arranged a doctor's appointment for the day of their release, this again creates a situation where they are forced to contend with an unnecessary gap in their treatment.

The above factors create a scenario whereby imprisoned PHAs on combination therapies suffer a disruption in their drug regimen at some point during incarceration, thereby diminishing or eliminating its effectiveness.

Leading community-based organizations are demanding that people living with HIV/AIDS in prison have access to the same treatment options as people in the community.

Given the known detrimental effects of interruptions in protease inhibitor combination therapies, people should *never* be cut off these medications without proper medical assessment and informed consent.

All instructions regarding the proper administration of medications must be followed. Prison routines that contradict medical instructions should be changed.

Prisoners on combination therapies should always be provided with a supply of their medications on release, or else have a doctor's appointment scheduled for the day of their release.

Diet

Access to nutritious food is a consistent problem for all prisoners. For prisoners living with HIV/AIDS, the effects of this problem are magnified.

We know that eating a well-balanced diet, complete with fresh fruits and vegetables, is an important component of health promotion for people living with HIV/AIDS.

Unfortunately, food choice in prison is very limited, and prison diets do not generally meet most people's criteria for healthy eating.

Diet is also an integral part of the proper use of many protease inhibitor combination therapies. Drug protocols often demand that specific medications be taken in conjunction with specific varieties of food, or in relationship to meal times. The effectiveness of these therapies can be contingent upon this link to proper diet.

Yet prisoners living with HIV/AIDS generally have no control over their diet. Policies about prisoners' diets are determined at the institutional level, and thus vary from prison to prison.

While some institutions have dieticians on staff, many others do not, and therefore do not allow for ready access to specialized diets.

Those institutions that *do* provide some dietary flexibility often have rigid meal times. If a prisoner needs to take medications at 8:00 am and 8:00 pm with food, for example, there is no guarantee that institutional meal times will coincide with this schedule. Furthermore, it can be an institutional offence to keep prepared food in one's cell, due to concerns about mice and insects. This makes it difficult for prisoners to save what food they are given until it is time to take their medications.

Even when prison health staff *do* make special meal arrangements for a PHA, this can jeopardize the prisoner's confidentiality. Other prisoners and staff may question why someone is receiving a different meal than everyone else, or receiving a meal at a different time. Therefore, resolving this issue often takes creativity and negotiation between the prisoner, the health care unit, and the AIDS worker.

Given the built-in policy variance, some institutions provide broader – or more restricted – access to food than others. On one extreme, people held in remand or detention centres often miss meals (and medications) altogether on the days they are brought back and forth to court. On the other hand, federal penitentiaries and some provincial institutions allow prisoners to purchase snacks from the "canteen". The diversity of canteen items

TIP:

In some institutions, prisoners can get "special diets" (i.e. vegetarian, Kosher, diabetic, etc.). In many cases, these diets provide better quality ingredients and a healthier balance of food groups than the standard prison fare. They also provide a credible "cover-story" to explain why the person is receiving a special diet. Investigate these options at your local institution, and insist that they be made accessible to PHAs.

available varies from prison to prison, but the best cases provide prisoners living with HIV/AIDS with useful options to supplement their diets. However, even this opportunity is limited or negated if the prisoner does not have the money to purchase items from the canteen. Some lower security institutions actually provide access to kitchen facilities for individual prisoners to prepare their own meals and manage their own diets, a useful option that is unfortunately unavailable at most institutions.

TIP:

While it is important to improve the diet for prisoners living with HIV/AIDS, this is best accomplished by improving the diet of all prisoners. By raising the overall quality of the prison diet, people living with HIV/AIDS need not be singled out by accessing a diet different than everyone else's.

While vitamin supplements could partially offset dietary deficiencies, access to vitamins can also be an ongoing problem for imprisoned PHAs. Many jurisdictions have severely restricted or eliminated access to vitamins as a cost saving measure. In these cases, vitamins are available only if prescribed by a doctor, or if the individual has money to purchase them through the canteen. However, even a prisoner with money will find that the choice is usually limited to standard multi-vitamins.

Some AIDS service organizations have made a significant impact on this situation by providing vitamins for their incarcerated clients. Such arrangements can be made through the prison's health care unit, although it may require advocacy to get them to agree.

Given the above factors, while PHA prisoners in some institutions are able to make do with the assistance of a prison dietician, or by adding vitamin supplements and/or canteen snacks, by far the majority are forced to contend with substandard nutrition and inappropriate meal schedules. Thus, in general, Canadian prison policies on diet both undermine PHAs' medical treatment and jeopardize their prospects for maintaining their health.

Leading community-based organizations are demanding that all prisoners living with HIV/AIDS have access to adequate and healthy diets in order to preserve and promote their health.

Diet and eating schedules must also be in keeping with HIV positive prisoners' prescribed drug treatments in order to maximize their efficacy.

Any policies facilitating HIV positive prisoners' access to proper diet should be reviewed with the goal of minimizing the risks of inadvertently breaching confidentiality.

Pain Management Medication

People living with HIV/AIDS often experience chronic pain as a part of daily life.

Many PHAs attempt to reduce or manage this pain using a variety of methods such as relaxation, meditation, massage, diet, exercise, and/or alternative medicines. Many need to supplement these methods with pain medications. Most people living with HIV/AIDS will need to utilize pain medications at some point in order to reduce their pain to manageable levels. For people in prison, however, this is very difficult.

Pain management medications are, by definition, narcotics.

Pain management is therefore an issue that fundamentally challenges the conventional thinking of correctional services.

Many prisoners living with HIV/AIDS have histories of drug use. This fact, combined with the prison system's zero tolerance approach towards drugs, creates situations where prison health care staff generally refuse – or are forbidden – to provide adequate levels of pain management medication. This is a serious issue for all prisoners living with HIV/AIDS.

In some cases, prison physicians who are inexperienced in diagnosing HIV/AIDS-related pain and/or harbour negative stereotypes about prisoners or drug users are reluctant to prescribe medication for pain management, or hesitant to provide it in the dosages necessary.

This situation is further complicated by the fact that drug users have often developed high levels of tolerance to the effects of narcotics, which means that a "standard" dose of a pain killer for non-drug users can easily have no effect on a drug user. This can also contribute to some prison physicians' unwillingness to prescribe sufficient pain management medications.

In other cases, entire institutions define themselves as *"narcotics free"*, which means that the prison completely opposes all prescription pain management medications.

For these reasons, PHAs who take pain medications while in the community usually have this medication either cut off or severely reduced upon incarceration. This practice creates an often unbearable situation of both increased pain from disease, and pain from withdrawal from their medication.

Far from addressing an individual's "drug problem", reducing or eliminating their access to prescription pain medications usually forces them to

TIP:

Accessing pain management is one of the most difficult barriers that prisoners face. If a prisoner has been prescribed pain management medications in the community, only to find them cut off or reduced upon incarceration, the best option is to contact the prescribing physician in the community, and request that s/he contact the institution to advocate on behalf of their patient. As the community-based worker, you can then intervene with the institution to argue that the recommendations of the prisoner's physician of choice be respected. While this approach is far from a guaranteed success, it is the most likely avenue for achieving some positive results.

TIP:

Prison administrators and staff often justify denying pain medications by asserting that prisoners receiving narcotic medications are prone to trade or sell them to other prisoners, or that weaker prisoners are vulnerable to having their medications stolen ("muscled") by stronger prisoners. However, creative approaches to administering pain management (liquid forms rather than pills, crushing and diluting pills, etc.) could alleviate these potential problems.

In any case, concern about illegitimate use of medications does not warrant their denial to people living with HIV/AIDS who need them. Should prison staff believe that pain management medications are being used improperly, it is their duty to provide some evidence to support that belief before taking any punitive action.

seek other avenues to manage their pain. Many prisoners turn to the underground drug economy in the institution, and begin to self-medicate using street drugs – often by injecting. Due to the lack of access to sterile injecting equipment, this creates an enhanced risk of spreading HIV among the injection drug using community in the prison.

If a prisoner *is* able to access pain management medication, they are often subjected to increased surveillance by staff. They also risk having their prescribed pain medications denied them on the mere *suspicion* of selling, trading, or giving the medicines away. Advocacy is usually required in such situations.

The above factors have created a scenario in Canadian prisons whereby PHAs are routinely denied pain management medication outright, or prescribed it in doses too low to be effective. This leaves many PHAs with one of two choices – either suffer in agony, or seek out illicit drugs (often injection drugs) in order to manage their pain. In the absence of adequate harm reduction measures, the latter exacerbates HIV transmission risks among imprisoned IDUs.

The prison has no right to deny prisoners living with HIV/AIDS access to legitimate prescription drugs, unless they are able to prove the allegation of improper use against the individual.[20] If they cannot, the denial of prescription medication violates the correctional system's statutory obligations to ensure the care of persons in their custody. It can also amount to negligent medical practice, professional misconduct by health staff, and discrimination in the provision of services contrary to human rights legislation.

Leading community-based organizations are demanding that people living with HIV/AIDS in prison have access to the same treatment options as people in the community. This includes pain management medications.

No prisoner should *ever* be cut off these medications without proper medical assessment and informed consent.

[20] Scott and Lines.

Palliative Care

Prisoners who enter the later stages of chronic or terminal illnesses – including but not limited to HIV/AIDS – need to access *palliative care*.

It is the opinion of leading community-based HIV/AIDS organizations that correctional institutions are simply not equipped to provide palliative care to the standard of that in the community.

The services provided by palliative care professionals are unique and demanding, and correctional staff lack the necessary training and resources.

The prison environment itself – with its security-focussed architecture and routines, lack of comfort and privacy, barriers to access for family and friends, lack of adequate training and resources for staff, etc. – is also generally non-conducive to the types of palliative care services that have become the community standard.

There are other, specific structural problems that undermine any potential for providing adequate palliative care in prisons.

For example, most correctional facilities do not provide 24-hour nursing care, nor do they have separate health units where chronically ill prisoners are housed apart from the general population. Therefore, many prisoners who reach a palliative stage are transferred to an institution that *does* provide such services. However moving the PHA in this way necessarily removes them from their support system within their home institution.

This isolates the PHA from the group of people whom s/he now considers friends and family. Access to outside family and friends is, of course, limited by virtue of the prison environment itself, and sometimes also by a prison's location if it is far from the PHA's home community outside. Prison hospital units are also frequently located in higher security institutions, and so palliative transfers can therefore result in an upgrading of the PHA's security classification. Security upgrades can have the incidental effect of further restricting the PHA's access to visitors. This scenario creates a palliative setting clearly inferior to that promoted within the community, where ongoing access to family and friends is a priority of care.

The problems do not stop there.

Proper palliative care – which often involves large doses of pain management medications – is thwarted by institutional barriers to pain medications (as described above).

TIP:

Many of these problems were publicly highlighted during the 1997 Coroner's Inquest into the death of Billy Bell. Bell, a federal prisoner housed in Kingston, Ontario, died in custody in May 1996 of AIDS-related causes.

The inquest jury found that the palliative care services provided by CSC did not meet "the principles and practices developed by the Canadian Palliative Care Association," and recommended that CSC "review and upgrade their palliative care approach."[21] At the time of writing, more than five years after Bell's death, CSC has yet to do so.

[21] Rick Lines, "Death Exposes Treatment of Prisoners Living with HIV/AIDS," *Canadian HIV/AIDS Policy and Law Newsletter*, vol. 3, no. 4/vol. 4, no. 1 (Winter 1997/98). The Bell Inquest findings are summarized in this article.

TIP:

Prisons' inability to provide adequate palliative care services is a concern for all prisoners, not only those living with HIV/AIDS. Many elderly prisoners, as well as those with diseases such as cancer, also suffer under current correctional policies and practices. The findings of the Bell Inquest are an important advocacy tool for all health care advocates working on palliative care issues.[22]

Finally, those prisoners experiencing *HIV dementia* find that the staff often view their behaviour through a correctional lens, rather than a health care lens. Therefore, PHAs who act aggressively because of dementia are frequently dealt with punitively, rather than attended to with an understanding of the nature of the disease. This is, of course, antithetical to the concept of palliative care.

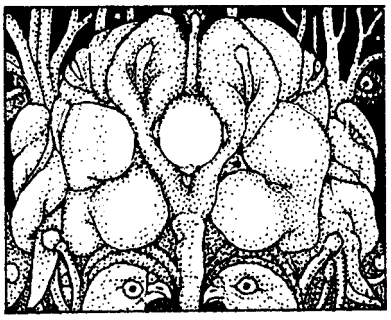
Prison palliative care policies and practices vary from jurisdiction to jurisdiction. While in a few systems, such as the Québec provincial system, PHAs are released from prison into a hospice when they experience a severe decline in health, this is unfortunately the exception. More often, prisoners are either transferred to an ill-equipped prison health unit, or left to deteriorate in whatever conditions obtain in the prison where they are serving their sentence. *Compassionate release* – while theoretically available – is rarely considered or granted in a way that would be judged "compassionate" by community standards

The reality remains that most Canadian prisons do not provide either palliative care or compassionate parole. For this reason, many PHAs in Canadian prisons see their health deteriorate, and too many die of HIV/AIDS related causes while inside.

No prisoner living with HIV/AIDS should be forced to die in jail. PASAN and other leading community-based organizations continue to advocate for compassionate release for all prisoners reaching the final stages of HIV disease.

[22] Ibid. This article is available at www.aidslaw.ca.

III. Conclusion



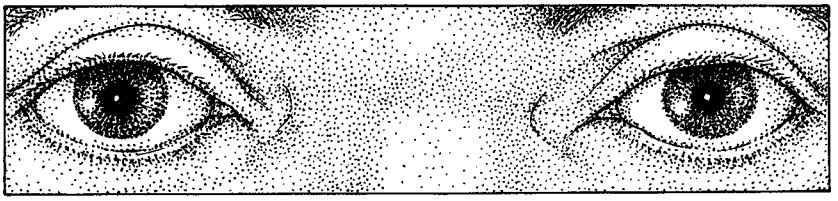
HIV/AIDS is an issue that challenges Canadian correctional services on many levels.

Corrections' own mandate to provide a standard of care comparable to that in the community should compel them to review and modify their standard practices. While some jurisdictions and some individual institutions have made important efforts in this regard, problems in accessing proper HIV prevention and treatment options remain the norm for prisoners living with HIV/AIDS across Canada.

Without outside scrutiny and advocacy, prisoners' rights to effective prevention measures and adequate care are routinely ignored. AIDS service organizations and other community-based groups can and must play a role in highlighting these problems, and in advocating for the implementation of effective and timely solutions.

HAVING REVIEWED the key issues confronting prisoners in accessing HIV/AIDS and Hepatitis C prevention, and HIV/AIDS treatment, care, and support, we will now look at concrete ways that community-based workers can intervene and make a difference.

"INSIDE" INFORMATION



My Experience Fighting the HIV Epidemic in Prison

by James Motherall, Advisor and Past Chair,
Stony Mountain Institution Peer Health Awareness Group,
Stony Mountain Institution, Winnipeg, Manitoba

I WAS ASKED to become part of the Stony Mountain Institution Peer Health Awareness Group in 1996.

The founding Chairman was being released, and he asked me if I would help support the remaining Executive. Until then, I had never thought much about illnesses like HIV/AIDS. I was like most people behind these walls. If it wasn't something that touched my immediate life, then it wasn't something I needed to be concerned about. However, the request to get involved was made by a friend, and so I agreed to attend the meetings.

As the weeks and months went by, I began to learn a lot more about HIV and the devastation it brings to the lives of those infected. I became more and more interested in doing something to help these men, and to advocate for changes that would help protect others from contracting this deadly disease. I began by asking questions. Reading and learning all I could. It was during this learning period that I discovered the roughest lesson of all – the prison system lacks the compassion, the will, and even the desire to deal with those suffering from HIV.

Within the prison, we have users who need their fix so badly that they are willing to share a syringe with someone who has HIV. The thought of contracting this horrible illness is less threatening to them than being without the high. HIV is spreading through the sharing of needles to the point where it is at epidemic proportions in the prisons. These numbers are only going to rise because the [anti-drugs] political agenda of [Federal] Corrections seems to takes priority over its mission statement, which speaks so boldly of trust, compassion, honesty, and working in the best interests of the prisoner.

Harm reduction is a key strategy in preventing the spread of HIV, yet Corrections will not entertain the idea of a needle exchange program. They argue that it condones the use of drugs. But those who are addicted will continue to use whether Corrections condones it or not, and those who do not use are unlikely to start simply because clean needles are available. The bottom line for Corrections is that if they sup-

port a needle exchange program, they will be admitting that drugs are finding their way into the prisons. With all of their efforts to crack down on drugs, failure is not what they want to admit to taxpayers and voters. The fact that HIV is spreading at an alarming rate, that human suffering is mounting, and that health care costs are going to rise dramatically does not seem to bother the politicians at all. Prisoners are dying because the government chooses to punish drug use rather than treat it.

Corrections is supposed to provide medical treatment to its charges, comparable to that given in the community. Methadone treatment programs are recognized and used in the community to treat addicts. The Federal Health Minister decided to introduce methadone for those who were on the program at the time of their arrest and conviction. A Phase 2 was promised, in which *all* addicts who met the criteria could participate in the Methadone program. We are still waiting for that promise to be fulfilled.

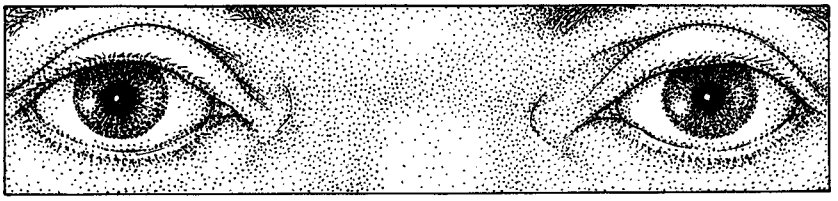
There are other treatment issues that must be fought as well. Those suffering with HIV are taken on temporary medical passes to clinics where they see a doctor. A treatment plan is worked out based on treatment given in the community. However, on several occasions, the institution doctor has overruled the outside doctor's order for certain medications. Actions like this confuse and frighten the prisoner being treated. He does not know who to have faith in.

As a member of the Executive of the Peer Health Awareness Group, I have the opportunity to work one-on-one with HIV positive prisoners. Sometimes they do not want to talk with someone who can give them information about their illness. They just want to talk. They are afraid and alone. They live in a system that is untrusting, uncaring, and prone to violence at the slightest provocation. There are still those who believe in the myths surrounding HIV/AIDS. In spite of our efforts to educate the population, I still find those who are afraid to sit beside someone with this disease. Some believe they should be put on a range of their own so they cannot mix with the population.

All these prisoners want is to be listened to and understood. They want to know that they matter and that someone will stand beside them. They do not feel sorry for themselves, and are often willing to share their stories so that others will not follow in their footsteps. They do not talk in terms of dying. They talk of going home to their loved ones. I have come to the belief that these men have a far greater courage than I do.

When Corrections speaks proudly of its Mission Statement, it should keep these men in mind because they could sure teach the politicians something about trust, compassion, honesty, and working in the best interests of others.

"INSIDE" INFORMATION



Safer Tattooing – A Prisoner's Guide[1]

by William Danks
Joyceville Penitentiary, Kingston, Ontario

TATTOOING IS AN ART FORM in which many guys and women in prison participate. If the work is done safely, by a skilled artist who values both their art and the health of their customers, tattooing is an activity that can give a lot of happiness and pride to the artist and customer alike.

However, *if proper precautions are not followed, tattooing can be high risk for the spread of diseases like Hepatitis B and C and HIV.*

People like to get tattoos in prison, and that's good because a lot of the best artists are in prison – artists that take pride in their work, and do mega-detail!

Here are some tips about choosing an artist.

When you're entering a prison, take your time before getting tattooed. Too many people want to *hurry, hurry, hurry.* Well, don't rush, because the people who do only end up looking for a good artist to cover up the *hurry, hurry* crap later on.

Take your time when looking for a tattoo, and in picking an artist to do it for you.

The artist should make sure that the art work the person wants is what they will get. If you're getting a tattoo, make sure you check out as much of the artist's work as possible to make sure he or she knows what they're doing.

If you can, try to see the artist in action first, and watch what he or she does. This can really help you make good decisions.

Anyone can follow a bunch of lines stencilled on someone's skin. The art comes from the shading. Every tattoo artist has a unique shade. Once you've been around a while and seen a lot of work, you should be able to tell who did it – and that's without a signature!

It's important to make sure that tattoos are done using safe tools.

In prison, it's very hard to be sure that the equipment (needles, shaft, ink) is clean. The only way to be sure that everything the artist is using is brand new is to have them make up the new needle in front of you. Therefore, *the artist you choose to do the work should be able to make up everything in front of you – the needle, shaft for the ink, and tip for the needle.* For this, the tattoo artist needs to be adept at making the equipment fast. If the artist can't make the

needle in front of you, tell him or her to drift.

A simple pen or lighter can be used for a tip and shaft. A pack of guitar strings can make endless needles for the price of a few dollars. An easy way to sharpen them is with a small piece of sandpaper stuck to your fan. Or you can sharpen them by hand, using slow pull-away and turn motions. The needle should be razor sharp. The shorter the point, the longer the needle will stay sharp.

The artist should also wear latex gloves.

If you have to boil your own equipment, do so for 15 minutes, with bleach if you have it. The best system I have found is to make everything brand new each time and boil it, and afterwards clean it with alcohol and let the person who got the work done keep the works. By making the customer responsible for their own personal works, they can get more work done later (if the piece isn't finished yet) and be positive that no one else has used the tools.

It's also important to make sure that the tattoo is done using safe inks.

You trust your life on the ink you use. Just because someone tells you the ink they're using is brand new doesn't mean anything, because you can't see the HIV or Hepatitis viruses. You can't tell by looking if the ink is clean or not.

Getting ink is a big problem within prison. In some institutions you can get access to good inks. In others, you have to make your own ink by burning paper and mixing it with water to make a thick paste. In this case, the artist should mix the ink in front of you, so you know it's disease free.

Also make sure that a new toothpaste cap is used (or styrofoam cup or whatever) and that it's cleaned with alcohol or bleach.

The standard practice for the serious tattoo artist is to obtain a sealed bottle of ink from somewhere (use your imagination!) and use that. Unfortunately, the Correctional Service of Canada banned ink from some federal institutions in their efforts to curb tattooing practices. This makes it hard to get, and creates a market for disease. In these institutions, ink that used to be only $5 a bottle is now $150. People pay a carton of cigarettes for a toothpaste cap full of ink. Because it's so expensive, this encourages people to save and reuse ink, rather than disposing of it.

Be very leery of buying into this underground ink trade. It's deadly and no one seems to care. Remember, it only takes one slip and you've got unwanted luggage for the rest of your life. *Reusing or sharing ink is very high risk for disease transmission (Hep and HIV)!*

Good technique also helps to make for safe work.

When using a home-made prison tattoo gun,[2] make sure that the area you're working on is flat and that you're holding the gun straight on. This will make the ink flow to the spot you're working on and stay there until you wipe it off. Never hold your gun on a tilt. This causes blotching and infection, and it doesn't do a lot of good for the tattoo either.

The tattooist should not break through all the layers of skin. If they do, it can result in infection and heavy scarring. There will always be a little scarring – remember, you're punching millions of holes to make a piece, but the ink will cover that. The heavy scarring I'm talking about – which seems to be abundant in prison – is the deep, rutted scarring. You can run your finger lightly over it and feel the indentations left from some butcher calling themselves a tattoo artist.

Finally, safe tattooing practice also involves safe disposal of the materials.

After you've finished a tattoo, you have medical waste. After the job is done, *everything* you used is waste and should be treated as such. The needle, tube or shaft that the needle goes in, the ink, the ink cap, the gloves, and the new towel that you had at the start which is now black, should be disposed of. *Don't ever re-use any of the stuff.* You can't take it to health care, so you have to throw it in the garbage.

When disposing of the needle (if the person's tattoo is complete and they don't need to keep the needle themselves for later work) make sure you cut the point off the needle and bend it up before you throw it or flush it. This will make sure the garbage man or whoever won't accidentally get stuck by it. This way you know for sure that you're not spreading any diseases. The gloves and rags should also be tossed or flushed and *never* reused.

[1] This article is also an illustrated information pamphlet produced by PASAN, and is available on request.

[2] While some prisoners do tattoos using only a single needle, more skilled and experienced prison tattoo artists build facsimiles of professional tattoo guns. Using motors taken from cassette recorders, the barrel of a pen, and other generally accessible items, these artists fabricate an electric tattoo gun that allows them to do quicker and more detailed artwork.

SECTION B

Program Planning

CHAPTER FOUR

Getting Started

YOU'VE BRIEFED YOURSELF on the basics of the Canadian prison system, and on HIV/AIDS issues in prisons. You have prepared yourself for the complexities and potential rewards of the relationships between "pros" and "cons". Now you want to get going on providing HIV/AIDS education and support programs to prisoners. But one big question remains before you.

How do I get into prisons to see the prisoners?

It seems a simple enough question. You'd think there would be an easy answer. However, as with all aspects of prison work, there are as many different answers as there are different institutions. In fact, the lack of a straightforward answer to this most basic question is perhaps the biggest obstacle for HIV/AIDS workers starting to do prison work. Hopefully this chapter will help change that.

This chapter will explain the mechanics of how to get into your local institution, so you can gain access to prisoners and start your programs. It will review initial things for you to consider when looking to establish a prison program. It will identify obstacles that may hinder your progress, and suggest options to surmount them. It will also address common concerns about security clearance, client confidentiality, and interacting with guards and with prisoners.

This chapter can be used interactively with the chapters that follow in this section. Details on developing HIV prevention education programs are covered in Chapter Five. Details on providing support services and advocacy for imprisoned HIV positive clients are covered in Chapter Six. While Chapters Five and Six deal in programming specifics, this chapter deals in preliminaries, and is applicable to both.

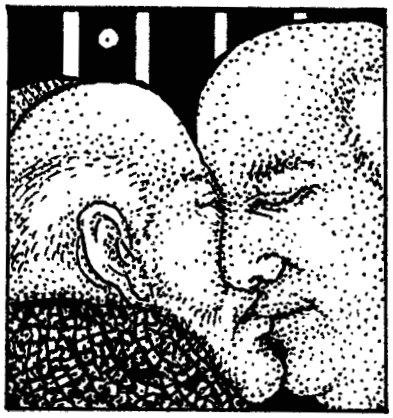
CHAPTER FOUR

Getting Started

As a community-based health professional, getting inside a prison to see prisoners should be a relatively straightforward process. However, *getting inside* the prison is only one component of getting started in prison programming, as you will see from this chapter.

Getting started in prison programming involves making initial contacts with the prison, and with its prisoners. It involves making initial assessments about what's available and what's not, in order to establish your best available options for programs and services. It involves developing your program proposal and/or decisions about individual counselling services. Finally, it involves making initial preparations such as ensuring that your agency is accessible by telephone, applying for your security clearance, and participating in an institutional orientation or volunteer training session.

So, let's get started.



I. Making Initial Contacts

Making Contact with the Prison

Contacting the institution itself is your very first step in all cases.

Contacting the institution itself is your very first step.

In most prisons, whether provincial or federal, there is a staff person responsible for assisting community volunteers to access the institution. The titles of these positions vary, but they are commonly referred to as the "volunteer coordinator", or the "social development" or "social programs" department. The Native Liaison Officer can also be very helpful for Aboriginal workers and organizations. If you are unsure, just phone the main switchboard at the institution and ask with whom you should speak about becoming a volunteer. [1] If you already have contact with the prison health unit, the nurses will also be able to refer you to the appropriate person.

Once you have identified the proper person to ask, just give them a call.

Introduce yourself and your agency, and explain what you'd like to do at the prison. Perhaps you're interested in visiting one client on a single occasion. Perhaps you want to arrange regular access to clients at that institution, or start an ongoing program or support group. In each case, there is a standard process at most institutions, and your request will not be unusual. Don't be shy.

You may be invited to meet with the prison staff to introduce yourself and your agency. In fact, you may want to suggest such a meeting yourself as the most efficient way of both providing and receiving information.

The institution may ask you to draft a written proposal describing the services that you wish to provide at the prison. If you hope to initiate some kind of ongoing program that will require space allocation on a regular basis, and security clearances for several staff/volunteers, it is probable that the institution will require this. (For more on developing a program/service proposal, see *Making Your Program Proposal*, below.)

If you only wish to receive individual clearance allowing you to have *professional visits* [2] with your clients, it is less likely that the institution will require a written proposal. (For more on providing counselling through the visiting process, see *Making Decisions about Individual Counselling Services and Client Visits*, below.)

In either case, however, the institution will subject you to a security check, and may also insist that you participate in their volunteer orientation pro-

[1] As an employee or representative of your organization – perhaps with many years of experience in HIV/AIDS or other community health work – you probably consider yourself a "professional". However, in some provinces, the prison considers you a "volunteer". This is because you are not an employee of correctional services. As far as your relationship with the institution is concerned, you will forever be referred to as a "volunteer". This can be confusing terminology at first, especially if part of your paid profession is to provide services to prisoners.

[2] "Professional visits" are the only instance when you as a "volunteer" of the institution will have the term "professional" applied to you.

gram before they clear you for entry and give you your security ID. (For more on these procedures, see *Making Initial Preparations: Applying for Security Clearance*, and *Participating in Institutional Orientation or Volunteer Training*, below.)

Making Contact with the Prisoners

It may be that an individual prisoner or prisoners have already contacted you requesting help, and this is why you have decided to undertake prison work. However, it is also possible that you or your agency have initiated this work for your own reasons, and have not yet made direct contact with any prisoners at the institution/s.

If you have not yet made contact with prisoners, initiating this contact is your next step.

As when working in any community context, it is much preferable to work *with* prisoners in a spirit of cooperation than to impose programs and services on them without any consultation. By consulting with the prisoner population at the institution, you will be able to undertake a needs assessment, and thus to develop or adapt your programs so that they are responsive to the prisoners' identified needs.

As when working in any community context, it is much preferable to work *with* prisoners in a spirit of cooperation than to impose programs and services on them without any consultation.

Generally speaking, contacting prisoners in your institution/s for these purposes is usually best accomplished by establishing relationships with their formal organizations and/or official representatives, where possible. This is a demonstration of your respect for the prisoners' own autonomy and established structures. You will find that these prisoner groups are your best allies within the institution. They often have the ability to assist you in organizing programs and workshops, and in helping to promote the credibility of your agency amongst the prisoner population.

How you go about making contact with prisoners, and what you can expect from such contact, partially depends on the type of institution involved.

Federal Prisoners

Federal prisons house people serving long sentences, and the federal population is therefore more stable and structured overall.

As discussed in Chapter Two, organized prisoner-run groups – such as Inmate Committees, Lifers' Groups, Native Brotherhoods and Sisterhoods, and Peer Health Groups – exist in most federal prisons and usually command the respect of both the prisoner population and the administration.

These groups are the best place to start if your agency is hoping to set up an HIV/AIDS program.

When you first contact the prison, also ask about what prisoner groups are established in the institution. Write a letter to the Chairperson of the group/s, introduce your agency and its services, and ask about setting up a meeting with the group/s to discuss possible programs. Meeting the elected prisoner representatives face-to-face is also crucial, both for properly assessing the needs of a given institution, and in building trust and credibility for yourself and your agency among the prisoner population.

Provincial Prisoners

Provincial correctional centres house people serving short sentences (less than two years), so their population is much more transient than in the federal system. The bulk of prisoners in the provincial system are serving sentences of only a few months.

Many provincial institutions have organized prisoner groups modeled on those in the federal system, but their membership is necessarily temporary and constantly changing. This transience makes both prisoner organizing and your own outreach a bit more difficult – simply because it's more difficult to establish ongoing relationships with individual prisoners. The opportunity to link with prisoner organizations is therefore more limited in provincial institutions, so you may need to seek alternate routes.

Even if the institution lacks prisoner-run groups, it will most likely have other social programs, possibly established by or in cooperation with outside groups. If so, you may be able to arrange to consult with prisoners through an outside agency during their established program. (See *Making Initial Assessments: Familiarize Yourself With Other Available Programs*, and *Making Your Program Proposal: "Piggy-backing" on Existing Programs*, below.)

As above, first establish whether any prisoner-run groups operate in the institution, and then contact them in writing. If not, arrange to consult with prisoners through another agency operating in the institution.

Remand Prisoners

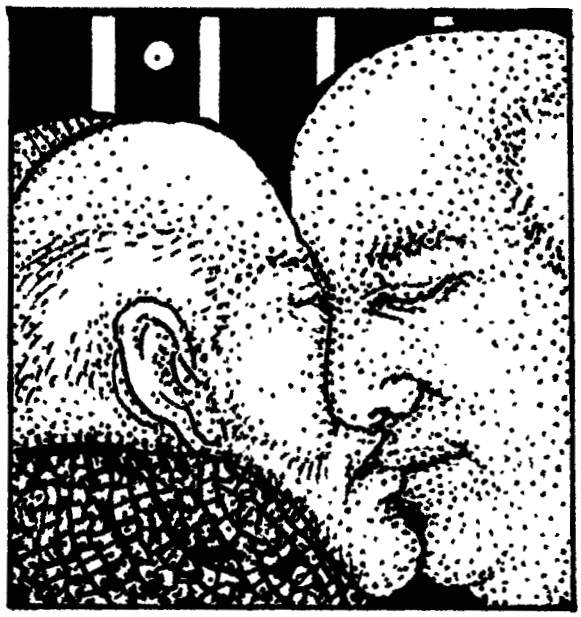
The populations of detention/remand centres and local jails can be the most transient of all. These institutions are where people go when first arrested, and they therefore serve as the "intake points" for the entire correctional system. People can be there for a couple of days, or a number of years, depending upon their individual situations.

In addition, because detention/remand centres house people charged with any manner of offense (from traffic violations to murder), they are usually run in the manner of maximum security institutions. This means that the prisoners are usually locked on their ranges for most of the day. Any movement that does occur within the institution is generally escorted by a guard. This substantially limits prisoners' opportunities to associate – both of their own accord, and in a more formal program setting.

The highly transient nature of the population in detention/remand centres and their limited opportunities to associate mean that prisoner-run groups such as those in the federal system are usually non-existent. Access to outside programs can also often be limited in such institutions.

For these reasons, your only option for meeting with groups of prisoners may be by partnering, or "piggy-backing", on an existing program. (See *Making Initial Assessments: Familiarize Yourself With Other Available Programs*, and *Making Your Program Proposal: "Piggy-backing" on Existing Programs*, below.)

HAVING MADE your initial contacts in the institution, the next step is to make the initial assessments that will inform your most basic program decisions.



TIP:

Despite the obstacles involved, the constant exchange between the detention/remand centre and the street means that these institutions offer an important opportunity to reach otherwise inaccessible street involved and drug using populations.

While jail is obviously not the ideal place to make such contact, it can provide a forum for raising the profile and accessibility of your agency and its services among these populations. Demonstrating a willingness to continue services for people even after they have been arrested will also help to increase the credibility of – and trust level with – your agency among such populations.

II. Making Initial Assessments

In order to make your decisions about program and service provision – and therefore to make your proposal to the institution, if required – you must first identify what's available and what's needed at the institution in question.

In order to make these assessments, you will need to familiarize yourself with institutional structures, policies, and procedures. You will need to familiarize yourself with existing programs. An environmental scan of this type will complement any needs assessment you may conduct with prisoners.

Below are four steps to help you make your initial assessments. More specific questions and considerations are detailed in Chapter Five, *HIV Prevention Education and Outreach*, and Chapter Six, *Client Support*.

1. Identify the Institutional Structure

As mentioned above, you must first determine the type of institution you are approaching. Is it a federal penitentiary, a provincial prison, or a detention/remand centre/local jail? The *Resources* section of this manual provides a province-by-province listing of all institutions, which will help you with this most basic question.

Determine the security level of the prison, as this will affect prisoners' freedom of movement and association within the institution, and consequently affect your program format. *Note that detention/remand centres are always run as maximum security institutions.*

Determine whether the institution is a "work institution" (where prisoners are expected to work during the day). If the answer is yes, this means that most prisoners will be unavailable to attend any outside programs during the day. Therefore, an evening program will enable more people to participate.

A quick call to the prison switchboard or the health care unit will provide all this information.

2. Identify Relevant Institutional Policies and Practices

What are the policies and practices in your region regarding HIV/AIDS prevention and treatment? Are condoms and bleach available? Does the prison provide methadone? Does the health unit utilize the expertise of an outside physician in caring for HIV positive prisoners?

As discussed above (and further below), you will also need to know how you obtain security clearance, and what the process is for visiting prisoners.

All of these questions are crucial to determining need in the institution.

A telephone call or meeting with the head nurse will often provide the easiest answers to these questions.

3. Familiarize Yourself with Other Available Programs

As discussed in Chapter Two, social, educational, and community-based programs of one sort or another are conducted in every prison and jail in Canada. These can include life-skills classes, *John Howard Society* or *Elizabeth Fry Society* support groups,[3] Aboriginal cultural and support groups, other cultural and/or religious support groups, *Narcotics Anonymous/Alcoholics Anonymous*, etc. Women's prisons also commonly host programs from sexual health organizations and rape crisis centres.

Find out what programs are already available in your target institution/s by contacting the institution's volunteer or social program coordinator.

You don't want to duplicate efforts. Instead, investigate opportunities to establish cooperation with these groups, or to "piggy-back" HIV/AIDS education onto one of their pre-existing programs (see *Making Your Program Proposal*, below).

It's preferable to provide a smaller number of services that are dependable than to promise a vast array of services that are inconsistent.

4. Consult With Prisoners

Making contacts with prisoners themselves is the most crucial element of the assessment process. Utilize whatever options you have to consult with prisoners, whether individually or in groups (see *Making Contact With Prisoners*, above). What is their perception of HIV and Hepatitis C in the institution? Is there a lot of injection drug use? If condoms and bleach are provided by the institution, are they actually accessible? What kinds of health information would be of most interest to people there? When and where would be the best place to hold programs? How do people feel

[3] The *John Howard Society* provides support services to male prisoners and ex-prisoners across Canada. The *Elizabeth Fry Society* provides similar services for women prisoners and ex-prisoners.

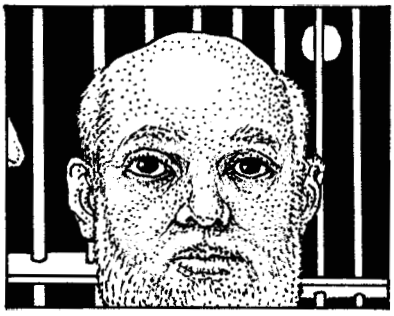
about the quality of service from the health unit? Which staff in the institution do the prisoners think are supportive of them, and therefore useful for you to contact?

HAVING MADE your initial assessments, you are now ready to make decisions about program and service delivery, and to make the necessary preliminary arrangements.

There are several important points to consider when deciding how your agency can best meet the needs of prisoners in your community, given the resources realistically available to your organization. These are discussed below.

Remember that it's preferable to provide a smaller number of services that are dependable than to promise a vast array of services that are inconsistent.

III. Making Your Program Proposal



If you intend to conduct any kind of program at your local prison – whether outreach, prevention education, or support for PHAs – there are two primary options available to you: initiating your own "solo program" or "piggy-backing" onto an existing program.

Initiating Your Own "Solo" Program

Initiating your own program means that you and your agency make a commitment to the prisoners and the institution to run a regularly scheduled program on a continuing basis, usually once a week or once a month.

This is no small commitment, and should not be undertaken without first ensuring that both you and your agency can dedicate the resources necessary to sustain such a program.

In order to arrange a regular program of your own, you will need to sit down with the institution and negotiate. The institution may not see an HIV/AIDS program as necessary, in which case you will have to advocate for it by educating them on the validity of your program.

Initiating your own "solo" program should not be undertaken without first ensuring that both you and your agency can dedicate the resources necessary to sustain such a program.

The prison will also have to consider whether they have space available for you to use on a regular basis. Depending on the institution, this can be a tall order. Many prisons – particularly detention or remand centres – have few rooms available for conducting programs, and a huge demand for their use. Educational programs, spiritual or religious groups, and cultural programs all vie for this limited space, as do the Parole Board, Legal Aid, and various other administrative bodies.

Given the stiff competition for space, the institution will likely want to see some kind of written proposal before allocating you valuable program space.

Take this application process seriously. Your proposal need not be long, but it should clearly outline your goals and objectives, the mandate of your agency, and the involvement of other community partners (if any) in your program. If you conduct programs in any other institutions, make sure to point this out. If you can solicit support from the prison's health unit, and have them lobby internally on behalf of your program, this can give your application a boost.

If your proposal is approved, your program will be assigned a regular time and space within the institution.

On the positive side, when running your very own program you have control of its content.[4] If you are in the institution on a regular basis, this will also raise your profile among both prisoners and staff, helping to build support for your agency's work. If you are a dependable presence in the institution, this further increases your accessibility for your HIV positive clients.

The downside is that conducting a regular program requires a significant commitment of resources. You are expected to be in the prison every week, or every month. For AIDS workers who are already overstretched, this can present real problems. Between travel time, routine institutional delays, and running the program, a ninety minute workshop can easily mean that you're out of the office most or all of the day. Having a regular program to maintain also demands that you spend time and creative energy developing new and interesting things to do on each visit. Simply repeating the same old agenda over and over again will soon grow tired, and negatively affect your attendance.

TIP:

When "piggy-backing", be aware of potential philosophical conflicts with your host group before they arise, specifically regarding harm reduction, drug use, and anti-homophobia education.

Another trade-off is that being a regular presence in the institution also means that your face and name will become familiar to staff and to other prisoners, and this may ultimately decrease confidentiality for your imprisoned clients.

If you do decide to "go solo", you need to remember that having a regular program will expand your agency's profile. This means there will also be an expansion in the number of imprisoned PHAs calling your agency for services. Your organization as a whole needs to be prepared to meet that increased demand, and particularly to meet the special requirements of an increased demand from *prisoners*. Your agency may need to undertake a process of specific education and training, to provide staff with the necessary skills and sensitivities to work with incarcerated populations.

If you fail to adequately consider and prepare, you will be setting up the imprisoned PHAs for disappointment and frustration. This can only undermine your work.

"Piggy-Backing" on Existing Programs

If your organization decides that it can't commit to a regular program, or if the prison has no available space for new programs, the best option is to "piggy-back" onto pre-existing programs. This means that you act as a guest speaker in an established program with a pre-existing audience.

You can usually obtain a list of volunteer programs from the institution, as well as the contact names for the individuals who coordinate these groups.

[4] Obviously, this control remains within the parameters agreed with the institution. Some institutions may want to prescreen your written materials, while others will not. Some will allow you to bring in condoms and syringes for demonstration purposes, while others will not.

After you assess which group or groups would provide the most appropriate context for a discussion of HIV/AIDS, give them a call. Most volunteer-run programs welcome the opportunity to bring in guest speakers, to provide something fresh for their audience, and to offset the work of maintaining a regular program.

Although probably not required, preparing a simple proposal ahead of time – along the same lines as any written proposal to the institution – will help focus your discussions on something concrete.

"Piggy-backing" gives you the opportunity to reach a diversity of audiences.

The positive aspects of the "piggy-back" approach are numerous. First, it enables your agency to reach prisoners with minimal work and resource commitment. It eliminates your need to negotiate time and room availability with the institution, or to advertise your program to get people to attend. Although you will still need security clearance, after that all you have to do is show up and talk for a couple of hours.

This arrangement enables you to come into the prison only as often as your work schedule or agency resources permit. Once a year, three times a year, six times a year – the option is yours so long as you can find appropriate programs to host you, and get their agreement.

"Piggy-backing" also gives you the opportunity to reach a diversity of audiences. Aboriginal community programs, Black/African community programs, *John Howard/Elizabeth Fry* programs, *Narcotics Anonymous* programs – all of these will attract very different participants, which can enable you to get HIV/AIDS information to a wider spectrum of the diverse prisoner population.

The primary downside to this approach is that you have less control over the content and agenda of the program. This can be most problematic when discussing homosexuality and drug use. If you're not careful, you can inadvertently find yourself in a program where the facilitator/s have approaches and beliefs that drastically conflict with your agency's principles.

Homophobia (particularly in some religious-based programs) and "abstinence" philosophies (particularly in *Narcotics Anonymous* and *Alcoholics Anonymous* groups) can make it very difficult to give out harm reduction information, or pro-sex/anti-homophobic safer sex messages, without the other volunteer/s who run the program contradicting you. This not only creates tense situations, it also undermines your effectiveness. To minimize the risks of walking into such a situation without preparation, do your homework on the groups and individuals with whom you are partnering.

For more information about developing the format, content, and structure of your programs see Chapter Five.

TIP:

Whether you run your own program, or "piggy-back" on someone else's: fulfill your commitments. If you say you're going to come on a certain date, make sure you are there. Otherwise, you risk burning your bridges with important community partners, the institution, and the prisoners themselves.

IV. Making Decisions About Individual Counselling Services and Client Visits

Perhaps you intend only to provide one-on-one counselling services by request, through face-to-face meetings, and by telephone. Or perhaps you hope to provide these counselling services in addition to an educational program. In either case, you will need to determine the most appropriate institutional visiting policy to facilitate this.

The type of visit you select will determine the security clearance requirements, how much privacy you will have with your client, and how much built-in confidentiality your visit will have.

In most instances, you will have two options for meeting your clients individually: the *"professional visit"* or the *"family visit"*.

The Professional Visit

The professional visit is a face-to-face meeting that happens in a private room inside the prison. Lawyers, clergy, counsellors, and various other categories of non-correctional workers can apply to access professional visits to meet with and provide services to individual clients.

The institution will demand security clearance from anyone wishing to avail of a professional visit, and may ask that an appointment be made ahead of time to reserve a meeting room.

The advantage of a professional visit is that it affords a greater level of personal contact and privacy. The main drawback to this type of visit is that it risks inadvertent disclosure of your client's HIV status, as you will be cleared for the professional visit based upon your employment as an "AIDS worker". (See *Common Concerns for Workers New to Prison Environments: Confidentiality Risks*, below.)

The Family Visit

The family visit is the standard visiting procedure utilized by the family and friends of prisoners. Family visits are usually held during set hours every day, and on weekends.

In some provincial institutions and detention/remand centres, you may be able to use this process to visit prisoners without first obtaining security clearance.

At these institutions, you simply show up at the prison during the normal "visiting hours" and ask to visit the individual. You will need to show ID, but you will not need to do any formal security check or prove any agency affiliation. Just tell the guard that you are a friend of the person you want to visit.

The advantage to this type of family visit is that it allows you to meet your client in a more discreet fashion than a professional visit. You can see the person without being identified as an "AIDS worker", thus better protecting client confidentiality.

The type of visit you select will determine the security clearance requirements, how much privacy you will have with your client, and how much built-in confidentiality your visit will have.

However, there are also drawbacks. These visits usually happen through glass (with you on one side, the prisoner on the other), and you and the client will have to talk to each other using telephone handsets that are monitored. You will also be in a huge visiting room, often with dozens of other prisoners and visitors. This can make private conversations next to impossible. Still, if a prisoner wants to reduce the risk of disclosure of their HIV status, family visits can provide a useful option.

While there are processes for family visits in every institution, it is not always the case that they can happen without prior security clearance. In Québec provincial prisons, for example, the prisoner must put in a written request for all visitors, and the prison does an ID check before clearing the visitor.

In federal prisons, *all* visitors must be security screened.

To check which type of family visiting option is available to you and your clients, call your local institution and inquire about their procedure for visiting a friend in custody.

For more information on other considerations involved in providing individual client support and advocacy, see Chapter Six.

HAVING MADE your preliminary decisions about programs and services, and having also made preliminary arrangements with the institution and/or your community partners, you are now ready to make the other initial preparations demanded by the prison context.

V. Making Initial Preparations

You have made your initial contacts with the prison and possibly with prisoner representatives. You have completed your initial environmental scan and needs assessment, and have identified your most promising program options within the given institutional parametres. You have made the preliminary inquiries about visiting options. You have successfully made your program proposal to the institution and/or your community partners, and have received their approval in principle.

There are now a few final preparations to make before you embark on your prison program.

You must arrange for your agency to accept collect calls from prisoners. You must apply for your security clearance, and you must participate in any mandatory institutional orientation or volunteer training sessions.

1. Arrange for Your Agency to Accept Collect Calls from Prisoners

Ensuring that your agency can and will accept *all* collect calls is a crucial first step in making your services accessible to people in prison.

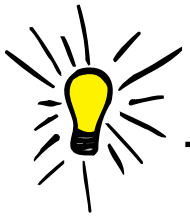
This may seem like an unusual first step. However, people in prison can *only* make collect calls.

This means that in order to talk to prisoners living with HIV/AIDS, *your agency must accept collect calls. If your agency does not accept collect calls, imprisoned PHAs cannot access your services.*

Collect calls will be an added expense for your phone budget, so you should have this discussion internally before you begin thinking about prison program development.[5]

You should also be aware that people incarcerated in *federal* prisons can only make collect calls to *pre-screened phone numbers* approved by institutional security.

This screening process can create two major barriers for federal prisoners wishing to access HIV/AIDS services. Firstly, the need for confidentiality can inhibit these prisoners from calling, as they would need to submit your agency's phone number to security before it will be included on their calling list. Secondly, it can often take as long as two weeks for the institution



TIP:

Most prisons do not allow prisoners to access toll-free phone numbers. Check the situation at your local institution.

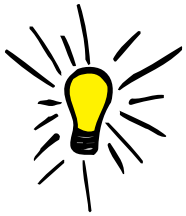
[5] See *Providing Support Through Communication: Thinking Ahead about Telephone Policies and Boundaries*, in Chapter Six.

to clear a new phone number, and this delay creates a barrier to crisis counselling (for instance, after receiving an HIV positive test result).

For these reasons, if your agency wants to provide services to federal prisoners, your organization should also apply to the institution to have your phone number placed on the prison's general access phone list. This is a list of phone numbers that are pre-approved by the prison, and accessible to all prisoners without prior authorization. Anyone can call these numbers at any time. Having your agency included on this list eliminates delays for prisoners wishing to call you, and eliminates the need for them to disclose to staff that they are in interested in calling an HIV/AIDS organization. Speak with one of the institution's social programs officers to assist you in this application.

If your agency accepts collect calls, and/or is on the general access list for your local federal institution, make sure to advertise this fact in your outreach materials, pamphlets, and newsletters.

For more details on the crucial role of the telephone in prison service provision, see *Providing Support Through Communication: The Telephone – An Imperfect Lifeline*, in Chapter Six.



TIP:

If your agency has an electronic voice mail system which answers incoming calls, rather than a live receptionist, prisoners will not be able to get through unless the voice mail message states at the beginning of the message that you accept collect calls. For example, "Hello. You have reached the office of PASAN. Yes operator, we accept all collect calls."

Make sure that you also mention this to your clients and in your outreach materials, as prisoners will have to go through a "live" operator rather than the standard computerized one if they want to access your voicemail system.

2. Apply for Security Clearance

One process that *will* be consistent for all institutions is that you will have to submit to a security check if you want to run a prison program, or make professional visits to imprisoned clients.[6]

Applying for security clearance is a simple process that involves completing and signing a one-page form that authorizes the institution to conduct a criminal records check.

Assuming your security clearance is granted, you should be authorized to come and go from the institution at your leisure during established visiting hours. However, each institution will have different processes you will need to understand and follow. Some institutions require that you call ahead and make arrangements to visit. Others may issue you with your own ID card, which will allow you to show up and enter the institution during designated times in the morning, afternoon, and/or evening.

If you have several federal penitentiaries in your area, you may be eligible to apply for *regional clearance*. You make this application by contacting the appropriate CSC Regional Headquarters.[7] If granted, regional clearance will provide you with a CSC ID allowing you access into all the federal prisons in your province.

[6] This security check is usually referred to as a "CPIC".

[7] See *Contact Information* in the *Resources* section.

TIP:

It only takes a couple of days to process a security clearance. If you haven't heard back from the institution in a week, call them to follow up. Make sure they haven't forgotten you.

If you have been in any kind of recent conflict with the law (arrest, conviction, probation, etc.), this will show up on the security check and may result in your being refused access to the prison. Even an ancient conviction on some types of charges (drug charges in particular) may be red-flagged and present problems. For more on this see *Common Concerns of Workers New to Prison Environments: Refusal of Security Clearance,* below.

3. Participate in Institutional Orientation or Volunteer Training

Some institutions will require you to attend an orientation or volunteer training session before they will approve you for professional visits or to run programs.

Many such workshops provided by institutions are useful in helping familiarize you with the prison's policies and practices.

Some institutions, however, run sessions that are full of "scare stories" – seemingly intended to frighten you out of volunteering with prisoners, rather than prepare you for work in the correctional environment. If you are unlucky enough to run into one of the latter, just recognize it for what it is.

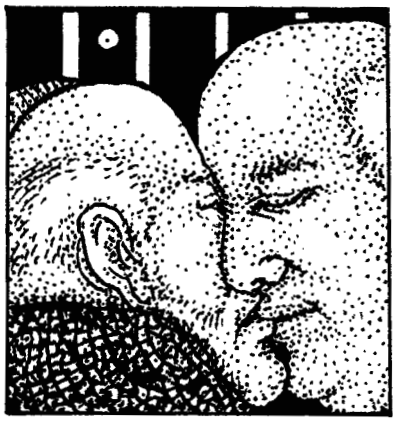
In either case, consider the volunteer orientation an opportunity to begin an environmental scan of the institution. The tone of the volunteer training may be a good indication of the institution's "friendliness" to community programs generally. The tone of the volunteer trainer/s may help you identify individual staff members you want to work with, or avoid.

TIP:

If you are walking past peoples' individual cells, do not look into a cell unless invited to do so by a prisoner. This shows respect for the prisoners' privacy and dignity.

At many facilities, part of the normal orientation process for new volunteers is an institutional tour. A staff member will be assigned to take individuals or small groups on a walk around the prison. While this is a useful process to help acquaint you with the institutional geography, it can also be an uncomfortable experience because a significant part of most tours consists of walking around observing people locked away in their cells. Be prepared.

VI. Common Concerns of Workers New to Prison Environments



Refusal of Security Clearance

If your security clearance is turned down, don't panic. There are always options available to appeal such decisions.

First, make sure to speak with the security staff responsible for processing the clearance and request the reasons for the negative decision. If possible, try to get these reasons in writing. You should offer to meet personally with prison staff for an interview, to address any concerns they might have.

You should also encourage your supervisor, executive director, or a Board member to intervene with the institution on your behalf, to promote the importance of your program, and to highlight the history and reputation of your agency in the community.

Personal letters of reference are also very useful, particularly if they come from correctional, law enforcement, or legal professionals, or any other professionals you have worked with who can vouch for your reliability and conduct (i.e. doctors, teachers, other community health workers, etc.).

If the refusal instead concerns a volunteer with your agency, also consider framing your appeal arguments based on how that person will be utilized in your programs. Will the volunteer be working alone in the institution, or will s/he always be in the presence and under the supervision of one of your agency's staff? If the volunteer will always be under your supervision, you should try to negotiate some compromise with the prison on this basis.

You will probably find that the most difficult appeal of a refusal to issue security clearance will be your first one.

Most prisons are reluctant to be the first to OK a "questionable" application. However, if you do succeed in appealing the negative decision at that first institution, you can use this as a basis for applying to other institutions. Most likely the criminal records check will again cause problems, but if you can demonstrate that you have been conducting programs in another prison without incident, you will find it a much easier process to appeal the second time around. Ask the staff person with whom you negotiated your first clearance to act as a reference for you at the next institution.

On the other hand, if your appeal is turned down at one institution, do not let that deter you from applying for clearance at another. You will find that every institution has different expectations for community volunteers. Some institutions are very supportive of community-based programs, and will do everything possible to assist you. Some institutions are very strict, and are generally uncooperative with all community-based groups. You may find that you were just unlucky in applying to a very strict institution on your first try. You may also find that the level of cooperation or strictness has nothing to do with the institution's security level, and that the lower security institutions are often the most difficult ones to access.

Bring a valid photo ID with you. If you do not produce ID you will not be allowed inside.

At the end of the day, the reality is that every institution has complete and total control over who they allow inside. Therefore, despite your best efforts, there is always the chance that once your security clearance is refused, you simply will not be allowed in.

If this happens, make sure to ask for the specific reasons why the application and/or appeal was refused (preferably in writing), and to find out what the institution would require in order to reconsider the application in future. Often you will find that the institution requires that the applicant be free of any criminal charges, convictions, or parole/probation for a set period of time (i.e., two years). Make sure to clarify this with the institution, and to discuss the possibility of resubmitting the application once their requirements have been met.

Refusal of Entry at the Gate

When you are new to the prison environment, the prospect of going through security at the front gate may make you nervous.

The guards at the front gate have broad discretionary powers to permit or restrict access of visitors into the institution. It is the experience of many community workers that this discretionary power is sometimes abused, denying access to legitimate programs and volunteers. Despite this fact, there are a number of things you can do yourself to minimize the grounds on which you can be refused entry.

When you first arrive at the prison you will be greeted by a guard at the front security desk. You will have to show identification at this time. *Bring a valid photo ID with you*. If you do not produce ID you will not be allowed inside.

If entering a federal prison, you will also have your possessions *"ion-scanned"* at the same time your ID is checked.

The ion-scanner is a machine that detects minute, residual traces of drugs on your hands, clothes, etc. Usually, a guard will rub a small piece of cloth on your ID, your coat, etc. and then place in the scanner to analyze it. The ion scanner provides three possible results: 1) *negative* – meaning you're clean, 2) *positive below the threshold* – meaning the scanner has detected drug residue, but not in great enough concentration to keep you out, and 3) *positive above the threshold* – meaning the test has detected residue in sufficient concentration to deny you access to the prison.

If your scan is clean, you will be allowed inside. However, if you test positive above the threshold you will be denied access to the institution for at least twenty-four hours. A series of such positive results may result in your being suspended from visiting the prison.

Be aware that the ion scan can create problems for workers entering the institution, *even if the workers themselves are not drug users.*

The ion-scanner does not tell whether a person actually has illegal drugs in their possession. Rather, it tells whether a person has touched drugs, or touched something that has come into contact with drugs, or touched someone else who has come into contact with drugs. This can present potential problems for front-line workers, especially those who work in drop-in environments, needle exchanges, or agencies whose clients are drug users or street-involved people.

Drug users obviously come into contact with drugs, and will therefore have residual (or greater) traces of drugs on their hands and clothes. These traces can be transferred to your work environment – doorknobs, telephones – and then onto you, or transferred more directly by shaking hands. Many community agencies fear that such client contact may result in their workers testing positive on the ion-scanner. Be aware of this possibility.

Once you've passed front security, you may be subjected to a physical search, either by a metal detector or a "pat-down". Prisons also have the right to strip-search people, although this is uncommon for professional visitors. If you are bringing in a box of written materials or pamphlets, this may also be searched.

While you will obviously not be permitted to bring contraband items into the institution (drugs, weapons, etc.), the physical search is highly unlikely to result in your being barred from the prison. If you are concerned about what types of items constitute contraband, contact the institution for a list.

TIP:

You will be asked to lock up your wallet, jacket, and other valuables in lockers that are provided at the institution's front entrance. Sometimes you need a quarter to use a locker, so be sure to bring one.

For this reason, it's better to travel light when going to the institution. Depending on the institution or the staff on duty that day, you may or may not be allowed to bring in a briefcase or carry-bag. Therefore, invest in a clipboard or portfolio in which you can carry a pad of paper and a pen, pamphlets, and business cards.

Confidentiality Risks

As discussed in Chapter Three, confidentiality is a primary concern for prisoners living with HIV/AIDS. Therefore, part of your job will be to monitor staff practice to ensure that professionally accepted standards for preserving confidentiality are met.[8] This is an obvious and familiar area of concern for all AIDS workers.

When working in prisons, however, community-based AIDS workers can also unwittingly compromise client confidentiality as a result of inattention to the specific features of the prison context. Therefore, it is equally your job to reduce confidentiality risks in your own work.

If you become generally recognized as the AIDS worker in the prison, others may assume that any prisoner you meet with is HIV positive.

Always remember that the prison is a closed environment, and has a staff culture of surveillance. Prison staff are necessarily curious about any new face they see walking around the prison. The prisoners are often equally interested in knowing the new volunteers. This creates situations where it can become difficult to protect the confidential nature of your involvement in the prison. Be aware that if you become generally recognized as the AIDS worker in the prison, others may assume that any prisoner you meet with is HIV positive.

Keeping these confidentiality risks in mind, it can be useful to prepare deflecting answers ahead of time to handle questions about your profession and your organization from individuals not involved in your program.

If a guard asks you what you are doing in the prison, tell them only that you are "a counselor". That is usually enough to satisfy their curiosity.

If your agency uses an acronym, it is always best to use the acronym rather than the agency's full name to identify your professional affiliation. If security staff press you about what the acronym stands for, you have the opportunity to provide a definition that eliminates "AIDS" or "HIV" from the title. For example, the "AC" (for AIDS Committee) that appears in the names of so many AIDS service organizations in Canada can easily be modified to "Addictions Counselling", or some other title which fits the acronym. Another good "cover-story" is to tell the inquisitive guard that you are there to do a housing application. This will also usually satisfy their curiousity.

Depending on the situation, (and if there is an immediate risk of disclosing a client's status) you may also want to use these strategies if questioned by prisoners about your affiliation.

[8] It is fair to expect the standards of confidentiality for prison staff to at least equal those of your own agency.

Further strategies to tackle confidentiality risks are discussed in *Getting Access to Prisoners: Outreach and Program Format Options*, and *Basic Advice on Running Your Prison Program: Provide "Cover" When You Advertise Your Program* in Chapter Five, and *Providing Support Through Communication: The Telephone – An Imperfect Lifeline*, *Face-to-Face Visits*, *Forming PHA Support Groups*, and *Creating an Advocacy Strategy* in Chapter Six.

Interacting With Prison Staff

When working in prisons, you necessarily interact with prison staff. These interactions can be positive, negative, or neutral in their tone. Often on a single visit you will encounter all three of these responses – and maybe more – from various staff as you move about the institution.

The basic guideline for all interactions with staff is to be professional, be courteous, and be smart.

The basic guideline for all interactions with staff is to be professional, be courteous, and be smart. [9]

If you receive positive feedback from a staff member about your work, be sure to make a note of the person's name. Identifying supportive contacts within an institution can make your work easier, and can even be crucial in getting things accomplished for your clients. The more departments in which you can cultivate contacts (health, security, administration, programs, etc.) the better.

However, you will also encounter staff who are openly hostile to you and your work. Depending on the individual, this hostility may be due to AIDS-phobia, or it may just be general disdain for community volunteers, who are often seen as nothing more than "criminal lovers". Unfortunately, dealing with this type of hostility is part and parcel of doing community-based prison work. While that does not excuse bad behaviour, it does mean that you need to emotionally prepare yourself to meet resistance of some type every time you go into the prison. The better prepared you are before hand, the better equipped you will be to handle such situations in a professional manner if they arise.

If you encounter hostility or disrespect from a staff person, *never return the hostility in kind*. Sometimes, a staff member may try to bait you into an unprofessional response, which can then be manipulated or exaggerated as an excuse to revoke your security clearance. If you can ignore the hostility, do so. If you feel the need to respond, challenge them in a measured, controlled, and professional manner. Just because they act unprofessionally does not mean that you should as well – especially when the potential ramifications for you and your program are much more severe.

[9] For more guidance on interacting with prison staff, see *Building Relationships: The Foundation of Prison Work – Building Relationships Between Your Agency and the Institution/*s in Chapter One.

Note that you may also want to recall the incident at a later date, to advocate the need for staff training in HIV/AIDS issues. If you have allowed yourself to be goaded into an unprofessional response, it will be more difficult to use the incident to illustrate the problem.

If an incident is particularly inappropriate or extreme, you have the right to file a formal complaint with the warden. Take note of the staff person's name if you can (they all wear name tags), or make note of the time and area of the prison you are in, and the person's general appearance. If the incident in question involves openly racist, sexist, homophobic, or AIDS-phobic behaviour and language, it is within your rights to lodge official complaints with both the institution and with the Ombudsman's Office (for provincial prisons) or the Correctional Investigator (for federal prisons). The telephone numbers for each are usually posted within the prison, or available in the government directory of the phone book.

You don't need be afraid to go into prisons to provide services.

Interacting With Prisoners

If you have never worked with prisoners before, the most shocking thing you will probably find is that they are no different than most other people you might meet in your life or work. People in prison have the same needs, desires, interests, and aspirations as any of us. The only difference is that they are incarcerated.

Don't allow fear to be a barrier. Despite sensationalist media reporting, and what politicians and police may lead us to believe, working with prisoners as a community-based professional is not dangerous. In fact, in many ways it is probably less dangerous – and more predictable – than other types of street outreach in which HIV/AIDS workers might be involved. That is not to say there aren't dangerous people in prison, but the reality is that the vast majority of prisoners in Canada are regular people who have made mistakes, or who have found themselves in unfortunate situations that have resulted in their incarceration. (See *Canadian Prisoner Populations: Who Goes to Prison and Why?* in Chapter Two.)

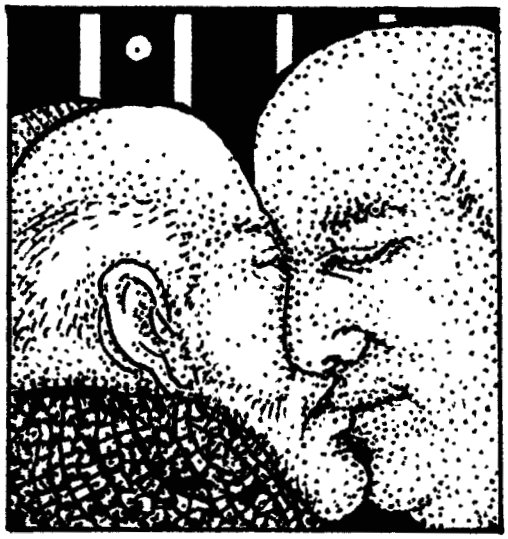
You don't need be afraid to go into prisons to provide services. As a representative of a community-based organization, you can expect to be warmly welcomed by most prisoners you will meet. Outside community volunteers and programs are highly valued and respected because our presence helps break down the stigmatization and isolation prisoners face. In general, prisoners *want* access to community-based programs, and will therefore be very happy to see you.

Once you have forged links with the prisoner population,[10] you can expect the prisoners to look out for you, and to help make sure your program runs smoothly. The following anecdote provides an illustration of this point.

In 1999, PASAN staff arrived at a medium security federal penitentiary one evening to conduct a pre-arranged outreach program with the Lifers' Group. When we arrived at the front gate, the guard on duty informed us that there had been a stabbing half an hour earlier, that the guys in the institution were very tense, and that it would be better if we cancelled our program. We explained that we had made arrangements with the Lifers to meet them that evening, and that they were expecting us. We said we would prefer to go inside and ask the Lifers' representatives whether they wanted to cancel or proceed with the workshop.

Since we had worked closely with the Lifers over several years, we had come to know and trust their leadership very well, as they had come to know us. We therefore respected their assessment of the situation. If the atmosphere was dangerous, we knew they would tell us to reschedule. If the situation was manageable, we trusted that they would ensure our safety. It was also important for us to speak personally with the Lifers' representatives before making any decision. If we decided to leave the institution without speaking with them first, the group could easily have been left with the impression that we had simply not shown up for the event. This might have damaged our relationship, and jeopardized future work.

We were able to meet the with the Lifers' representatives at the entry gate. They confirmed that it was safe to proceed with the workshop, and we did. Needless to say, we ended up having a great evening sharing HIV, Hepatitis C, and other information with about fifty guys.

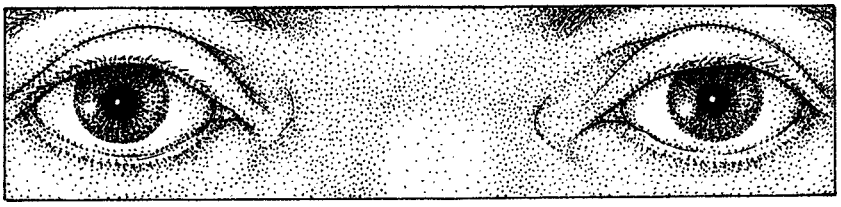


[10] For more guidance on interacting with prisoners, see *Building Relationships: The Foundation of Prison Work – Building Relationships Between Yourself and the Prisoners* in Chapter One.

VII. Conclusion

You have acquired some basic background knowledge on the Canadian prison system, and on HIV/AIDS prevention and treatment issues in the prison context. You have given initial thought to how best to establish your prison program and/or services, and have had your proposal cleared by the institution, if necessary. You have initiated communication and co-operation with prisoners' representatives in the institution, and possibly with other agencies engaged in program work. You have arranged your security clearance, and for telephone access to your agency by collect call. Now you are ready to develop the structure and content of your HIV prevention education and outreach program, and to develop your client support services.

In the next chapter you will find information on the programmatic barriers and opportunities presented by the prison structure; prison-specific HIV prevention and harm reduction strategies; ideas for promoting your program to prisoners; and tips on facilitating group dynamics in the prison context.



Supporting Peer Health Initiatives at Stony Mountain Institution

by Holly Wiggins, External Liaison Officer, Stony Mountain Health and Welfare Group
Winnipeg Chapter, John Howard Society, Winnipeg, Manitoba

IN FEBRUARY 1995, prisoners formed a Peer Health and Welfare Group in Stony Mountain medium security penitentiary. Forming this group was the only solution – other than reverting to violence – the prisoners were able to come up with. There had been another suicide among them and they were frustrated, scared, and felt helpless to prevent this from repeating.

The prisoner who hanged himself was HIV positive. There were many reasons why he took his own life. I am not doing him justice here, as his whole story is one of frustration and pain. In his memory, prisoners formed this peer health group.

With this death it was reported that Stony Mountain Institution (SMI) had the highest rate of suicide in the federal system of corrections. This opened the way for *any* intervention, even from prisoners.

Administration was receptive when approached for a possible solution, especially one that was not going to cost the system a great deal of funds. I believe, as well, that at the time it could be viewed (from the outside) as the administration working towards a solution for this very embarrassing report.

One area of concern for the prisoners was that they wanted a group where their peers could vent safely, without fear of any recourse from the institution. However, it was and is the practice at SMI that a staff person must be present whenever any prisoners gather. A compromise was therefore decided in this case. The John Howard Society – an outside agency, trusted by the administration but not a staff person – was approached to help facilitate the prisoners' peer group.

The John Howard Society – known to advocate for prisoners – was already contracted to do advocacy work, HIV education, and community integration work in the prison. However, up to that point our HIV education was being done in a vacuum. I was presenting a program to new prisoners at intake, but there was no input from prisoners themselves. Because I am Aboriginal, and had one brother who took his life because he was diagnosed with HIV, I did have added aspects of relevant life experience to put into the educational program, but it continued to lack one vital component – prisoner input. The formation of the peer Health and Welfare group changed all that.

At the time the prisoners' Health and Welfare Group formed, both the administration and the John Howard Society thought it would be short-lived: the group would form, and dissolve in months. However, this was not the case.

The prisoners who were involved (and had initially petitioned the administration for this support group) absorbed every bit of information on HIV I brought them. They worked furiously, educating themselves on the subject. The Health and Welfare guys constantly asked for more information – sometimes information that wasn't even available yet on the street.

Soon, I was the student and they were the teachers. Within months I was bringing the peer group members (with special permission) into the intake unit to assist me in the education of new prisoners. They added so much to the program, such as safer practices in sadomasochistic acts, facts on Hepatitis, and how to hide and transport contraband safely. These were components of the program that *they* taught *me*.

Doing the educational piece at intake also gave these prisoners the opportunity to constantly fuel their peer group with new prisoners. It made all new recruits available to them. As a result, instead of fizzling out, the Health and Welfare Group grew in membership and political strength.

The group has evolved from being just a handful of prisoners meeting unofficially to being a recognized group with a membership of forty eight, as well as making some very big differences in the institution.

Most of the peer group's accomplishments have been in the area of advocating on behalf of HIV positive prisoners for what most of us take for granted: doctor's appointments, healthier food supplies, medical supplies and medications, proper attire, and visits with their families. But this same group has also taken on bigger battles with the institution (challenging dirty kitchen practices, and petitioning for a needle exchange program, and for better health care in the institution for those infected) and with the National Parole Board (fighting for early releases). One of the most exciting things the group has come up with is a music tape. The tape was made by the committee (of which two also happen to be band members) and the proceeds donated to infected prisoners. These funds have been used to purchase educational tapes and medical supplies not covered by CSC.

After five years we now have one paid position for the group, and five volunteer positions. The responsibilities have more than doubled for the committee members. Refilling the condom supplies throughout the prison and checking the bleach supply is only part of their job. The hardest part is being there for others when they are diagnosed.

In the five years I have been the external liaison officer for this Health and Welfare Group, I have gone through numerous prisoners as the Chairmen and committee members. This happens because they keep letting these guys out. It sometimes feels like I just get someone trained and they are either being released or they are moving on to a lower security prison. It seems to work out better if I have a lifer or a longtimer as Chairman. Then *he* is in charge of the training and oversees what the committee is doing.

We now also have the Chief of Health Care as the group's *internal* liaison officer. This has helped, as she is dedicated to the health of these men, and not just her paycheque. She is there when we need her, but also allows time for the members to vent,

and sometimes this is all they need.

Regrettably, the John Howard Society no longer does the HIV education in the intake unit for the new prisoners because the Correctional Service of Canada has developed their own program, *CHIPS*.

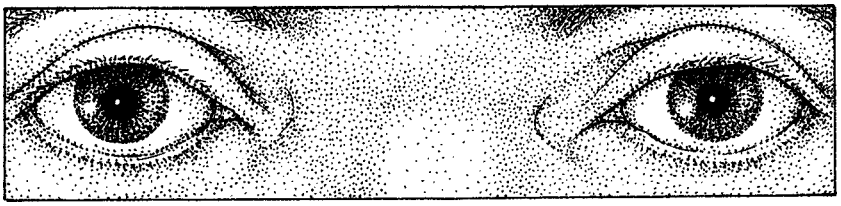
CHIPS is not a street-based program. It does not talk about the real risky practices that go on in prison – except when the peer Health and Welfare committee members assist the nurse delivering this program for one day.

The John Howard Society contract that allowed me to act as external liaison officer for the peer Health and Welfare group was a separate contract, and I believe this has saved it from being terminated.

Meanwhile, the peer Health and Welfare group continues to have weekly meetings to do educational sweeps throughout the prison, and to advocate for those infected.

Recently, the prisoners have applied for their group to become a member of the Manitoba AIDS Cooperative, which should give the group even more resources and a bigger voice.

"INSIDE" INFORMATION



The Sherbrooke Detention Centre Experiment

by Thierry Pinet, Outreach Worker, SAP Program
Eastern Townships Regional Centre for HIV Prevention and Anonymous Testing/
Sherbrooke Detention Centre, Sherbrooke, Québec

FOR SOME PEOPLE, time spent in detention can mean a decrease in the overuse of drugs or alcohol and an opportunity to question various aspects of one's life. It's often the best time to take stock of one's health, possibly take a test, receive a vaccine, or simply get one's health-insurance card. It's a time when people are sometimes more receptive to health messages.

This is the positive approach underlying the Sherbrooke Detention Centre's preventive healthcare intervention experiment known as the "SAP" Program.[1]

The SAP Program originated in the spring of 1995, following the Sherbrooke Detention Centre (SDC)'s participation in PASAN's First National Workshop on HIV/AIDS in Prisons in Kingston, Ontario. The SDC had already organized HIV and Hepatitis C information sessions in collaboration with the local AIDS group, but wanted to offer counselling or "intervention" services to inmates on a more regular basis.

The SDC decided on a consultative and cooperative approach to its program development. After holding information sessions with both staff members and inmates, the SDC approached the Eastern Townships Regional Centre for HIV Prevention and Anonymous Testing for collaboration on the implementation of a prevention awareness and information project for inmates concerning HIV, the various kinds of Hepatitis, and other STDs. A committee formed to support and supervise the SDC's activities, consisting of an SDC manager, a member of the SDC health service, a nurse from the testing centre, a specialist counsellor, a member of the region's community AIDS group, and a prison outreach worker hired specifically for this project.

In addition to its consultative aspect, there are several other unique features of the SAP Program that have since made it a model for others in Québec.

In developing the SAP Program, the committee decided to adopt an approach to prevention that emphasizes outreach work. An outreach orientation makes it possible to "go to" the prisoner rather than wait for them to come to our offices. Outreach makes possible intervention with people who are unreachable by traditional means such as formal prevention seminars, stand-

ard printed materials, or doctor's consultations, due to factors such as fear or mistrust of institutions, or weak reading skills, for example. In this way, the SAP Program's prison outreach worker is analogous with a street outreach worker.

Prevention education and counselling at SDC now take place in the inmates' everyday surroundings – in cells, on the ranges or living units, in corridors, in the outreach worker's office, or in the cafeteria. It takes place whenever the prisoners want it, and wherever they are when they're prepared to talk and listen.

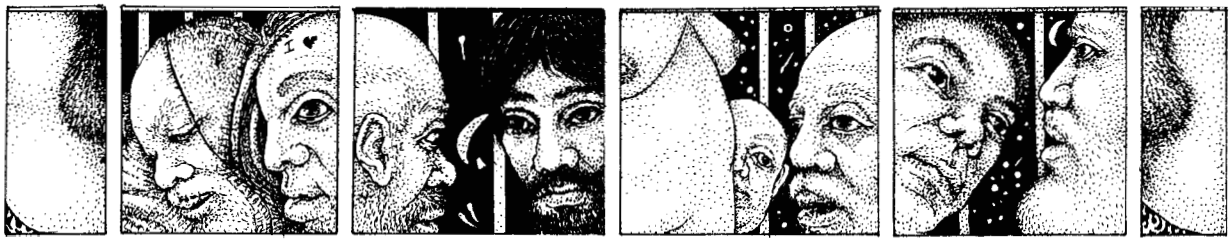
Another unusual feature of the SAP Program is that the prison outreach worker is in the SDC for 21 hours a week, mixing with the prisoners: neither visitor/volunteer, nor staff. Although the outreach worker is bound by the same regulations and restrictions as everyone else in SDC, he is free to circulate, to come and go where he feels the need to intervene. Unlike the prison staff, however, the outreach worker doesn't have access to the inmates' files, and has no authority over them. He makes himself available as a helping, non-repressive, neutral person. This kind of intervention and availability was unknown to prisoners before the SAP experiment.

Also unique is the way in which SDC personnel have integrated the outreach worker as a resource for them as well as for the prisoners. SDC staff have been briefed about the importance of prevention, and therefore sometimes call upon the outreach worker for advice in their own work, or else refer prisoners to the outreach worker for support and prevention materials. Staff and inmates can also call on the outreach worker to help lower the tension when fear sets in concerning a risk of infection, or when an HIV-positive person is a victim of prejudice.

Of course, risk reduction and the acquisition of safer behaviours is only possible if concrete means for adopting safer behaviours are provided. As a result of this project, SDC has made condoms available from a self-serve dispenser, and everyone has access to it. Bleach is now available on each of the ranges. Tattooers have access to basic materials for safe tattooing (ointment and gloves) through the outreach worker. Methadone is also now available in SDC for those admitted with a prescription, or those who wish to begin the program upon entry.

The realization of the SAP experiment was made possible through SDC's open-mindedness, the cooperation between corrections and community health resources, and, above all, the conviction of all the stakeholders that inmates are capable of taking their health in hand when you take the trouble to listen to their needs.

[1] "SAP" stands for *Sensibiliser*, *Animer*, *Prévenir*. In French, a "*sape*" is also a ditch that is shovelled along a wall in order to make this wall fall.



CHAPTER FIVE

HIV Prevention Education and Outreach

THE PRIMARY CHALLENGES confronting HIV/AIDS educators in the prison environment relate to *access*. First, you have to get *access to the prisoners* in order to provide prevention education. This is not always a straightforward proposition.

After you succeed in getting together with prisoners, the issue of access again confronts you. Actually reaching the prisoners requires you to create *accessible HIV prevention messages and educational materials*. That is, your prevention advice must reflect *prisoners' real access – or lack of it – to HIV prevention tools in the prison environment*. This means that many standard approaches and materials will not suffice – and may be irrelevant.

This chapter will assist you to develop the format, content, and structure of an accessible HIV prevention education and outreach program specifically for prisoners. The material in this chapter is geared towards the needs of AIDS workers who already have some experience or training in basic HIV prevention, and wish to adapt their skills to the prison environment.

If you are new to HIV/AIDS prevention and would like to develop these skills for use in your prison work, you will also find much useful information in this chapter. However, *this chapter will not teach you how to do basic HIV prevention education.* That is knowledge you can and should obtain from other sources. If you would like to develop more comprehensive skills in HIV prevention, contact your local AIDS service organization or public health office, as many provide free training to community groups.

CHAPTER FIVE

HIV Prevention Education and Outreach

The institution has approved your proposed HIV prevention program. You've been cleared by security. You've scheduled your trip to the prison. All that remains is to meet with the prisoners and provide them with information.

Not so fast. You now face three major tasks in preparation: deciding on the most appropriate format for your program and outreach strategy; developing the content of your program; and structuring your approach.

Before getting started, it might also be useful to say a few words about the difference between HIV "prevention education" and "outreach".

The goal of *HIV prevention education* in prisons is to pass on accurate information, to promote safer behaviours, to challenge AIDS-phobia, and to encourage support for people living with HIV/AIDS (PHAs) in the institution.

The goal of *outreach* in prison is to get yourself known, and thereby raise the profile of your organization and its services (particularly, although not necessarily, to PHAs) in the institution. There is no *inherent* educational component in this interaction. That will hopefully come later if the outreach process is successful.

While prevention education programs are definitely a form of outreach – as your presence in the prison will raise the profile of your services – outreach is not necessarily prevention education, as it may provide no opportunity for any educational intervention other than passing on a business card.

Despite these differences in purpose, these two efforts are often related, mutually beneficial, and pursued through similar means within the prison context. Therefore, they are both addressed together in this chapter.

I. Getting Access to Prisoners: Outreach and Program Format Options

While Chapter Four detailed the basic steps for getting into prisons to establish your program, you must also assess the *specific* options available for meeting prisoners at your local institution.

Different institutions house and manage their prisoner populations in different ways,[1] and this will have a direct bearing on how you structure and run your program.

Some institutions allow prisoners little or no free movement within the institution. This is particularly true for detention or remand centres, which tend to keep most people locked on their ranges all day. Any movement outside of the range must be escorted by a guard. Conducting programs and outreach in such institutions can be a real challenge. Sometimes the guards decide they don't want to escort numerous prisoners from various parts of the facility, and therefore they don't announce a program in the institution. Sometimes the prisoners themselves don't want to come to a program because of the lack of confidentiality, a shyness to discuss sensitive topics in a group setting, or because it's just too much hassle to get there. Therefore, in many detention centres it is difficult or impossible to actually gather together groups of prisoners for a program.

Your options for reaching out to prisoners will depend on the type of environment you are entering.

In other institutions, however, prisoners are *expected* to take part in programs during the day. Some may have institutional jobs for which they are paid a small wage. Some may be enrolled in educational classes. Some may be taking life skills, drug treatment, or other kinds of social programs. Participation in these programs is usually mandatory, and individuals may only be excused from attending under special circumstances. Therefore, HIV/AIDS programs in such institutions face a dual challenge: that of attracting prisoners' interest such that they want to be excused from work or other programs, and *then* arranging for these individuals to be excused from their regularly scheduled responsibilities.

Still other institutions – particularly federal penitentiaries – allow the prisoners some periods of free association time. This time is often in the evenings. During these periods, prisoners are free to move about the institution, and to participate in various activities on a voluntary basis. Prisoner-run groups often hold their membership meetings during this time. Some prisoners may engage in sports or other exercise activities. Others may just

[1] See *Canadian Prisons: Systems and Structures – Canada's Prisons: Two Systems, Multiple Challenges* and *Other Common Structures of the Canadian Prison Environment* in Chapter Two.

socialize with their friends. Under these circumstances, there is no shortage of individuals available. The challenge instead is to make your program attractive enough to draw prisoners away from these other recreational and social activities.

As you can see, your options for reaching out to prisoners will depend on the type of environment you are entering. As a community worker, you will have no control over this environment, so you must be prepared to work within the limitations of each situation. Each has its own barriers and opportunities.

Each situation has its own barriers and opportunities.

While the word "option" describes each of the possible outreach and program formats below, this does not mean you will always have the ability to choose which one to use. You may have this luxury in some circumstances, but in many others the institution will "choose" your "option" for you.

Whatever option you do pursue, you will need to arrange prior permission and security clearance through the proper institutional channels. See Chapter Four for details on this process.

Options for Secure Environments with Limited Free Association

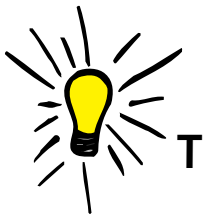
In secure environments with limited free association (such as most detention and remand centres, for example) a separate room in which to hold your program may or may not be available. Whatever the circumstances at your particular institution, there are options to effectively address both situations.

If You Don't Have a Room

While having access to your own room to hold a meeting obviously has many advantages, it is not essential to your ability to reach prisoners with HIV/AIDS information. Below are two informal options for reaching prisoners when you don't have the benefit of a private program space.

FORMAT 1 – "Walk-abouts"

Some institutions will allow community volunteers to walk freely between sections of the prison during established hours (usually set times during the mornings and afternoons). This provides you the opportunity to walk from range to range and speak to prisoners – usually on an individual basis – through the "grill" (the bars separating the prisoners' living units from the connecting hallways).



TIP:

Living in prison is a very boring experience most of the time, and most prisoners are desperate for new reading materials. For this reason, written materials that come into the institution are often passed from person to person. Therefore, you can expect that many different individuals will read the pamphlets, newsletters, or other written materials you bring into the institution.

That said, the more discreetly the materials are packaged, the more likely prisoners are to read them. For example, try to avoid materials where "HIV" or "AIDS" appears prominently on the cover.

If possible, look at developing materials specifically for the prison context. They need not be fancy. Photocopied materials will be fine. Make sure your materials take literacy problems into account. Use plain language, vernacular, illustrations, and diagrams.

While obviously not an ideal or confidential situation for conducting comprehensive prevention education, "walk-abouts" provide an opportunity for you to conduct outreach in all areas of the prison. This approach can therefore significantly boost the profile of your organization amongst the prisoner population. Done regularly, it can also lead to incremental trust-building, eventually motivating individuals to volunteer to attend a more formalized workshop at a later date. Walk-abouts allow you to broadly distribute written HIV prevention information, health promotion information for imprisoned PHAs, and contact information for your agency.

Despite the advantages, be warned that doing "walk-abouts" can also be a difficult and frustrating process. Going from area to area in the institution means that you necessarily interact with a larger number of guards. This can increase the risk of revealing your identity as "the AIDS worker", as well as the likelihood that you will encounter some type of obstruction or "attitude" from a staff member.

Talking to people through "the grill" is also difficult. The ranges themselves are very loud environments, given the competing sounds of radios, television, and people's voices. This can make it difficult for you to attract attention without resorting to shouting, and can make normal volume conversations almost impossible. If you do manage to attract someone's attention to come and talk to you at the grill, there is no guarantee that s/he will be interested in HIV information. More likely, they will just be curious about who you are. Still, most individuals will be happy to take a stack of your educational materials onto the range for others to see.

FORMAT 2 – "On the Range"

A few detention/remand centres will allow community workers to actually enter the living units and conduct programs at pre-arranged times.[2] This can be a very effective way to reach a substantial number of people at one time, as a single range may house several dozen people.

Despite the obvious advantages to this approach, there is one caveat. The atmosphere on the range is not like that of a private meeting, and you must conduct yourself accordingly.

Always remember that by coming onto the range, you are entering the prisoners' living space - essentially their "home". You must respect this fact at all times. You must also accept the reality that many of the people there will have no interest in talking to you. They may be watching TV. They may be playing cards. They may be having a conversation. It is rude, counter-productive, and ultimately ineffective to demand everyone's attention. Announcing who you are and what you are there to talk about is fine.

[2] In our experience, this is a rare exception.

However, once this has been accomplished, it's best to take a more low-key approach. People *will* come up and talk to you based on your announcement. Once one or two people sit down with you and start talking, more will generally follow. Most outreach opportunities on the range eventually evolve into a series of small group discussions, which are excellent opportunities to meet people who would otherwise never hear about your service.

In some cases, meeting on the range can also provide a greater level of confidentiality for prisoners. There are lots of people moving around and lots of background noise, and therefore greater opportunity for an individual to ask you quick question, or to pick up a pamphlet or business card without drawing attention to her/himself.

In other instances, however, being on the range can be very invasive. Depending on the architecture of the building, the bathroom and shower area may not be private. This can create an uncomfortable situation for both the prisoners and the outreach workers (especially for male workers on women's ranges, and vice versa). To decide whether it is appropriate for you to do outreach on the range, you should first assess the layout of the individual institution.

TIP:

When you go on the range, always leave a selection of your outreach and educational materials behind on a table. That way, people who were too shy or too busy to talk to you will still have a chance to pick up the information later.

If You Do Have a Room

Having access to a room obviously allows you to provide a depth of information that is often not possible through the more informal approaches above. The ability to sit with a group for an hour or more allows the educator an opportunity to explore issues in greater detail, answer questions, and facilitate group discussion on various topics.

When you do have a program room, the institution will determine the specific methods by which prisoners are allowed to participate in your program. Two of the most common are detailed below.

You may find that some institutions allow you to both have a regular room, *and* to use the more informal outreach options listed above. In such cases, you will find that informal contacts can play a significant role in enhancing the success of structured programs held in a private meeting space.

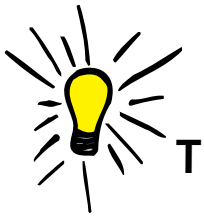
FORMAT 1 – "Sign-ups"

Even if the institution provides you with a separate room to conduct your program, this doesn't necessarily mean that prisoners will be free to attend your workshop without prior arrangement. Whether you're in an institution that confines people to their ranges, or an institution with established mandatory work or school programs, you will have to secure the institu-

tion's cooperation in order to get people out to your meeting. Most commonly, this happens through a "sign-up" list.

Having a "sign-up" list means that at some time prior to your arrival, staff will circulate a sheet of paper and individuals interested in attending your meeting or workshop will put their names down. Those people signing-up will be excused from work or school, or escorted from their living units, in order to attend your program.

Although it may seem straightforward, be aware that this practice can also present barriers to attendance, as it means that people must be willing put their names down for the "AIDS program". Many interested people may choose not to participate due to the risk of stigmatization. PHAs in particular are rarely willing to volunteer their names for these types of programs. This arrangement can also result in the same group of people attending your program each time you visit the institution, simply because they are the only ones willing to come forward.



TIP:

If possible, try to get prisoners you already know to promote your program amongst their peers. This can help to break down reluctance among potential participants.

Another potential drawback to this method is that it depends completely on the willingness of staff to assist you – first in distributing the sign-up sheet to prisoners, and second in escorting the interested people to your program room at the appropriate time. If you are lucky enough to encounter helpful staff on your day, you may get a good attendance. On the other hand, if the staff on duty are uncooperative, you may get no one. If this occurs, your only option is to cancel your program that day. However, be sure to follow-up with your institutional contacts to find out what went wrong, and try to put a strategy in place to ensure it doesn't happen again.

FORMAT 2 – "General Calls"

If you are in an institution where prisoners go to work or school during the day, the general call is another common practice. When approved programs are beginning, a general announcement will go out over the PA system. Any interested individuals may decide at that moment to leave what they are doing and come down to the program.[3]

Where available, this system is good in so far as it allows prisoners more personal autonomy to decide whether to attend, and does not rely on staff willingness to distribute a sign-up sheet ahead of time. However, it too presents confidentiality barriers. When the announcement goes out that the *"AIDS program is starting in the chapel in ten minutes,"* how many people do you think will jump up to attend? In the case of a general call, decisions about how to advertise your program are especially crucial. (See *Basic Advice on Running Your Prison Program: Provide "Cover" When You Advertise Your Program*, below.)

[3] In some institutions, a general call is used in conjunction with a sign-up process. For example, prisoners may have to sign-up to attend the program, but will only be brought down to the group once the announcement is made over the PA system.

Options for "Open" Environments with Greater Freedom of Movement

Different outreach and program opportunities exist in institutions which allow people time for *free association* (such as most federal prisons).

In such institutions, prisoners are allowed to leave their living units and move around the institution during "general association" or "recreation" hours – usually in the evenings. Many prisoners will congregate in specific areas, such as the gymnasium, the weight room, the yard, and various program and group rooms.

These general association times can provide ideal opportunities for outreach and education, simply because a large number of prisoners are circulating around "freely" without guards escorting them.

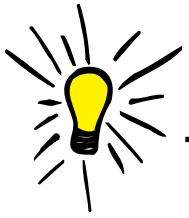
Obviously, in such "open" environments, arranging for sign-ups and general calls is unnecessary, as prisoners have more autonomy in how they spend their "free" time. However, you may still want to try to arrange to have prisoners put up posters promoting your event. (See *Format 3 – Sponsored Programs* below. For advice about drafting any promotional materials see *Basic Advice on Running Your Prison Program: Provide "Cover" When You Advertise Your Program* and *Be Aware of Literacy Issues in Developing Your Printed Materials* below.)

Once again, you may or may not have your own program room allocated. Many of the following options work well for outreach, but can also double as program format options if you don't have access to your own room on a regular basis.

FORMAT 1 – General Outreach Sessions

If you are working in an institution where the prisoners have specified hours each day for general association or recreation, you may also have the opportunity to organize your own general outreach session, much as you might in the outside world.

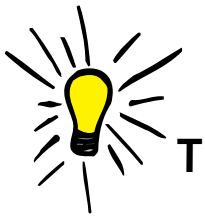
Try to arrange to set up a table in a high traffic area (near the gym or weight room, for example). You can then put out a display of materials, and distribute information as people walk past. Talk to your contact/s at the institution (prisoners and/or program staff) to assess the best areas of the prison for you to set up shop.



TIP:

Ask the institution if you can bring in cookies or donuts with you to serve during your program. Outside food is always a popular attraction, and will bring a large number of otherwise uninterested people into your program. Some will stay for the whole program, and some will just grab a donut and leave. For those who only want to "eat and run", suggest that for every donut they take with them, they have to take one pamphlet as well. Most people will go for it.

The presence of outside food also provides good "cover" for people to attend. Rather than having to admit an interest in HIV issues, they can say that they're only there for the food.



TIP:

If you succeed in arranging a meeting with a prisoner-run group, you should approach it not as a one-time workshop, but rather as an opportunity to begin developing a longer-term relationship with that group. Look at it as a partnership opportunity.

You can provide health information, and the prisoner group can help identify broader needs and opportunities for further outreach at the institution.

FORMAT 2 – Addressing Pre-Arranged Meetings as a Guest Speaker

As discussed in Chapter Two, all federal prisons and many provincial correctional centres have established prisoner-run groups. These groups offer excellent opportunities for you to get in and meet with prisoners. First, they meet on a regular – often weekly – basis, and will have the use of designated meeting-space within the institution. Second, as prisoners themselves run these groups, their meetings are usually well attended.

Consider approaching a preexisting group that meets regularly in the prison. Offer to make a presentation to their members either as a special item on their agenda, or in a meeting specifically set aside for this purpose.

If you choose this option, the first step is to find out what groups meet in the institution. Once you have identified an appropriate group or groups, write a letter addressed to their Chair/s.[4] Introduce yourself and your organization, and ask for an opportunity to come and meet with their membership. *Remember to state clearly in your letter that you represent a community-based organization, and do not work for correctional services.* Also let the group/s know whether and when they can call you collect at your office to discuss a possible meeting.

You may hear back within a few days, or a few weeks. You may not hear back at all. If you have received no response within six to eight weeks, try writing back. At this point you might also try calling the social development/social programs office – or Native Liaison Officer if you are approaching the Native Brotherhood/Sisterhood – to ask their advice. Sometimes the group in question may be disorganized due to internal politics, the death of a member, or some other crisis. If this is the case it's best to back off for a few weeks, and try again later.

FORMAT 3 – Sponsored Programs

Another option is to ask a prisoner-run group to sponsor a visit from your organization.

If the group agrees to be your sponsor, they can often arrange to reserve a program room for you, or give you advice on how to do it yourself (through the health unit, or the social programs department, for example). You can also ask your sponsor group to advertise your program within the institution prior to your coming. They may put up announcements or posters, or just encourage their friends to show up via word of mouth.

In either case, having your program sponsored by a prisoner group gives you immediate credibility, increasing your chances of both good turnout and acceptance by the other prisoners.

[4] Remember, prisoners cannot receive incoming calls.

If you decide to request sponsorship by a prisoner organization, the logistics are similar to those outlined above for requesting to make a presentation before a membership meeting.

Dual-Option Format – "Piggy-backs"

"Piggy-backing" your HIV prevention education workshop onto an already established program is discussed in detail in Chapter Four. (See *Making Your Program Proposal: "Piggy-backing" on Existing Programs*.)

This strategy works equally well in any kind of correctional setting.

ONCE YOU HAVE determined the format/s available for your program, you are ready to develop its prison-specific content.

TIP:

Many correctional centres and penitentiaries have a "reception unit". This is a specific unit within the prison where all the new, incoming prisoners are housed for several weeks while undergoing a general institutional orientation and assessment program. Find out if your HIV prevention program can be incorporated as a regular component of the reception program. If so, this will ensure that your program reaches every single individual coming into the prison each month.

II. Creating Accessible HIV Prevention Messages

As HIV/AIDS educators, our goal is to promote behaviour change. Through our work, we seek to provide people with the knowledge, skills, and initiative to adopt practices that will reduce their risk of HIV and Hepatitis C infection or transmission. We encourage and educate people to use the tools – condoms, dental dams, needle exchanges, etc. – that are known to reduce the risk of HIV and Hepatitis C transmission.

However, as discussed in Chapter Three, in the prison environment we are working with a population that simply *does not* have access to many of these risk reduction tools. The question for prison HIV/AIDS educators is *how do we promote behavior change when our target audience has drastically reduced prevention options?*

The answer is simple. *We educate and encourage people to use whatever tools* are *available to them*.

In this sense, we approach prison work with exactly the same philosophy we use in the general community. The only real difference is that the tools at prisoners' disposal are limited or non-existent.

In this context, creating accessible and effective HIV prevention messages for prisoners involves finding out what prevention tools *are or are not* available to the specific group of prisoners you are addressing, and then tailoring your messages accordingly.

Experienced AIDS educators will know that many of the prevention strategies we are forced to discuss as best com-

THE ESSENTIAL FIRST STEP to preparing effective HIV prevention messages for prisoners is to learn what tools *are* available in your specific institution or region, and what tools *are not* available.

You also need to get a clearer sense of the risk profile of your local institution/s.

You need to seek answers to the following questions:

1. *Does your local institution provide condoms, dental dams, or water-based lubricants*?

   (If the answer is yes, how are they distributed and accessed by prisoners?)

2. *Does your local institution provide access to bleach?*

   (If the answer is yes, how is it distributed and accessed by prisoners? If the answer is no, can the prisoners get access to bleach via "unofficial" channels?)

3. *Can prisoners get access to latex gloves, either officially or unofficially?*
4. *Does your local institution engage in random urinalysis?*
5. *Does your local institution provide methadone, and under what circumstances*?
6. *What street drugs are most popular and prevalent in your local institution?*

promises are inadequate. However, they reflect the frustrating reality of the environment in which prisoners must live, and in which prison AIDS educators must work.

Some of your questions will be easily answered by a phone call to the prison health unit. Other questions will be answered by the prisoners themselves in the course of your outreach.

You will find that for many of these questions, you will get different answers from the staff and the prisoners. This is because there is frequently a gulf between official policy and everyday reality. In such cases, go with the information provided by the prisoners, as they are the people for whom you need to develop practical – not theoretical – prevention strategies.

Risk Behaviours and Prison-Specific Prevention Strategies

Injection Drug Use

The major risk factor for transmission of HIV and Hepatitis C within the prison context is the sharing of injection equipment.[5]

While safer sex and condom use is likely the main topic when doing HIV/AIDS prevention workshops in the outside community, in prison you need to be prepared for and comfortable with answering questions on harm reduction and safer drug use.

In an ideal environment, no one would ever have to share a syringe. However, prison is far from an ideal environment, and incarcerated injection drug users (IDUs) rarely have the option of using a brand new needle. This means that IDUs in prison are either forced to share needles, or to use their own personal rigs over and over again. Most often, syringes are used and/or circulated until they literally fall apart. Even when offered a "new" syringe in prison, there is no guarantee that it has never been used.

This situation is not the fault of the users. Indeed, you will find many IDUs who never shared a needle in their lives before going to jail.

The prevention messages you give prisoners must be as accurate as possible, while remaining practicable within the limitations of their environment. It is one thing to tell an outside audience to always use a needle exchange. It is unreasonable to present this as your *main* message in the prison.

While it is essential to be clear about the risks of sharing injecting equipment, the reality in prisons is that injection drug users have to share their

TIP:

To do harm reduction education most effectively, it is important to familiarize yourself with the common slang/street names for different drugs and drug use practices. This will enable you to use the same language as the prisoners themselves when doing education sessions. While some of these terms are standard across Canada, others can be very specific to certain regions, institutions, or groups of users. Achieving some level of fluency in these terms and expressions will assist you in conducting harm reduction education in a specific and accessible manner for your audience. It will also add to your credibility among the prison population, and make prisoners more comfortable in discussing drug use issues with you.

[5] For more background information see *Close-Up on Prisoner Populations With Special Needs: Drug Using Prisoners* in Chapter Two, *"Inside" Information: Charlie's Story*, and Chapter Three.

TIP:

During the course of your prison program, you will encounter many unique harm reduction strategies that incarcerated users adopt in an attempt to reduce their risks. These may include owning and maintaining their own syringe that they do not share (but use dozens or hundreds of times themselves). They may include using liquids other than bleach to flush their rigs.

In discussing these strategies, it is crucial to emphasize that none of them are 100% effective – and in fact some are of very limited effectiveness. Still, given the limitations of the prison environment, they may represent suboptimal ways to reduce the risk of HIV or Hepatitis C transmission.

It is also important to support prisoners in becoming familiar and comfortable with adopting harm reduction practices generally, as they may continue such efforts after their release, using the much more effective tools available in the outside community.

works. Therefore, in order for your message to be heard and effective, you need to provide *harm reduction options* that prisoners can actually adopt.

Since needle exchange is not an option in prison, you must be prepared to provide prisoners with harm reduction alternatives to sterile syringes. A few such options are listed below.

Bleach

The most effective harm reduction option currently available to prisoners is bleach.

Bleach is *not* an optimal choice to prevent HIV transmission, nor is there conclusive evidence that bleach is effective in preventing the transmission of the Hepatitis C virus.[6] However, bleach is still an important tool available in many prisons across Canada. Therefore, educating prisoners on the correct use of bleach for cleaning injection equipment is essential.

Some jurisdictions – most notably the federal prison system – make bleach available to prisoners for harm reduction purposes. In institutions where bleach is prohibited, prisoners can sometimes access bleach through "unofficial" channels.

For those prisoners who cannot access bleach because of institutional barriers or restrictions, you must be prepared to discuss other less effective – but still important – harm reduction options.

Non-Injecting Options

Be prepared to suggest options for taking drugs that do not involve injecting. Choosing an alternative delivery method such as smoking or snorting is an option for those unable to access clean syringes. However, ingesting drugs by these other methods *will* increase the likelihood of detection by random urinalysis, which may cause many prisoners to choose to continue injecting as a less detectable strategy.

Spoons, Cookers, Filters

Discussing the risks of HIV and Hepatitis C transmission through sharing syringes is important, but it is equally important to address the other equipment used when injecting. Sharing spoons/cookers and filters also poses a significant risk of transmission.

If it is necessary to share spoons or cookers, again, ideally bleach should be used as a cleaning agent. Filters should *never* be shared because it is impossible to clean them.

[6] Canadian HIV/AIDS Legal Network, "Prevention: Bleach," *HIV/AIDS in Prisons: Info Sheet 5* (2001/2002).

Safer Sex

In Canada, many prison jurisdictions now make condoms available. Others also provide dental dams and/or water-based lubricants. While accessing these materials is often problematic for prisoners (as outlined in Chapter Three), their availability at least provides AIDS workers the opportunity to engage in safer sex education in an environment where prevention tools are present.

That said, the prison environment itself can make it difficult for many prisoners to engage in open discussions of sexuality, and same-sex partnering – the primary form of sexual activity within prisons.

In Men's Institutions

Levels of homophobia in male institutions can be very high among both prisoners and staff. While this obviously does not mean that sexual activity is not occurring, it does mean it is not readily discussed. This environment is best summed up by one prisoner's comment that *"everybody's getting blowjobs, but nobody's giving them."* This atmosphere, combined with the complex make-up of the sexually active prisoner population, makes doing inclusive and accessible safer sex education very challenging.

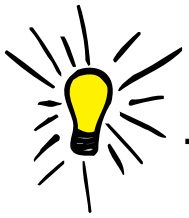
In men's institutions, discussion of safer same-sex practices in a supportive and comfortable environment is difficult, and sometimes impossible. However, there are several strategies that can promote safer sex discussions.

The most common method is to focus your discussions on safer sex practices in a heterosexual relationship. Within this framework, you can still talk openly about safer anal sex and safer oral sex without having to limit the discussion to only same-sex relationships.

That said, *institutionalized homophobia should not prevent you from also discussing same-sex relationships.* Challenging homophobia is essential, not only to help "normalize" gay relationships in the institution, but also to demonstrate that you and your agency are accessible and supportive for gay prisoners.

In Women's Institutions

In women's institutions, HIV/AIDS educators will rarely encounter the same barriers raised by homophobia in men's institutions. In fact, you will likely find most women prisoners quite open to discussing same-sex relationships, and safer sex options, between women.



TIP:

Seek out the expertise of the needle exchange programs in your region, as they will be useful sources of information on harm reduction, vein maintenance, and avoiding other injection-related infections. They may also be able to suggest other harm reduction practices that can be followed by prisoners despite their restricted access to HIV prevention tools.

You may also contact PASAN for more advice on prison-specific harm reduction strategies.

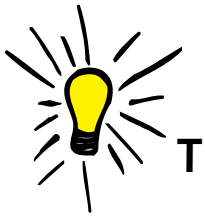
IN MALE INSTITUTIONS, sexually active prisoners are a very diverse group that includes:

- gay and bisexual men
- transsexual and transgendered people
- heterosexual men who engage in same-sex relationships only when incarcerated
- heterosexual men who engage in relationships with TS/TG prisoners (most often considered heterosexual relationships both by the lovers and by much of the prisoner population)

The last two categories of men often *do not* identify as gay or bisexual, and can sometimes be very homophobic.

When doing safer sex education with incarcerated women, it is always essential to also discuss power issues within heterosexual relationships, and strategies for negotiating safer sex with their male partners on the outside.

For many women, convincing their male partner to wear a condom can be difficult. The greater the disproportion of power within the relationship, the greater the difficulty can be. Many women prisoners may be reliant upon their male partners for financial support, housing, and/or access to drugs. This vulnerability can make asking to practice safer sex very difficult. If the woman's partner is also physically abusive towards her, the difficulty may be compounded by risk of physical harm. Therefore, it is very important to discuss negotiation strategies, and offer suggestions about ways for women to introduce condoms into their relationships while minimizing their vulnerability.



TIP:

Given the high levels of injection drug use in prison, AIDS workers also need to be knowledgeable about issues related to overdosing (OD-ing). Seek out needle exchange programs and/or drug user groups in your region for additional information and training in this regard.

You will also find that HIV/AIDS education workshops in women's institutions will often lead to questions and discussion about broader sexual and reproductive health. When doing HIV/AIDS programs for women prisoners, it is important that the educator be knowledgeable about broader sexual health issues. You may therefore want to consider inviting a co-facilitator with experience in this field to partner with your organization in delivering the program.

Private Family Visits (PFVs)

While it is necessary to discuss safer sex within same-sex relationships in both male and female institutions, some prisoners are also able to maintain heterosexual relationships while inside.

In the federal system and in some provincial systems, prisoners can apply for *Private Family Visits (PFVs, often referred to as "trailer visits")*.

If approved for a PFV, a prisoner's partner, children, and/or other family members are invited into the institution to stay for twenty-four to forty-eight hours. These visits are held in special units within the prison grounds – sometimes little cottages, sometimes trailers, sometimes specially designed suites. The families are allowed to cook their own meals, and spend

time together in a more personal and private environment. PFVs are very important in allowing families to spend time together under more "normal" circumstances, and especially in allowing children to spend time with their incarcerated parent. They are also important in allowing partners to maintain their own loving relationships. Therefore, it is important to raise safer sex discussions about PFVs within those institutions where they are allowed.

Sexual Assault and Non-Consensual Sexual Relationships

Within the prison context, it is also important to be aware of, and sensitive to, the reality of non-consensual sexual relationships.

Rape does occur in Canadian prisons, but it is not the overwhelming problem we hear about in many U.S. prisons. This is in large part due to the existence of a culture in most male Canadian prisons that ostracizes rapists (both those who are convicted of raping women or children, and those who prey on other men in the institution). Being known as a rapist means a severe loss of status and respect in prisons. *"Rape hounds"*, as they are generally known, are held in disdain by other prisoners, socially isolated, and often subject to physical violence. However, this "convict code" does not mean that sexual assault does not exist. Rape can and does occur.

It is also common for non-consensual sexual relationships to take forms other than a one-time sexual assault. Transsexual and transgendered prisoners, for example, are generally more vulnerable to rape within the institution. In many cases, this risk is exacerbated by placing TS/TG prisoners in the *protective custody unit* (ostensibly to protect them from violence).[7] Many known rapists are also held in protective custody. As a result, this attempt to protect TS/TG prisoners from sexual assault frequently increases their vulnerability.

Given this situation, many TS/TG prisoners choose to enter a sexual relationship with a "strong man" as a means of protection from random sexual violence. While these relationships are not necessarily violent in nature, they are often less than completely consensual, as they are based upon trading sex for protection. Such dependence reduces the TS/TG prisoners' ability to negotiate safer sex and condom use with their male partners. Therefore, discussing negotiation strategies may also form a necessary part of a support system for some TS/TG prisoners.

While institutional rape is not as common in Canada as in some other countries, this should not be taken to mean that rape as an issue is insignificant. Sexual assault in general is a huge issue in prisons, and particularly in women's institutions. Many incarcerated women are survivors of

TIP:

Dental dams are sometimes unavailable in women's institutions. Even when they are, they are often disliked because they are made from very thick latex, which reduces sensitivity. However, many women's institutions do allow access to condoms, which may be converted into dental dams.

Take the condom out of the package, cut off the tip, and then cut again along its length. When unrolled, it will now be a flat piece of latex. This can provide a useful option for women prisoners who wish to practice safer oral sex on other women.

[7] Protective custody ("PC") is used to house people deemed to be at risk of physical harm in general population. The institution may place an individual in PC, or an individual may "check themselves in" to protective custody if they fear for their own safety. People with "skin beefs" (sex offenders), child molesters, and "rats" (people who have given evidence against another prisoner) are most often designated PC. However, transsexual and transgendered people, openly gay men, and openly HIV positive people are also frequently placed in protective custody.

rape and other sexual assault in their lives, and a great number of prisoners (both female and male) have survived childhood sexual abuse.

AIDS workers must be prepared to hear disclosures of sexual assault from their imprisoned clients, and to act in a positive and supportive manner.

This may be an area in which you and/or your agency require additional training, support, and/or links with other organizations to facilitate client referrals when appropriate. Local rape crisis centres and/or women's shelters are useful contacts to direct you to appropriate sources of additional training and support.

TIP:

During your safer sex discussion, alternate between using "he" and "she" throughout.

For more on the specific challenges of doing safer sex education in prisons, see *"Inside" Information: Breaking "Out" – Same-Sex Relationships, Homophobia, and HIV/AIDS in Prisons.*

Other Risks

Within the prison environment, there are also other risks for transmission of blood-borne viruses. Make sure to mention the following in your workshops and written materials.

Tattooing

See *"Inside" Information: Safer Tattooing – A Prisoner's Guide*.

Sharing Razors and Other Personal Hygiene Items

Within many institutions, personal hygiene items are in short supply, and therefore routinely shared. The most common, and also most dangerous of these, are razors.

In some detention/remand centres, for example, institutional practice dictates that prisoners *must* share razors. This poses a significant risk for Hepatitis C, and possibly HIV, transmission.

If this is the case at your local institution, you should advocate with the warden/superintendent to end this practice.[8] Also make sure to notify the Medical Officer of Health in your public health region about this situation, and request their intervention with the prison.

Other shared personal hygiene items that can pose a risk for Hepatitis C transmission include nail clippers and toothbrushes.

These risks are unfortunately often overlooked in many educational sessions.

[8] For more on advocacy in prisons, see *Providing Support Through Advocacy* in Chapter Six.

It is important that prisoners be made aware of these specific risks, as they may have the ability (through advocacy, ingenuity, or canteen purchase) to ensure that they have their own sets of these personal hygiene items.

"Sharps"/Slashing

Another potential risk behaviour commonly found in prisons is "cutting" or "slashing". This is a practice whereby an individual deliberately cuts or slashes their body with "sharps" (objects such as broken glass).

Some prisoners use cutting to release stress, anxiety, or anger; for relief of deep emotional pain or trauma; and as a form of feeling "alive" within the numbing prison environment.

This is a particularly prevalent activity in women's institutions.

Since they are considered contraband, sharps are often in short supply. A prisoner who wants to slash may therefore need to borrow one. Borrowing someone else's sharp puts the prisoners at risk for HIV or Hepatitis C transmission.

Some workers will understandably find this topic difficult to discuss. However, it is important that you overcome any personal squeamishness you may feel about slashing. Prisoners will quickly recognize your discomfort, and this will inhibit them from asking questions about the practice, and the risks involved.

To reduce the risk of transmitting disease by slashing, recommend the use of bleach as a cleaning agent in which to soak a sharp between uses. Be sure to emphasize that the sharp should be rinsed with water after being in contact with the bleach.

As an additional harm reduction measure, discourage people who slash from cutting *along* (parallel to) their major veins and arteries. Slashing parallel to the veins and arteries (down the length of the arm from the elbow to the wrist, for example) is a *very* dangerous and potentially life-threatening practice, due to the risk of severe vein damage and loss of blood. Cutting *across* (perpendicular to) veins is one strategy that may reduce the risk of large scale vein damage or accidental death.

Finally, the unclean prison environment also poses increased risk of cuts becoming infected. To minimize the risk of other infection, encourage people who slash to wash their cuts carefully, to use polysporin anti-biotic ointment (in those institutions where it is available through health care or the canteen), and to wrap them with sterile bandages as soon as possible.

TIP:

When doing your HIV prevention educational session, identify the fact that you will be talking about many different risk behaviors. Point out that not all of the information will apply to everyone. However, it is important that all the information is discussed, because it might be useful for someone the prisoners know or care about.

Washing the area with soap and water prior to cutting can further reduce the risk of infections.

Slashing is another issue around which you as an AIDS worker may want further training. Seek out women's organizations or crisis centres in your community who are familiar with the issue, as such links can provide both a support to you, and a point of referral for clients.

Theoretical Risk Situations

When conducting HIV/AIDS prevention education in prisons, it is also important to be aware of areas of a *theoretical risk* of transmission. In simple terms, theoretical risk means a situation where it is scientifically possible for HIV to be transmitted, although in reality such transmission would be *highly unlikely*.

MAKE SURE to debunk the common myths of HIV transmission through:

- sharing a cell
- sharing bathroom and shower facilities
- sharing the telephone
- sharing food
- sharing cigarettes
- sharing plates, cups, and cutlery
- non-sexual physical contact (touching, hugging, shaking hands, etc.)
- spitting
- sneezing
- biting

In doing prison work, two theoretical risk situations often come into the conversation.

The first is that of the "bloody fight". A common question is, *"What if I punch a guy in the mouth and give him a bloody lip, but cut my knuckles on his front teeth? Am I at risk?"* The answer is, if either person is HIV positive, this situation does present a theoretical risk of transmission.

Another other common question regards cleaning up blood spills. *"Suppose after the fight the guards make me clean up the spilled blood, and I have a cut on my hand. Am I at risk?"* Assuming the blood is HIV infected, this again presents another theoretical risk situation.

The best advice, for prisoners and for staff, is to always observe universal precautions and wear latex gloves in all situations where blood is present.

Knowing How HIV is Not Transmitted

When doing HIV prevention education in prisons, dispelling myths about transmission is an important part of your task.

The group living environment tends to heighten fears about transmission. Therefore, you need to spend time talking specifically about how HIV and

Hepatitis C *are not transmitted*. This is of equal importance to discussing risky behaviours.

A frank discussion of how HIV is *not* transmitted is critical for promoting a less hostile atmosphere for prisoners living with HIV/AIDS.

You should also emphasize that, within the prison, the HIV-positive prisoners are at much greater risk of illness from casual contact with the HIV-negative prisoners than vice versa. Prisoners know that illnesses such as colds and flus spread very easily in the closed living quarters. Make sure to explain how very dangerous these sicknesses can be to people with weakened immune systems.

Giving Advice About HIV Testing

There is no mandatory HIV testing of prisoners in Canada, just as there is no mandatory HIV testing of any Canadian citizen.

HIV testing is generally available to prisoners by making a request to their prison health unit. The testing done in most institutions is known as "confidential testing", which means that the health unit shares all HIV-positive test results with the local public health department. The public health department then engages in "contact tracing" or "partner notification".

With only a handful of exceptions, such as some Saskatchewan and Québec institutions, *anonymous* HIV testing is *not* available in Canadian prisons.

With only a handful of exceptions, *anonymous* HIV testing is *not* available in Canadian prisons.

Prison is not a supportive environment for receiving an HIV-positive test result. Due to the real and pressing concerns about confidentiality within the prison system – as well as the frequent ostracization of prisoners known to be HIV-positive – many people choose not to get tested while inside. In addition, proper pre- and post-test counselling are rare in most institutions, which places further stress on prisoners testing positive. Many prisoners who tested positive inside have indicated that they received no information at all about the meaning and implications of their test result. Such neglect causes great anxiety, despair, and isolation for many of these individuals.

For these reasons, in some cases you may want to suggest that people interested in getting tested wait until they are released, so that they can access proper pre- and post-test counselling and support.

However, you should emphasize that when making this decision, all individuals must take into account their current health issues and the length of

their sentence. For prisoners experiencing potentially HIV-related symptoms, immediate testing is obviously more urgent. Similarly, for prisoners serving lengthy sentences, waiting to get tested until after release is poor advice. Still, a large percentage of prisoners – including all provincial prisoners – are released within a year or less. For many of these individuals, waiting to test in the community – at an anonymous testing site if possible – can be the best advice.

Talking About Hepatitis C

While your job may be to conduct HIV/AIDS prevention education, it is essential that you also be prepared to discuss Hepatitis C prevention within your prison workshop.

For most Canadian prisoners, 25-40% of whom are infected with the Hepatitis C virus, Hepatitis C is a more urgent issue than HIV. Therefore, your audience will probably have as many or more questions about Hepatitis C than about HIV, at least at first. As an HIV/AIDS educator, this awareness of and interest in Hepatitis C is actually an important opportunity for you to reach prisoners with comprehensive prevention information.

It is essential that you be prepared to discuss Hepatitis C prevention within your prison workshop.

In the prisons, you will also find that the stigma attached to Hepatitis C is much less than that of HIV. This is primarily because of the high rates of Hepatitis C infection among prisoners, but also because homophobia is not a barrier for Hepatitis C discussions in the way it can be for HIV/AIDS discussions. You will find that prisoners are generally very interested and open in talking about Hepatitis C.

Therefore, it is a useful strategy to begin your presentations by talking about Hepatitis C rather than HIV, because your audience will respond much more quickly and openly to this issue. People are much more open in disclosing their Hepatitis C risk behaviour, and you may also find people in your group freely disclosing their Hepatitis C status. All of these things will help to promote a good, participatory group dynamic that is focused on health issues. Since the transmission risks of HIV and Hepatitis C are similar, you can begin to work in your HIV prevention messages once you've established a group discussion about Hepatitis C.

This proven strategy demands that you educate yourself on Hepatitis C issues. This is again an area where you and/or your agency may need to seek out specific training. Contact your local chapter of the Hepatitis C Society of Canada, or public health department for more information and assistance.

Tackling Stigmatization

Due to persistent stigmatization in prison, prisoners living with HIV/AIDS will rarely come out to your workshops. PHAs fear that by showing any interest in the topic they risk calling attention to themselves.

It is useful to identify this fact near the end of your workshop. Talk about the fears people living with HIV/AIDS have about breaking their confidentiality, and the fact that many people who might benefit from the services of your agency will not come to your program because of that fear.

Be prepared to respond to discussions in the group about *"why HIV-positive people should disclose their status."*

Since trust issues are so central to prison relationships, prisoners sometimes feel that not disclosing one's status to friends, or to drug using/sexual partners is a breach of faith. Some will view mandatory testing/disclosure as a necessity to "protect" other people in the institution. These are common themes that come up in HIV educational sessions in prisons. Be prepared to facilitate such discussions, and to educate people about the importance of both confidentiality, and of us all taking our own responsibility to protect ourselves against HIV infection.

You should also be sure to address the fears and phobias that HIV negative prisoners may have about sharing living space with HIV positive prisoners.

Begin by reviewing the ways that HIV is *not* transmitted, and the fact that there is no risk of HIV infection from routine daily activities. (See *Knowing How HIV is Not Transmitted*, above.) Once this point is established, point out that within the closed living environment of the prison, people living with HIV/AIDS are very vulnerable to getting sick from other prisoners (colds, flus, stress, effects of inadequate hygiene and sanitary conditions). This illustration challenges the incorrect assumptions among many HIV negative prisoners that they are at risk from living together with PHAs. Be sure to emphasize that it is PHAs who are much more vulnerable to serious (even life-threatening) illnesses from being in group living environments.

TIP:

Once you have discussed the stigmatization issue, ask that each person in the group take a stack of pamphlets back to their range and leave them lying around. In this way, those people who couldn't or wouldn't come to the workshop can still find out about your agency – because information has a way of getting into the hands that need it. You will find that people will respond very positively to this request, and will be more than willing to bring the information back to their living units. Adding this request also provides good "cover" for those in the group who might actually want information for themselves, but are too fearful to be seen to pick it up.

III. Basic Advice on Running Your Prison Program

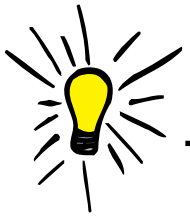
Now you have determined your outreach and program format/s and have developed their prison-specific content. Before you get going, there are a few key programmatic guidelines that have proven effective in a prison environment.

1. Be Open, and Prepared to Talk About Anything

If you come into the institution and try to strictly adhere to a traditional AIDS 101 presentation, you will be ineffective and most likely alienate your audience.

It is much more likely that the prisoners' first interest will be Hepatitis C, or overall problems in accessing health care, rather than HIV/AIDS issues. You need to be willing and prepared to go with whatever issues your audience raises, and provide accurate and accessible information and advice.

That's not to say you should ignore your job to provide HIV prevention messages, but rather that you prepare to do that in a more creative, and strategic manner – in the course of the broader conversation, and by drawing parallels or connections between HIV issues and whatever other issue you might be discussing. This is the art of doing HIV education within the prison setting, and it's a skill that you can develop with experience.



TIP:

"You can't con a con."

Never pretend to know more than you know. If you do not know the answer to a particular question, just say so. Offer to look up the information for the individual and mail it to them, or ask them to call you at your office if they can.

The more broadly knowledgeable you are on health, the more useful you are for the prisoners. By demonstrating a breadth of knowledge, and a willingness to discuss multiple health topics, you will drastically increase your own credibility amongst the prison population, and thereby the credibility of your program. If you earn a reputation for being able to talk about issues other than just HIV/AIDS, this also reduces the stigmatization of your program, and your audiences will be larger and more receptive.

2. Work in Pairs

It is generally preferable to work in pairs for any prevention education workshop or outreach opportunity.

Having two speakers – and two voices – to lead discussions can make for a more interesting and interactive experience for your audience.

Having a partner to share the work can also expand the opportunities for prisoners to access information. For example, commonly while one worker is speaking at the front on the room to the larger group, individual prisoners will seek out the second worker at the back of the room for more confidential one-on-one conversations.

For more open and informal outreach environments, where your program is more group discussion than formalized "lecture", having two workers to mingle in smaller groups again maximizes your ability to provide education.

This is not to say that both educators need be from the same agency. On the contrary, it is usually preferable to partner with outreach workers from different agencies, as this will help provide a greater scope of information, experience, and services for your audience. If your co-presenter works for an agency *other* than an AIDS service organization (i.e., a needle exchange, an Aboriginal organization, an STD clinic, etc.) it can also help to de-stigmatize your program.

Depending upon the institution, you may find it useful to have a man and a woman doing the workshop together. In other situations, you may find that two men or two women are more effective. This decision will become clearer as you become more familiar with the atmosphere of your local institution, and experiment with methods of delivering HIV/AIDS information.

There are also safety considerations for working in pairs. Having two community workers together can help limit any harassment you may receive from guards, or at least provide an outside witness should you encounter unprofessional treatment from staff and wish to complain. While there is no need to be afraid of working with the prisoners, for those community workers less familiar with the prison environment, having a co-presenter (especially one who *is* familiar with prison settings) will probably make you feel more secure and comfortable. The more comfortable and relaxed you feel, the more effective you will be.

TO BE SUCCESSFUL in the prison environment your base of knowledge needs to be much broader than it needs to be for the outside community. You must not only know HIV prevention issues, but also study up on issues such as:

- broader federal and provincial prison policies (especially regarding health care)
- drugs and drug use (both injection and non-injection drugs; prescription drugs and street drugs)
- Hepatitis A, B, C
- Tuberculosis
- tattooing
- STDs
- reproductive health and pregnancy (especially important for women's prisons)
- psychosocial issues (self-esteem, positive mental health strategies, etc.)
- harm reduction strategies

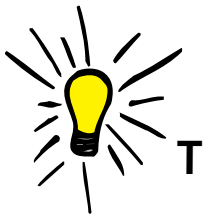
3. Use Peers

For an incarcerated audience, providing an HIV-positive speaker who has served time in prison is the single best method for giving out accessible information.

Make it a priority to use prisoner and ex-prisoner "peer educators" as part of your prevention education program.

Particularly if your agency is interested in utilizing *ex-prisoner* peers, there are several issues to keep in mind in creating the program.

The first issue is security clearance, because you may face difficulties getting ex-prisoners authorized access. For more detailed discussion of strategies for obtaining peer clearance, refer to *Common Concerns for Workers New to Prison Environments: Refusal of Security Clearance* in Chapter Four.



TIP:

Bring a supply of 8" x 11" plain envelopes along with your supply of pamphlets and other written materials. This allows prisoners to bring information back to their ranges while maintaining confidentiality.

The other main issue is providing adequate emotional support for the peers. For any PHA, standing up in front of an audience and discussing their life story can be a stressful experience. If the individual also has a long history of incarceration, s/he may find that going back inside the prison to do a "speak" presents an additional level of anxiety, and poses a number of potential triggers. The peer may not realize how difficult it will be until s/he is actually in the institution.

It is your job to ensure that every peer speaker takes the decision to participate having fully considered the potential implications and impact.

The peer may have done time at that particular institution. How do they feel about going back in? They may know people in the institution, either prisoners or staff. How would they feel about having someone they know in the audience? The peer may not have disclosed their HIV status while incarcerated. How would they feel about disclosing their status if there are people they know in the audience? Perhaps they may encounter people with whom they shared works or had sex. They may be concerned that they will end up back inside at some point. The peer may also experience feelings of guilt or abandonment over being able to walk out of the institution at the end of the day, while leaving their friends and peers still locked inside.

All of these situations can present additional stresses for the peer speaker, and need to be clearly addressed *prior* to going in to do a program. Make sure to sit down with the peer beforehand and review these issues with them. This is the best way to ensure that they are not caught in a situation

for which they are unprepared. You must also make sure to allow time after you have left the institution to debrief the peer/s and to offer them some additional support.

A broader discussion of the use of peers, and of establishing peer education programs, is beyond the scope of this manual. Indeed, it could be a manual in itself. However, many AIDS service organizations (ASOs) and other groups have utilized peer educators over the years. If you are thinking about starting a peer program, call around to ASOs in your region for direction or referral. You may also call PASAN directly for information on our own program.

4. Provide "Cover" When You Advertise Your Program

How to advertise your program is a crucial decision, because how you choose to promote your program will determine who – if anyone – comes out to participate.

In prisons, an "AIDS Awareness" program will attract far fewer participants than a "Health Information" program. Therefore, it's important to strike a delicate balance between advertising your AIDS program as accurately as possible, and making it "neutral" enough so that people will not feel stigmatized by attending.

Beware the danger of giving your program too generic a name, however. If you give your program a billing as broad as "Health Information", you will attract a lot of people looking for information on cancer, heart disease, diabetes, tuberculosis, etc. Unless you are ready and qualified to provide this breadth of health information, you need to come up with a title that is more self-limiting.

Advertising your program as talking about drug use and methadone can be one effective way of attracting an audience, and also provide an easy and logical link to discussing HIV. (In this case, don't forget that you must also be prepared to talk about Hepatitis C.)

5. Foster Group Participation

Remember that you are the outsider coming into the prison environment. While you have expertise in HIV prevention strategies, the prisoners in your group will have expertise on the environment in which they are living. It is essential to bring these two bodies of knowledge together through the forum of your program. This can only happen by involving the prisoners in

TIP:

"You can't con a con." – PART II

When doing workshops for prisoners, some people feel the need to embellish their own life histories of drug use, or conflict with the law. If you do indeed have a real history in these areas, disclosing that fact can be of significant advantage to you in connecting with prisoners on a peer-to-peer basis. However, if you don't have such history, NEVER create or exaggerate one. Getting busted by campus security for smoking a joint while at university is not *comparable to doing a ten-year bit. It's silly and disrespectful to even make such comparisons. Never pretend to know more than you know.*

the discussion, and by creating an atmosphere in which they feel comfortable and motivated to discuss issues with you.

In order for your prison workshop to be effective, therefore, you must create a participatory atmosphere. Don't expect to do a theatre-style lecture, where you are standing at the front of the room and the prisoners are a passive, silent audience.

In some cases, you must use facilitation skills to draw out conversations from reluctant participants. In others, you may need to constructively manage raucous debates, ensuring that accurate HIV information does not get lost in the fray.

In more "open" environments, you will find that people will drop by over the course of the evening just to see what's going on. Some people will stay for the whole program, while others may leave half way through. Some programs might have two or three people participating, while others might have twenty or thirty. Rarely, if ever, can you predict any of this before hand. You must instead be prepared to do the most effective work with whatever group you have in front of you.

Likewise, in the prison context, do not equate "rapt attention" with effectiveness, nor casual attention with failure to reach people. Instead, accept that an informal atmosphere – complete with comings and goings – will ultimately allow you to reach larger numbers of people, and allow prisoners to access your program in a more "anonymous" way. It can also provide the opportunity to distribute written materials more widely, and to engage in ongoing group and/or individual discussions, which may have more impact on some prisoners than a formal presentation.

TIP:

Title the back page of your pamphlets "Contact Numbers" and leave the rest of the page blank. Many prisoners will use this space to write down notes to themselves, phone numbers, etc. If people write down their own information on the pamphlet, they are more likely to keep it and bring it back to their range, rather than simply throw it away.

6. Manage Group Dynamics

The group dynamics of prison programs are very different from those in outside community programs. You should be prepared for this.

Learning how to work effectively within this particular environment comes with time and practice.

One of the first things you should anticipate is that everyone in the group will want to talk at the same time. This includes people talking to you, and people talking to each other in separate conversations. This is a different experience than most outside community presentations, where audiences generally listen quietly, and take turns speaking. However, this communication dynamic is the everyday norm within the often noisy and over-

crowded prison environment, so it's not surprising that it will carry over into your program.

Additionally, your program will likely mix people housed in different areas of the institution, and so your workshop might be one of the rare times that friends are able to see each other. It is therefore natural that they would want to talk together about their own stuff, regardless of what you are presenting. *Do not take it personally*. Being comfortable within – and able to manage and facilitate – this often chaotic dynamic takes practice.

Personal power also has a significant impact on group dynamics within the prison. The prisoner culture is strictly hierarchical, and some prisoners merit a great deal of power and authority. They may be popular or well respected based on their character or personality. They may be individuals who are tough and feared. They may be people controlling elements of the underground economy, such as drug dealing. On the other extreme, some prisoners are held in great disdain by their peers. They may have been convicted of sexual offenses, or crimes against women or children. They may be seen as "rats", and generally untrustworthy. They may simply have unpleasant or annoying personalities. If you are new to the prison, it may take you a bit of time to figure out who is who in the social strata, but it is something you must be alert to.

Who is present in your program will also influence how people interact with one another, and how comfortable people feel in disclosing personal information. A vibrant and open group discussion may immediately die when a "rat" walks into the room. On the other hand, an unresponsive group may open up when a respected con begins to ask questions and show interest in the topic. Again, this is something you will usually have no control over, so be prepared to adapt as necessary.

Over the course of a ninety-minute workshop, you may experience several ebbs and flows in the group dynamic based solely upon who is in the room at any given time. This will be particularly true if staff is present. *It's always preferable that staff not be present in your program*, because this will reduce people's comfort in disclosing personal information, particularly about drug use. You may find that guards will pop in and out of your program at different times. When this happens, you should expect that the group discussion will fundamentally change when staff is present in the room. If you experience problems in this regard, consider having a discussion with the guard/s on duty before the program starts. Sometimes they can be quite accommodating.

TIP:

Opening questions for starting conversation in your program:

"What's the health care like in this institution?"

"What's the smoking policy in this institution?"

"When do you get canteen? Can you get healthy food from canteen?"

"The guard at the front gave me a big hassle getting in today. Are they always like that?"

"What's the food like in this institution?"

"Do they piss test you at this institution?"

"Can you get access to bleach at this institution?"

7. Be Consistent

As discussed in Chapter One,[9] trust-building is a crucially important aspect of developing prison programs. Therefore, consistency on your part is essential.

Fulfill your commitments.

TIP:

Seating arrangement is particularly important. Avoiding a standard lecture-style format helps reduce the perception of you as "the teacher", and promotes a more informal, relaxed, and conversational atmosphere. Setting up your session in a circle, or around a table, will encourage people to participate.

8. Be Aware of Literacy Issues in Developing Your Printed Materials

As discussed in Chapter Two,[10] many prisoners have low literacy and educational levels. Others may have learned (or be learning) English or French as a second (or third) language, and so may have difficulty functioning in English or French.

For these reasons, it is important to ensure that your printed materials are accessible for this audience.

Use plain language. Use the vernacular. Use illustrations and diagrams. If you need help in developing materials at an appropriate literacy level, seek the assistance and advice of a literacy and/or ESL organization in your community.

Prisoners and/or prisoner groups themselves can often be very helpful in developing or advising on appropriate printed materials.

9. Evaluate Your Work

Evaluation must form an ongoing part of your HIV/AIDS prevention education program.

Only by honestly reviewing the effectiveness of your work can you ensure the highest quality programs for prisoners. Evaluation also plays an important part in justifying the value of HIV/AIDS and prison work to your organization, your funders, and the prison administration.

Evaluation at the end of your workshops can and should take many forms.

You might distribute written feedback forms to prisoners. Again, be aware of and sensitive to literacy issues. Keep it simple, use tick-boxes as well as space for written comment, and make sure to read through the form with the group.

[9] *Building Relationships: The Foundation of Prison Work – Building Relationships Between Yourself and the Prisoners.*

[10] *Canadian Prisoner Populations: Who Goes to Prison and Why?*

You might also use the last five minutes of the program to generate verbal feedback. Questions such as *"what would you like me to focus on next time?"* will give you a good indication of information you overlooked, and provide an easy opening for people to identify those topics.

You might also periodically talk with the prison health care staff, who may have a sense of the impact of your program. Are they receiving more requests for information on HIV or Hepatitis C since your last workshop? Have they heard any complaints about the format, or about the accessibility of the program (time, location, etc.)?

All of this information is valuable in helping to ensure that your program continues to improve.

10. Document Your Work

As with evaluation, maintaining good written documentation of your program is an important part of effective program management.

Keeping good records will help you evaluate the impact of, and participation in, your program over time. It is also useful information to have, should the institution raise questions about the usefulness of your program. If you leave your organization, these records will also provide an invaluable resource for new staff coming into your position, and help ensure a smoother continuity of service.

TIP:

Laughter is good medicine, so don't be afraid to use humour. You're talking about serious issues within an oppressive environment, but this doesn't mean you can't have a good time in your program. Humour is a great tool for group bonding and for increasing everyone's comfort level. It is also useful for deflecting or alleviating any hostility that may arise.

IT IS USEFUL to create a one-page standardized recording form that includes:

- the date, time, and location of the workshop
- the name/s and phone number/s of the contact person/s at the institution
- the number of participants
- the information covered
- any written materials distributed
- any new issues arising
- any incidents or problems
- the evaluation results
- any further comments

IV. Conclusion

This chapter has provided a breakdown of the nuts and bolts of doing HIV/AIDS prevention education and outreach in prisons. Now you know some of the options for accessing prisoners, and some reliable strategies for making the content and structure of your educational programs accessible, relevant, and effective.

However, it is important that this chapter be viewed only as a guide to potential opportunities, and not as a complete and comprehensive list of every option possible.

Perhaps the most important element in doing effective prison programming is flexibility and adaptability.

As a worker hoping to do HIV prevention education and outreach in prisons, you must be ready and able to change your approaches to different situations that present themselves. Your local institution may provide an opportunity to structure a program in ways other than those described above.[11] If that opportunity seems a valuable one, grab it. Don't worry that it's not addressed in this manual. You must always strive to reach prisoners in the most meaningful and least stigmatizing manner. If one of these recipes doesn't meet your specific needs, invent a new one, and please tell us about it so we can learn from it and share it with others.

The same goes for the content and structure of your programs. View the above guidelines as ideas that have worked in some situations. If the information and ideas fit the needs of your particular environment, use them. If they don't, use the above advice as a template to creating your own unique educational tools. The nature of effective HIV/AIDS education is that it must always change and evolve to stay relevant and interesting. The challenge you face is taking the above knowledge and applying and adapting it over time to meet the changing needs of prisoners in your region.

Finally, it is crucial that the role of advocacy not get lost in the discussion of HIV/AIDS prevention in prisons.

No matter how extensive your access to prisoners, no matter how clever your prevention messages, without access the basic tools of HIV prevention (condoms, sterile syringes, etc. as discussed in Chapter Three), the options that people in prison have to protect themselves from infection are severely limited. Therefore, advocacy for institutional and systemic change must go hand in hand with providing direct educational services. The nuts and bolts of advocacy are discussed in greater detail in Chapter Six.

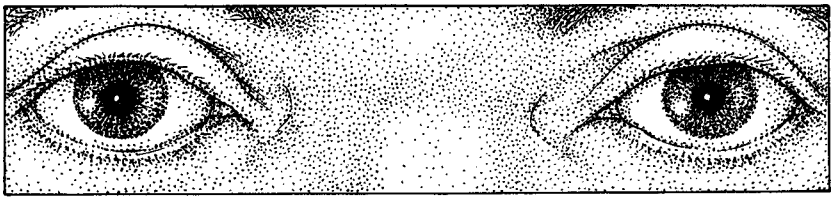
[11] For example, see the program described in *"Inside" Information: The Sherbrooke Detention Centre Experiment.*

As an individual worker, you should familiarize yourself with the recommendations made in the several comprehensive documents published on HIV/AIDS in prisons over the past ten years (see *Further Readings: Useful Publications* in the *Resources* Section). You should also be documenting everything you encounter in your work relevant to those recommendations, such as barriers to community programs, anecdotal evidence of barriers to prison-approved HIV prevention materials, and the need for implementation of new HIV prevention programs. Documentation of such information on a local level is crucial to identify national trends and needs, and to advocate effectively for change.

As an agency, you should be utilizing the information documented by your staff to advocate for changes to prison regulations at a local, provincial, and/or national level. Contact the community-based organizations that have taken leadership on this issue (listed under *Contact Information: Useful Community Contacts* in the *Resources* section) and lend your support and local knowledge to the effort to extend equal health care rights to prisoners.

The next chapter looks at ways to support the needs of people living with HIV/AIDS in prison, and strategies to advocate for changes in individual prison conditions. You will find information on using the telephone as your main support tool; visiting with clients; advocacy strategies; writing effective advocacy and support letters; testifying in court; client advocacy at parole hearings, detention review hearings, and compassionate release hearings; and providing additional support through pre-release planning.

"INSIDE" INFORMATION



Traditional and Cultural Healing for HIV Positive Aboriginal Prisoners

by NaWalka Geesy Meegwun (Long Feather) Lyndon George,
Ontario Aboriginal HIV/AIDS Strategy, Guelph, Ontario

ALL THE ABORIGINAL PEOPLE I have worked with who are living with HIV and AIDS and who are incarcerated are dealing with stressors well above and beyond the disease itself.

In addition to the issues common to all HIV positive prisoners, Aboriginal HIV positive prisoners also experience a huge amount of stress because of cultural insensitivity or outright racism on the part of the institution, discrimination and threats from other inmates (both Aboriginal and non-Aboriginal), and other emotional issues related to their specific experiences as Aboriginal people.

It would be difficult to find one Aboriginal person who has not been influenced by the experience of racism or discrimination. It would be equally difficult to find an Aboriginal person who has not felt the negative impact of injustice, and who has not had trust broken to some degree.

As an Aboriginal person who has worked in federal institutions in Ontario, I have felt the cold and bitter hand of racism and discrimination myself. I have witnessed it first hand in many of the institutions. In my experience, Aboriginal people living with HIV and AIDS who are incarcerated find themselves confined in institutions brimming with racism, discrimination, intolerance, hatred, mistrust, and ignorance.

Given these stressors, Aboriginal HIV positive prisoners need not only physical healing, but spiritual healing as well. They are also in need of *cultural healing*.

Aboriginal people have been raped of our culture, and stripped of our pride. The 500 years-plus of oppression has resulted in a loss or abandonment of our traditional cultural values, morals, attitudes and beliefs. Many Aboriginal people now accept and conform with a foreign culture – a system of values, attitudes, beliefs, and morals that is very different from our own traditions.

These changes in values and resulting behaviours happen when we become separated from our traditional teachers. This separation has produced many problems within Aboriginal communities in both rural and urban environments, including the Aboriginal communities within federal and provincial institutions.

Probably one of the most problematic sets of attitudes and behaviours we have accepted from foreign culture is that of

prejudice and discrimination, in the form of homophobia and AIDS-phobia.[1]

Our acceptance of these foreign beliefs, and continued isolation from our traditional cultures, practices, and customs, have contributed to our misunderstanding of HIV and AIDS. This misunderstanding has influenced Aboriginal attitudes towards HIV and AIDS, and our attitudes and behaviours towards those who are living with HIV and AIDS.

Aboriginal homophobia and AIDS-phobia therefore aggravate the already high levels of discrimination and hatred that Aboriginal HIV positive prisoners experience within the institutions. Aboriginal prisoners living with HIV and AIDS very often find themselves ostracized from the larger Aboriginal community behind the bars, known as the Brotherhoods and Sisterhoods.

There are a *few* cases where Aboriginal prisoners living with HIV/AIDS have succeeded in creating strong traditional and cultural bonds with the broader Aboriginal population. Unfortunately, however, many Aboriginal inmates still have a limited understanding of HIV/AIDS issues. They may also be unaware of current statistics related to HIV, AIDS and Aboriginal people, and of traditional Aboriginal sexuality, with its inclusive history of homosexuality. Aboriginal prisoners are also subjected to both peer pressure from other inmates to reject homosexuality, and to CSC guidelines dictating and enforcing the intolerance of homosexual activity.

Finally, Aboriginal prisoners lack supportive programming that would help them to discuss issues relevant to hatred, racism, prejudice, discrimination, injustice, isolation and above all, trust.[2] These difficulties confront both Aboriginal prisoners and the HIV/AIDS workers who go into the prisons to work with them.[3]

This ongoing isolation and mistrust – even between Aboriginal prisoners themselves – further reinforces the need for spiritual and cultural healing.

If Aboriginal HIV positive prisoners have additional and specific needs, Aboriginal culture has a means of providing them with the necessary supports, through traditional healing.

Traditional healing includes the healing of the emotional, physical, mental, and spiritual being. Through our forms of traditional practice and ceremony we address issues that relate to discrimination, racism, and prejudice. These things bring pain and discomfort to an individual, and often play very important roles in illness and suicide.

The most common cultural practice that we have for addressing these issues is the incorporation of the wisdom and experiences of our community Elders. Elders are valued teachers in our communities. They bring stories of our ancestors that teach us about life, and help us learn to deal with harsh realities such as discrimination, racism, and prejudice.

Other important individuals in our traditional and cultural communities are the spiritual leaders. They come with many different gifts such as healing, seeing the future or the past, or the gift of song and music. Our spiritual leaders provide us with teachings about our history and our culture that assist us in understanding the teachings behind life circumstances and situations, and how they directly relate to us. They provide us with a way to look within ourselves to find meaning in the teachings and, more importantly, to discover how the teachings affect us.

This learning process happens through various cultural and traditional practices and ceremonies. It also incorporates an oral educational tradition that is

very important in the Aboriginal culture. This involves intense story telling about personal experiences.

Story telling is one of the most valued and informative teaching processes that we have as Aboriginal people. Traditional stories and cultural folklore help us to understand the world in a very culturally specific manner. Our stories teach us about who we are as Aboriginal people, where we fit within Canada's multicultural framework, and who we are as individuals (our Aboriginal self-identity).

These traditional teachings and practices not only promote healing, but can also help break down the isolation and mistrust experienced by HIV positive Aboriginal prisoners by reinforcing traditional values of inclusion and acceptance. Traditional and cultural healing can therefore have a profoundly positive impact on HIV positive Aboriginal prisoners' health and well-being.

Despite the potential benefits, Aboriginal HIV positive people who are incarcerated have yet to receive consistent and positive traditional and cultural programming.

One of the biggest problems I found within the institutions is the lack of Elders' and Spiritualists' participation in the delivery of HIV/AIDS services, and in harm reduction and prevention education. Community Elders and Spiritualists *must* be directly involved in the delivery of HIV/AIDS information to provide it with relevance, validity, and importance to other Aboriginal people. They can provide an understanding of HIV and AIDS that would be both culturally and traditionally sensitive, from an Aboriginal perspective.

However, when Elders and Spiritualists *do* get involved in HIV/AIDS services in prisons, their programs are frequently undermined by persistent ignorance, racism and discrimination, and intrusion by institutional staff.

In light of this problem, the Correctional Service of Canada (CSC) has attempted to introduce a number of *Commissioner's Directives* to allow Aboriginal people within federal correctional institutions to maintain or facilitate important cultural and traditional practices. These *Directives* provide CSC staff with an outline of Aboriginal culture that includes naming important differences in cultural approaches to learning, definitions of the extended family, and descriptions of the roles of Elders, and of spiritual and cultural ceremonies and practices, and ceremonial objects.

Despite the *Directives*, from my professional experience as an Aboriginal service provider to many federal institutions, it is clear that many CSC staff *do not* understand or respect Aboriginal culture. This may be because the CSC guidelines fail to adequately convey the importance of the sweat-lodge, the pipe ceremony, our Elders, medicine people, medicine bundles, etc. in our everyday routines. As a result of their continuing ignorance, some members of CSC staff continue to engage in behaviour that violates official CSC policy in this regard.

While working in the federal correctional institutions, I found a series of problematic situations, behaviours and attitudes on the part of security staff.

For example, although the *Directives* specify that medicine bundles are not to be manipulated or exposed by CSC staff, there are many occasions when this has happened.[4] I have had my own medicine bundle desecrated in a cross-gender search. From the Aboriginal perspective, these teaching, training, and healing tools and medicines are no longer clean (good for use) after such handling, and have to be dis-

carded or properly cleaned through spiritual and cultural practice.[5]

Extreme levels of racism and discrimination continue to confront Aboriginal Elders and Spiritualists who try to enter the federal institutions. I have seen our Aboriginal female Elders strip-searched in open public view. I myself have been refused entrance into institutions on many occasions, as a result of security staff denying access to my medicine bundle. Such experiences frequently influence Elders' and Spiritualists' decisions not to return to provide services.

In my view, CSC security staff would benefit from specifically designed cultural sensitivity training. The *Directives* alone are clearly not enough.

As they stand, the *Directives* lack the information that would help CSC staff understand the importance and the significance of cultural issues as they relate to the Aboriginal *person*, and more specifically their importance to the Aboriginal *offender*. A clearer and more precise understanding of the significance of Aboriginal cultural practices, ceremonies, objects, and interactions should help alleviate the misunderstandings and the illusions that many non-Aboriginal people harbour, and create a better working knowledge of Aboriginal culture.

Such knowledge and understanding would also benefit all HIV/AIDS workers with imprisoned clients.

Aboriginal people are experiencing an epidemic of HIV and AIDS. We cannot afford to limit the services of either conventional or traditional forms of healing to First Nations people. However, for the reasons I have given, services for Aboriginal populations are far more beneficial and effective when they are delivered by Aboriginal people. We need the opportunity to address HIV and AIDS in a manner that recognizes our cultural forms of healing, practice, and traditions.

Aboriginal people within federal and provincial institutions must have an equal opportunity to become educated on HIV and AIDS and related issues, in a way that is culturally appropriate, and that utilizes both traditional elements of healing and mainstream harm reduction strategies that will enable Aboriginal people to prevent or survive unnecessary infection.

Aboriginal people have survived and conquered many conflicts that have crossed our path. We have struggled to re-identify with a culture that was threatened with extinction. We have survived because we have become an active party to our situation and circumstances in Canada. We have become educated in a foreign system that once dictated assimilation, and have begun to speak loud and clear for ourselves. We cannot afford to assume that others will act in our best interest. We will make sure our interests are well protected and acknowledged by becoming actively involved in all situations that are relevant to our survival as a unique culture, and as Canada's First Peoples.

Those who wish to support us in this process should consult, include, and build alliances with us, and above all, respect our experiences and leadership on these issues.

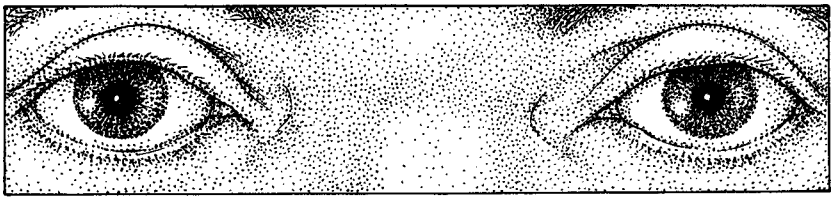
[1] An Elder once told me that we, Aboriginal people, have been very good students. We have become oppressed oppressors. To this day, I take this teaching with me everywhere.

[2] Trust has been a central issue with Aboriginal people for many years. Understanding the full implications of trust as an Aboriginal issue requires a critical understanding of the historical and current relationships between Aboriginal people and Canada. History is not confined to the dustbin of the past. It is very much alive for Aboriginal people, and part of a continuum of Aboriginal/non-Aboriginal relations today.

[3] Given the centrality of the trust issue, for HIV/AIDS workers to work effectively with the Brotherhoods and Sisterhoods in the institutions, there must be a reasonable amount of time allocated to develop the trusting relationship between the outsider (whether Aboriginal or non-Aboriginal) and the incarcerated Aboriginal population. A continued and consistent program offering traditional Aboriginal cultural values of respect would benefit the process of building trust relationships, and thereby weaken the current attitudes held by many Aboriginal inmates toward those who are living with HIV and AIDS.

[4] A "medicine bundle" is a sac, bundle, or container that has been prepared by a traditional Aboriginal person. It may contain various sacred medicines, such as tobacco, cedar, sage, and/or other plants, roots or medicines seen to be beneficial by Aboriginal people. The medicine bundles are usually prepared specifically for an individual, and are assembled and constructed based on their unique needs. Medicine bundles are prepared for many different reasons, to heal the physical, emotional, mental or spiritual being of a person. The medicine bundle is considered highly spiritual in Aboriginal culture.

[5] Many believe that there are different medicines that men and women use, and that neither should use the medicines specific for the other. Likewise, we believe that the process of building the bundle includes the use of spiritual forces that can exert a powerful influence on the effect of the bundle. Therefore, if a woman, for instance, should happen to examine the bundle of a man while she is on her moon cycle, the power and strong energy from this gift may overwhelm the medicine bundle and cause spiritual confusion. Equally, if a male should examine the bundle of a woman, this can also cause spiritual confusion. Cross-cultural examination is often thought to have similar affects on Aboriginal medicine bundles, meaning that handling by a non-Native person could cause spiritual confusion and chaos to the bundle.



Black Coalition in Prison

by Trevor Gray, Coordinator, Men2gether Project
Black Coalition for AIDS Prevention (Black CAP), Toronto, Ontario

THE MISSION of the Black Coalition for AIDS Prevention (Black CAP) is to reduce the spread of HIV infection within the Black communities, and to enhance the quality of life for Black people living with or affected by HIV/AIDS.

When most people think about "community", prisons do not come to mind. However, we at Black CAP take a different view. We believe that the inmates in these institutions are just as much a part of our communities as we on the outside are.

For almost a decade, Black CAP has been involved in advocacy, outreach, and support in various prisons in the Metropolitan Toronto area, and other parts of the country. We receive many calls from Black inmates, and are very open and willing to build relationships with them while they are inside, and to continue these relationships after their release.

In my role as Education Coordinator, I have conducted workshops and presentations for male inmates from the African and Caribbean communities in the Metro West Detention Centre in Toronto, as well as in Warkworth, Joyceville, and Kingston federal penitentiaries. Black CAP's Support Coordinator has also worked with women incarcerated at the Vanier Centre for Women in Brampton, the only provincial correctional centre for women in Ontario. Her work has involved both supporting Black women prisoners living with HIV/AIDS, and participating with PASAN in outreach and education programs.

For Black people living with HIV/AIDS, living in prison does not make coping with the disease any easier.

Our imprisoned clients routinely tell us of the specific difficulties they face as Black people in accessing adequate health services and social supports.

For example, proper diet is obviously of great importance to HIV positive people. But poor diet – and particularly the inability to access culturally appropriate food in prison – is one complaint we hear most often from our imprisoned clients.

Some might think this is a luxury, but it is actually essential for Black PHAs' health. For all people, eating is more than just a source of nourishment for the body. It has significant emotional and social aspects as well. Cultural foods are therefore essential for all people's health and well-being. But in prison it seems to be burgers and fries all the time.

There is no good reason for this. It's not that culturally appropriate foods are

more expensive for corrections to provide. In many cases, prisoners in federal penitentiaries would have the ability to grow cultural foods in the prison farms and vegetable gardens, if only encouraged or allowed to do so. In one federal prison I visit, the Black inmates have to pool their spare money together in order to purchase culturally appropriate foods for themselves. It is disgraceful that this is the only recourse available to them. In many prisons, even this would not be allowed due to institutional regulations.

Obstacles to maintaining ongoing family contact and support is another big issue for our imprisoned clients.

Black inmates often feel frustration at not being able to financially support their families (some of whom are quite vulnerable economically) while they are away in prison. In addition, their family members frequently find they are treated disrespectfully by prison staff when trying to visit their loved ones. Both experiences increase the trauma for both the inmates and their families.

So racism and economic marginalization of Black people in Canadian society have specific effects on our imprisoned clients and their families that we have to help them deal with.

Another example of this for our clients is the way in which Black prisoners are denied equal opportunity while in prison, further reducing their post-release prospects.

Assumptions and prejudices of prison staff frequently create barriers for many African and Caribbean inmates trying to access programs. For example, staff often stream Black inmates into manual labour and work programs, rather than directing or encouraging them to participate in educational opportunities.

Again, there is no excuse for this. Inmates' files generally have details of their education, and their literacy levels. Therefore, corrections has all the necessary information to identify and help those people most in need of educational opportunities. But in my experience this rarely happens as it should.

Prison programs *should* be designed and available to help all inmates enhance their abilities, and enable them to create change in themselves. However, this will not happen for Black inmates unless equal access is provided to everyone in the system.

In addition to our work educating and supporting Black prisoners on remand or serving time, Black CAP also works in collaboration with Community Residential Facilities (CRFs) – halfway houses – to do outreach and support to Black people on day parole or other forms of release.

This job is made more difficult because Black inmates frequently experience discrimination when they apply for parole to halfway houses, and as a result few are approved. In my experience, this is not because Black inmates do not apply for parole to CRFs, but because their applications are more likely to be stockpiled and forgotten.

Halfway houses are rarely proactive in encouraging or assisting Black inmates to access them. This is because there is often a perception among the staff that a Black caseload is more "difficult" to handle. There is an assumption that Black inmates will break their parole conditions, so the feeling is *"why even bother to go through the effort to bring them here?"*

Those few Black inmates who *do* get paroled to halfway houses face other forms of discrimination once they get there. It's been my experience that, like prison streaming, white people in halfway houses are

encouraged to go to school during the day, but Black people are encouraged to get a job. Equality of opportunity is therefore an issue in CRFs as well. This pattern is even more disturbing, as those inmates who work must pay a percentage of their wages back to the halfway house, but this is not the case if they go to school.

As in prison, access to family is also an issue for Black inmates living in halfway houses. Halfway house staff often behave differently towards Black family members. Their perceptions and attitudes towards Black women are particularly troubling.

I myself have witnessed on several occasions Black women arriving at halfway houses to visit their male partners, only to be told by the staff on duty that their partners are not there. But we all know that they must be there, because all inmates have to be back at the halfway house by a set curfew time, or else be subject to arrest.

I remember one incident in particular when a woman was made to wait outside the halfway house in the winter for fifteen minutes or more. Eventually the staff sent her away, telling her that her partner was not there. This woman went down the street to a telephone booth and called the halfway house: her partner indeed *was* there.

This is just one example of the kind of insensitivity and lack of equality of access that Black people must face in the system. It is also an example of why cultural competence training is so essential for all correctional staff. They must be able to work non-judgementally with the whole diverse prison population. We can have all the correctional policies in the world that forbid discrimination, but if these are not applied in practice and violations penalized, this situation will continue for our clients. Promises and "policies" are not enough. Our HIV positive clients suffer as a result of this treatment.

At Black CAP, we do our best to provide the support and advocacy these clients need around all these issues.

While many of the problems our clients face relate to institutional policy and practice, and racism, our clients also have to deal with AIDS-phobia within the Black community itself, where being a prisoner or ex-prisoner and living with HIV is like having a double stigma.

This means that confidentiality is of prime importance to our clients – both inside and outside of prison.

Many PHAs who connect with Black CAP while they are inside never tell their families about their HIV status, and are released from prison without their families knowing they are living with HIV/AIDS. This is a reality that Black CAP understands and respects. It means that we must always be sensitive and responsive to individual client needs around confidentiality, and adapt our services accordingly.

Supporting Black HIV positive inmates on parole or after their release is another important and challenging area for Black CAP.

The stigma that persists around HIV/AIDS within the Black communities creates both barriers and confidentiality concerns for these clients.

Many Black PHAs fear the possibility that others in the Black community may find out that they are HIV positive. Accessing AIDS services can therefore seem particularly risky to them. This presents challenges to Black CAP in providing services to people in our communities in a way they feel is confidential.

This means our Support Coordinator has to be flexible in her work, and be willing and available to meet clients off-site, in

ways and places that they feel comfortable.

This need for enhanced confidentiality measures is no less important for many Black ex-prisoners.

Other barriers to our clients accessing the HIV/AIDS services they need have to do with homophobia.

A lot of people who hear about Black CAP assume it's a gay organization. The perception that Black CAP is strictly a gay organization leads some men to stay away from our programs.

To address this barrier, Black CAP always emphasizes that our mandate is to serve the whole *Black community*. As a result, many more people have come to know our mission and values. But there are others who still stay away, and this includes some prisoners and ex-prisoners.

Providing and promoting meaningful services is another way we work to overcome this barrier. For example, not everyone is interested in participating in groups or programs. Some people just want to access a particular service. They don't care about the organization *per se*, or the broader mandate of the agency, they simply want the help that a particular service of ours provides. We therefore allow clients to connect with the agency in specific, limited ways in which they are comfortable. This has increased accessibility for all our clients – both prisoners and those in the outside community.

Another example of Black CAP's willingness to adapt our support services to meet the specific needs of our community is the support we provide our clients on immigration issues.

This is a particularly challenging area for Black CAP, as it is not part of our mandate *per se*. It is not a service we would advertise ourselves as providing. Still, questions about immigration are a major issue for many of our clients, as there can be concerns about their immigration status, and the possibility of deportation and family separation. This causes huge stress, not only for the client, but also for their family. It is therefore important that we can provide some basic information, and appropriate referrals. Since immigration matters are such a significant concern for our clients – and especially for prisoners and ex-prisoners – we have had to adapt to meet these needs.

This type of flexibility – allowing clients to identify their own needs and priorities, and then building programs and services that address them – is a crucial component of effective HIV/AIDS work. It's particularly important when working with inmates and ex-inmates, whose needs are often different than those of our clients not in conflict with the law.

While we *are* committed to serving the whole Black community, doing HIV work with inmates is not always easy for Black CAP's staff.

As a Black man going to do work in prisons, I have had to deal with racist attitudes by the staff myself. There is always an assumption by the guards that I am there on a personal visit, rather than to carry out my work as a professional. Every time I show up at a prison, I automatically get placed in the (family) visitors' line. I can't remember ever gaining easy access, whatever the prior arrangements. Messages don't get passed. Faxes get lost. Even when I bring my own copies of documents and letters from the institution, things are still difficult. My documents are scrutinized more closely than those of others. Still, it's important not to allow this type of behaviour to deter you from your work, or drive you away from prison work altogether.

I know the prison work is important, that my clients depend on me, so I keep

going. I know that appropriate services and supports for Black prisoners and PHAs are precious few.

While Black prisoners and PHAs have specific needs as a result of *who they are*, not all Black prisoners in Canada will necessarily have access to Black community supports such as those provided by Black CAP. However, this shouldn't mean that these prisoners and ex-prisoners have to go without the services they need, and could get from other agencies.

While the issue of representation and staff diversity is an important one in HIV/AIDS organizations, it is not necessarily the case that you need to have a Black case worker in order to work with Black clients.

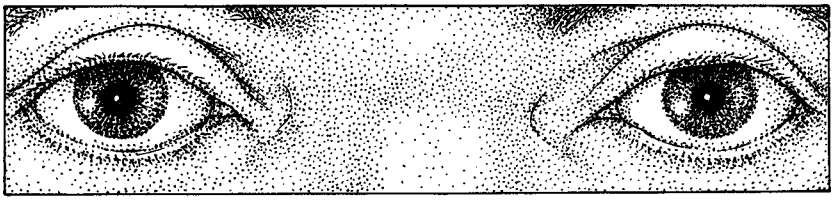
However, it *is* essential that *all* workers receive training on cultural competence and anti-racism issues. It is crucial that non-Black workers be able to engage respectfully with people from Africa, or people from the Caribbean, and that organizations are made welcoming and accessible to the community as a whole.

Finally, the Black community in Canada is very diverse. When working with Black people, HIV/AIDS workers need to avoid a "one-size-fits-all" approach.

It's essential that HIV/AIDS workers take the time to listen, and allow Black people to identify their own needs. It's only through this process that we can all begin to build the kinds of relationships, and provide the kinds of support, that will most fully meet the needs and enhance the lives of Black people living with HIV/AIDS.

For our part, Black CAP remains committed to providing culturally appropriate, flexible, and responsive HIV/AIDS services to Black inmates, and to bringing our work to places such as prisons – where the incidence of HIV infection gets very little attention from either the government or the general population.

"INSIDE" INFORMATION



Breaking "Out": Same-Sex Relationships, Homophobia, and HIV/AIDS in Prisons

by John MacTavish, Regional Services Coordinator,
Patti McGuirk, Prison Support Coordinator,
and Jeffry Piker, Education Coordinator,
HIV/AIDS Regional Services, Kingston, Ontario

LIKE EVERY COMMUNITY across Canada, every federal and provincial institution is populated by individuals with an array of sexual orientations.[1] However, for most inmates, at least for the duration of their incarceration, same-sex sexuality is the only sexual outlet available to them other than auto-eroticism (and, for some, occasional private family visits with opposite-sex spouses). Therefore, same-sex attraction and behaviour are very common in prisons.

For this reason, providing same-sex safer sex information in an accessible and supportive manner is a top priority for community-based workers doing HIV/AIDS work in prisons.

An important group for HIV/AIDS workers to understand, contact, and support is those inmates who are sexually attracted to those of the same sex as themselves, who are or have been sexually active with the same sex inside or outside the institution, and/or who identify as gay, lesbian, or bisexual. However, there are two factors that make prisoners in this group difficult to recognize, and that make safer sex more difficult to promote and to practice in the prison context. The first factor is the inherent fluidity of sexual orientation, which is amplified by the circumstances of the prison environment. The second factor is homophobia in institutions, which encourages covert activity and/or denial for fear of punishment or retribution. These two factors together create significant challenges for HIV/AIDS workers in prisons.

The first factor, sexual orientation fluidity, is not unique to the prison context. "Sexual orientation" can be a complex, dynamic, and challenging aspect of many people's lives – queer or straight, incarcerated or not. It combines attraction, (whom do I find sexually interesting and arousing?), behaviour (with whom am I sexually active?), and identity (do I think of myself as being "gay", "lesbian", "bisexual", "straight" or something else, or don't I know for sure?). Sexual attraction, behaviour, and identity

can all change over time, depending on stage of life, personal circumstance, and social context. At different points in people's lives, these elements can be in or out of sync. For many individuals, over their lifetimes, their sexual orientation is more fluid than static.

For many people, this potential for fluidity is enhanced by the circumstances of imprisonment, where incarcerated men and women live for extended periods of time in same-sex environments. Whatever prisoners' sexual identities might be on the outside, same-sex attraction and behaviour are always possible on the inside. In prison it is not uncommon to find people who strongly identify as straight (and who behave as heterosexuals on the outside) engaging in same-sex behaviour while in the prison environment, all the while adamantly maintaining their "straight" identity. As one straight male inmate told an HIV/AIDS worker in a moment of rare candour, *"a hole's a hole."* In other words, the prison context makes it difficult to know or predict which inmates are likely to engage in same-sex behaviour while inside, on the basis of identity alone. Same-sex behaviour in prison thus extends well beyond those individuals who openly (or privately) identify as lesbian, gay, or bisexual.

The second factor, homophobia, intersects with this fluidity to further obscure the full extent of same-sex behaviour, and hinder open and frank discussion of safer sex practices.

Homophobia is strongly present in prisons, both institutionally, and informally in the inmate and staff cultures. While homophobia is also not unique to prisons, it again has manifestations specific to the prison environment.

In many prisons, for example, *all* same-sex behaviour violates institutional rules, and if discovered can result in punitive disciplinary measures. This discriminates against same-sex couples, and creates significant barriers to accessing safer sex materials.

In male institutions especially, macho ingredients of inmate culture further intensify the taboo against same-sex attraction and behaviour. Inmate culture equates homosexuality with weakness. This results in increased social isolation for same-sex oriented prisoners, and can also undermine their physical security. To reduce their vulnerability, therefore, prisoners are often unwilling to identify themselves as anything other than "straight", regardless of their actual sexual orientation and/or behaviour .[2]

Inmates who *are* "out" about being lesbian, gay, or bisexual face unique stressors in prison. "Out" prisoners are more likely to be "hit on" or pressured for sex in exchange for favours or protection, or simply for shared intimacy. Many times, sex inside is consensual. However, it can sometimes proceed in an exploitative way, or occasionally involve physical force. In these situations, a lesbian, gay, or bisexual prisoner's ability to negotiate safer sex with an aggressor can be limited or non-existent. Since "out" inmates are at elevated risk for such sexual advances and situations, and thus for unsafe sex, they are in special need of useful information and effective support from community-based workers.

Thus, homophobia remains a huge barrier for same-sex-oriented inmates, and for HIV/AIDS workers providing queer positive programming. It prevents open and honest discussion of prisoners' lives and desires. It subjects them to taunts, insults, and threats from other inmates and staff. It weakens their self-esteem. In all these ways, homophobia prevents same-sex-oriented inmates from accessing the information and skills

that would enable them to protect themselves from infection with HIV. It also creates additional support needs for these prisoners.

In this climate, inmates who have experienced, have contemplated, or are vulnerable to same-sex behaviour – whatever their specific sexual orientation/s – will also need support for their self-image and self-esteem. This is particularly true for younger prisoners, whose sexual orientations may still be in flux, and for whom longer prison terms can pose challenges to their personal and sexual development. Same-sex oriented HIV positive prisoners face a double stigma – homophobia and AIDS-phobia – making it even more difficult for them to manage a physically and emotionally healthy response to their infection, and further increasing their needs.

Obviously, same-sex oriented prisoners do not have the range of options for validation and support available to them that people on the outside have. They are not generally free to seek out and avail of the support of the gay and lesbian community, and their options for physically removing themselves from homophobic scrutiny, harassment, and violence are even more limited. The one "in-house" option available for their security – voluntary segregation in protective custody – carries with it an even more extreme stigma and risk: this is where sex offenders are generally held. Thus, same-sex oriented prisoners tend to engage in other self-protective strategies, most of which involve keeping a low profile. It is therefore much rarer to find "out and proud" prisoners with whom AIDS workers can ally as peers to assist us with our efforts. Those few who are inside and "out" take big personal risks, and possess rare courage.

These are the main issues unique to – or predominant in – the prison environment around which same-sex oriented prisoners need our outside advocacy and support.

Based upon our experiences in the prison context, we would offer three tips to community-based HIV/AIDS workers to work effectively with same-sex oriented prisoners.

The first is to make no assumptions about the sexual orientations and behaviours – inside or outside – of your individual clients, or the members of the inmate groups with whom you work. You should be prepared to accept that some people will be same-sex oriented and never disclose this to you. This requires that you develop ways to talk about safer sex (to prevent getting infected if they are HIV negative, or to prevent transmission if they are HIV positive) in such a way that inmates do not need to disclose their sexual orientations to you in order to participate or ask questions.

The second is to be queer-positive and inclusive in all your interactions with inmates and staff. Be clear from the start that you respect all sexual orientations, and that your organization is open and accessible to everyone. You should also plan in advance how you will respond to homophobic comments that may arise in individual counselling sessions, in group presentations, and in interactions with prison staff. Such comments are unfortunately common, and the more comfortable and skilled you are in addressing them, or redirecting them back into positive and constructive discussions, the more effective your programs will be.

The third is to get training for yourself and your co-workers about sexual orientation issues and homophobia. While this is particularly necessary in regards to HIV/AIDS, it is also important for broader issues around self-esteem, sexual health, and inter-personal relationships. While it may be

more socially acceptable (especially in men's institutions) to talk openly about harm reduction in drug use, risk-reduction in same-sex behaviour must also be addressed clearly, non-judgementally, and as comfortably as possible.

When designing your prison programming, there are two other key issues to consider in your approach.

The first is the issue of appropriate content. For the reasons outlined above, you may need to adapt your own standard "outside" approach and/or educational materials to the realities of the prison environment.

Bottom line: it is *essential* that *all* inmates receive information about HIV/AIDS that is *as applicable* to same-sex as to opposite-sex encounters and relationships. Especially important is clear information on routes of transmission, methods of protection, and levels of risk.

There is something else to consider in developing the content of your materials and programs. Remember that many inmates – whatever their sexual orientations outside or inside – have experienced psychological and sexual abuse earlier in their lives, often during childhood. This is particularly true for women inmates. Such experiences can make it harder for these prisoners to incorporate healthy sexuality, including safer sex, into their current lives. Abuse history is therefore another stressor in addition to homophobia that makes some prisoners resistant to safer sex messages and practices. HIV/AIDS workers must be sensitive to this reality, and also prepare to offer appropriate support.

The second issue is that of prisoners' access to safer sex materials and tools. Even if you are able to develop great programs and educational materials, the institution may impose constraints around access. Make yourself aware of the potential constraints at your particular institution, and be ready to advocate around them.

It can still be difficult for same-sex oriented prisoners to get access to educational materials reflecting their needs and realities. For example, while some federal and provincial jails make safer sex pamphlets available to inmates through health services departments, most of these materials focus on opposite sex behaviour, and few are inclusive of same-sex challenges and how to resolve them. Prison libraries seldom contain books or magazines of specific interest to queer inmates. In fact, those prisoners who *do* identify as lesbian, gay or bisexual generally have difficulty accessing queer-themed publications, as many institutions prohibit inmates from receiving them. It is not unheard of for prison officials to also challenge queer positive safer sex pamphlets (and any sexually graphic materials) used by HIV/AIDS workers. Be prepared to explain and defend the necessity of these educational tools to the appropriate correctional decision-makers.

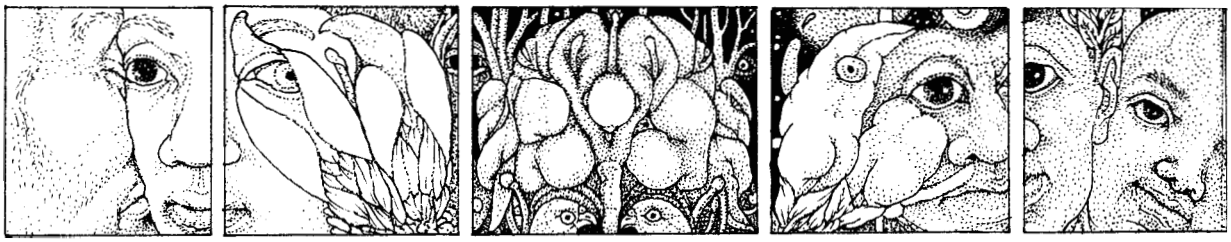
Likewise, it can still be difficult for prisoners to get access to safer sex tools. In most provincial jurisdictions in Canada, and in all federal prisons, condoms are now available to inmates. This does not, however, mean that safer sex materials are as genuinely accessible as they need to be. For this to happen, male inmates would need to be able to get condoms easily, quickly and anonymously, which is not always the case. They would need similar access to water-based lube, which is seldom made available. For oral sex they would need non-lubed and flavoured condoms, which are still unavailable. Likewise, female inmates would need comfortable access to latex gloves, water-based lube and dental-dams, which is seldom the case. Again, it is essential that you familiarize yourself with the

situation in your local institution, adapt your educational messages accordingly, and be prepared to engage in advocacy with the institution to increase accessibility of safer sex materials.

As HIV/AIDS educators working in prisons we all need to figure out how best to challenge and educate around homophobia in a way that protects same-sex oriented prisoners' individual privacy, confidentiality, and physical security. We need to promote safe sex in a way that is effective in the prison environment. We must also be equipped to understand, support, and validate the unique needs of same-sex oriented prisoners as an integral part of our programs, and be prepared to advocate on behalf of our clients in an appropriate way. We look forward to the day when prisoners are fully equipped to protect themselves from contracting or spreading HIV, and can enjoy their sexuality safely, without fear of either infection or retribution.

[1] Sexual orientation is different from gender orientation, even though transgendered people are sometimes categorized together with gay, lesbian and bisexual people under the label, "queer". For further information about transgendered prisoners, see *Close-Up on Prisoner Populations With Special Needs: Transsexual and Transgendered Prisoners* in Chapter Two.

[2] Inside prisons, it is generally easier – that is, less socially risky and personally dangerous – to be "out" about lesbian identity. It is therefore less stigmatizing for women inmates to engage in same-sex behaviour. When working in the prison context, this often means that HIV/AIDS workers will have an easier time discussing safer sex in same-sex behaviour with women than with men, an easier time identifying lesbian and bisexual women than gay and bisexual men, and a much easier time discussing same-sex behaviour among straight women than among straight men. However, real and potential HIV infection and transmission via sexual contact is a far more significant issue for same-sex oriented men than for same-sex oriented women. While this does not mean that we ignore the importance of developing and delivering prevention messages specifically addressing the lives of incarcerated women, it does mean that HIV/AIDS workers doing safer sex education in male prisons face unique challenges and urgencies in creating accessible educational messages.



CHAPTER SIX

Client Support

WHEN DOING HIV/AIDS WORK IN PRISONS, client support work is synonymous with advocacy work. This is because existing institutional barriers in the prison environment make it impossible to provide adequate support to PHAs without also engaging in advocacy on some level.

This chapter explores the relationship between HIV/AIDS support work and advocacy. Hopefully, it will de-mystify the advocacy process, and better enable you to help prisoners living with HIV/AIDS.

This chapter also gives concrete advice about providing client support to HIV positive prisoners: through communication and advocacy while the client is in prison; at various types of hearings; and at the pre- and post-release stages.

This chapter will not teach you how to do support work or counselling. Those skills come only through training and experience. It will instead provide specific information enabling HIV/AIDS support workers and counsellors to work more effectively with prisoners, and prison support workers to address common issues for clients living with HIV/AIDS.

This chapter will teach you how to advocate on behalf of your clients. It will take you step-by-step through proven strategies that will help you defend the rights of your clients in prison.

CHAPTER SIX

Client Support

Living in prison can be a dehumanizing and isolating experience for anyone. For persons living with HIV/AIDS (PHAs), this experience is intensified.

In general, imprisoned PHAs struggle with the same issues as do PHAs in the community. However, living in prison exacerbates many of those issues, and indeed creates new ones that support workers need to be prepared to address.

For example, PHAs' common fears about deteriorating health and death are compounded for prisoners – where dying in prison means dying alone, separated from loved ones.

Daily struggles with failing health or the side effects from medications are more profound in prison, due to the lack of privacy, comfort, and hygiene (this is particularly true for those suffering from nausea or incontinence).

Accessing medical specialists and new therapies in prison can be difficult or impossible, depending upon where a person is incarcerated.

All of these factors – combined with their being trapped in an environment generally hostile to people living with HIV/AIDS – create a highly stressful atmosphere for imprisoned PHAs.

All of these issues affect the types of support services needed by prisoners living with HIV/AIDS.

Just as the inherent institutional and physical barriers of the prison system have an impact on your clients, they equally have an impact on you, the support worker.

Prisoners live in a totally controlled environment, so you will rarely be able to provide direct assistance to clients yourself.

All of those things that you would normally do for your clients in the community – bringing them to a doctor, helping them access their medications, giving them food or vitamins, giving them clothing, etc. – are things you now must convince a prison staff member to do for you.

The process of convincing the institution to do something for your client is the *advocacy process*. Thus, in the prison context, supporting the health and social needs of your HIV positive clients necessarily means doing advocacy work on their behalf.

As discussed in earlier chapters, all our support and advocacy work is premised upon the belief that people living with HIV/AIDS in prison are entitled to the same access to care, treatment, and support, as are people in the community – in *practice*, not just in theory.

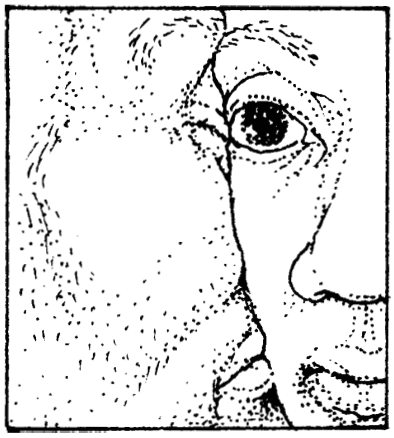
This chapter explores the interlocking relationship between HIV/AIDS support services and advocacy, addressing the practical considerations of each in their turn.

People living with HIV/AIDS may need support and advocacy at all stages of the criminal justice process – on remand, in court, in prison, while preparing for release, and after their return to the outside community.

We'll start by reviewing the kinds of support you can provide to clients while they are in custody.

As on the outside, you can provide support to your incarcerated HIV positive clients in two main ways: through communication and through advocacy work.

I. Providing Support Through Communication



The Telephone – An Imperfect Lifeline

For people in prison, the telephone is *the* primary mode of communication with the outside world. It is no exaggeration to call it a lifeline, and for many prisoners the phone provides the *only* opportunity for regular contact with family, friends, lawyers, and support services.

As with all aspects of prison life, however, there are structural constraints that impact on the telephone's utility as a support tool. These limitations create challenges for AIDS workers hoping to providing counselling or support to prisoners.

Before undertaking telephone support, you should be aware of the following.

a) Cost to Your Agency

The only way prisoners can use the phone is by placing collect calls. They cannot make calls directly. This means that the person or agency on the other end must be both willing and available to accept the call. Therefore, *if you or your agency wants to begin providing support services to prisoners, you must accept collect calls.*

If you or your agency wants to begin providing support services to prisoners, you must accept collect calls.

For more on other considerations for your agency, see *Making Initial Preparations: Arrange for Your Agency to Accept Collect Calls from Prisoners* in Chapter Four, and *Thinking Ahead About Telephone Policies and Boundaries*, below.

b) Restricted Access

Prison telephones are not available for use at all times. When prisoners are locked in their cells the telephone is not available to them. In some places this can be for as long as twelve hours at a time, or even longer in segregation units. Similarly, if your clients have jobs within the prison, or are participating in school or other programs during the day, they cannot use the phone during those times. As a result, there is often high demand – and sometimes long waits – to use the phone. Therefore, you must make efforts to be available in the office to receive collect calls from clients during times when they can access a phone.

c) Restricted Time

While some prisons allow people to talk for as long as they like, others have electronic systems in place, which automatically terminate calls after a set period of time (i.e., fifteen or twenty minutes). Therefore, you must learn to quickly assess situations and provide some meaningful support during brief conversations.

d) Limited Confidentiality

Most prison phones are found in public spaces, so it is often difficult or impossible to have private conversations, out of earshot of others. Telephone conversations may also be monitored by staff.[1] You must therefore adapt your listening skills to "read between the lines" of conversations where the person on the other end of the phone may be in a room full of people, and not at liberty to talk openly about their fears, concerns, or needs.

Despite these barriers and limitations on the telephone as a support tool, given the lack of alternatives – and given their high levels of need – PHAs in prison can and will call support organizations as often as possible.

Why People Call

Obviously, imprisoned PHAs call because they need to speak with someone. They need to hear a friendly voice. They need to discuss something, and they feel they cannot confide in others around them.

While this generalization is broadly accurate, you can also expect *four distinct categories of calls*.

a) Task-oriented Calls

Prisoners will often call their support workers to request assistance in a specific matter. They may want you to advocate on their behalf with the institution. They may request a letter for court or a parole hearing. They may need assistance with housing or other services. They may simply be looking for information. All these types of calls are quite common, and require that the worker take some action.

A familiarity with the workings of the prison system in general, and with your local institution/s in particular, will contribute to your success in addressing these calls efficiently, as will your knowledge of the mechanics of the advocacy process itself (see *Providing Support through Advocacy,* below).

b) Crisis Calls

Testing positive. The onset of HIV-related illnesses. Drops in T4 counts or increases in viral load. The death of a friend. Bad news from home. These

[1] In federal prisons, this general lack of confidentiality is compounded by a system where prisoners must also submit all phone numbers for security approval. For more information on how to increase confidentiality for prisoners in such instances, see *Making Initial Preparations: Arrange for Your Agency to Accept Collect Calls from Prisoners* in Chapter Four.

are but a few of the situations in which you may be called upon to provide crisis support to prisoners.

In this sense, crisis calls from prisoners are not dissimilar from crisis calls you might receive from people in the community. What is different, however, is your ability to intervene. If you receive a crisis call from a client living in the community, you often have the opportunity to meet with them personally to provide more intensive support. When the call is from a prisoner, you may not have that option.

Do not underestimate the effect that this can have on you as a support worker, particularly if you are accustomed to providing face-to-face counselling to clients in crisis. You may very well feel that your telephone intervention was inadequate compared to the person's needs, and this may leave you with feelings of anxiety, stress, or depression.

However, do not underestimate the positive and reassuring effect that good telephone support can provide for someone who is isolated in prison. That person is reaching out to you in the only way available to them. A friendly ear and a compassionate voice can go a long way to helping ease imprisoned PHAs through crisis situations.

It is also important for support workers to learn to distinguish a real crisis from a perceived crisis.

You will find that for many clients calling from prison, everything is an "emergency". For some, this reaction is an understandable psychological response to the lack of control they have over their lives. For others, it is a conscious or unconscious survival tactic developed from living in an institutional environment, where only "emergencies" earn a timely response. If you do not learn to separate the real crisis from the perceived crisis, you will quickly burn yourself out by responding in a manner inconsistent with the urgency of the situation. This is not to say that you should trivialize or ignore your client's anxieties. However, it does mean you must be willing to objectively assess the urgency of each situation, talk the client through your assessment, and honestly explain how you will respond to the situation. If done with sensitivity, this can also help the client to put things in proper perspective.

c) "Needy" Calls

Also as on the outside, you may find that you have certain clients who will call you repeatedly. Some may call you several times a week, or even several times a day. You may find that they retell the same story each time they call, and will quite happily keep you on the phone for very long periods of time, if they can. For some prisoners, this is the understandable result of

social isolation. For others, it can be related to mental health issues, drug use, or the onset of HIV-related dementia.

It is important not to ignore the needs of these clients. At the same time, it is perfectly acceptable for you to set limits on the calls you take. You still have to do your work, and more time spent on the phone with one person is less time available to serve other clients. In addition, the costs of receiving ten or twenty calls a week from one client – or having calls go on for hours at a time – can put a strain on your agency's financial ability to accept collect calls generally.

When these situations arise, discuss the issue honestly with the client. Come to an agreement about how often s/he can call you (apart from emergency situations). Perhaps agree to a weekly telephone "appointment", where you commit to setting aside a specific time each week just to talk to them, and in return they make a commitment to only call you at that time.

d) Just To Talk

This is by far the most common reason why imprisoned clients will phone you or your agency. Since prison can be so isolating, people understandably want to avail of any opportunity to reach out and hear a friendly voice. For this reason, you will probably find that the greatest number of calls will be from people who just want to check-in, have a chat, and "escape" from their immediate surroundings for a few minutes.

Don't discourage these types of casual calls. They are invaluable for building trust and strengthening the relationship between yourself and your client. They are also a useful opportunity for you to get information on what's happening in the institution, which may become useful later on in interactions with other clients, or with institutional staff. Keep in mind that such "friendly" calls can be important as a stress reduction tool for your clients, and therefore as a method for promoting their positive mental health.

Basic Guidelines for Providing Phone Support to Prisoners

1. Find Out About Access to Other Telephones

If the person calling needs to talk about issues for which they require *real* privacy, you can sometimes arrange for them to get access to a staff member's phone in a private office. Try approaching a social worker, Native liaison, case management officer, chaplain, or nurse with the request. Unfortunately, this is not a favour you can ask for everyone who calls you, but under special circumstances you can often make an acceptable arrangement.

2. Listen Actively

Most HIV/AIDS counsellors and support workers will be accustomed to working face-to-face with their clients. However, the bulk of your support work with prisoners will be conducted via telephone. Therefore, you will have no visual cues or body language to help you interpret a conversation. This requires that you listen in a different way than you would if the person were sitting in front of you.

For example, when a prisoner calls with a problem, they will often relate it via a long story rather than name the issue directly. They may be surrounded by other prisoners, and lack the privacy to identify the issue explicitly. They may have so many other issues and problems going on that day that they cannot single out the one related to their HIV needs.

Whatever the situation, you need to be active in your listening skills in order to piece together the real reason for your client's call. If you fail to do this, you can easily mistake a person who is calling with a real problem for someone who's just calling to chat, or your client can lose access to the telephone before you are able to determine the issue at hand.

If you begin to suspect that there is a deeper issue behind the long story, try reflecting the issues back to the client as you are hearing them*: "so what I'm hearing is you need this and this done."* This can help ensure that you understand the situation clearly, and can also help focus the client.

It's essential to make clear what services you do and do not provide.

3. Be Clear and Consistent

It's essential that you make it clear to your clients what services you do and do not provide. It is also essential that you are consistent between clients about the accommodation of requests. Clarity and consistency ensure fair and impartial service access for all your clients.

If you do feel the need to make an exception to a rule to meet the needs of a specific situation, be clear with yourself and with the client about why you have made that decision. *Don't assume that no one else will find out that you've made the exception, because they will*. People in jail talk to each other, particularly those that know they are all clients of your agency. If you make an exception in one case, you should assume that others will hear about it and come to you wanting the same treatment. Unless you are very clear in giving your reasons for the exception, you can easily give clients the mistaken impression that you are playing favourites.

4. Check With Other Agencies Around Support Work

In some instances, your client may access support services from more than one community-based agency, or more than one ASO. This is always a good thing to find out at the beginning of your relationship.

If this is the case, try to get written permission from the client to talk with the other worker/s.

If the client calls with specific tasks they need done, it's useful to check with the support worker/s at the other agency or agencies, as it is quite possible that the client has asked them to do the same things. There's no point in duplicating the work. Perhaps share it out instead.

In other cases, communication with the client's other workers can also be useful to coordinate your advocacy efforts.

However, *do not speak with other workers about your client unless you receive the client's express – preferably written – permission, as this could constitute a breach of confidentiality*.

5. Don't Be Alarmed by Yelling or Hanging Up

If the client yells at you and hangs up, don't take it personally. Prison can be a very frustrating and stressful experience, especially if you are HIV positive. If your client yells at you or hangs up the phone, it doesn't necessarily mean that they are angry with you. It's quite possible that you are the only person with whom they feel comfortable venting such emotions. There's also a different socialization around yelling in prison. Very often, people do not get any attention from staff unless they make some noise.

While it is important to keep the incident in perspective, you should not simply ignore it altogether. Perhaps you have inadvertently done something to make the client angry or upset. Ask them about it next time they call.

6. Be Aware of Mental Health Issues

Unfortunately, many people with mental health problems end up incarcerated instead of getting help. This means that you will often have clients who are struggling with mental health issues in addition to HIV/AIDS. These clients will need special attention and specific mental health support.

If you are not professionally prepared to provide this kind of support yourself, you and/or your agency may benefit from additional training in this area. Check with community-based mental health professionals and/or psychiatric survivor groups in your area for suggestions. You may also find it useful to develop a partnership with a local group specializing in mental health, and help provide them the skills to do work with imprisoned PHAs.

Remember, if you do not have the appropriate skills or training, do not hesitate to refer clients with mental health problems to those who do.

7. Don't Lose Sight of the Bigger Picture

Life in prison is a day-to-day existence. Prisoners are therefore often exclusively focussed on whatever is unfolding in the institution at that particular moment. As a result, prisoners will usually call to talk to you about what's going on *today* – at the time of the call. This is not necessarily a problem, but it does mean that *you* may need to take the initiative to focus the client on some of the longer-term work you're doing together (planning for release, etc.).

Of course it is important for you to talk with the client about their reasons for calling on the day, and offer support as necessary. However, it is also important for *you* to maintain perspective on the bigger picture. Try to keep your client thinking about those longer term goals as well.

TIP:

Given the high rates of attempted and successful suicide in prisons, it could be useful for you and/or your agency to investigate whatever training on suicide risk, identification, and intervention is available in your region. Establish links with other community-based agencies with this expertise, and develop working partnerships. If you encounter a situation that you are not trained to address, ask for help.

Thinking Ahead about Telephone Policies and Boundaries

Given the primacy of the telephone as a tool in prison support work, it is useful to establish some telephone policies at the outset of your program, as they will help you respond to tricky situations that inevitably arise.

You might set some of these policies as part of your own individual boundaries, while others may require broader organizational discussion and decision.

a) Collect Calls

Decide *how* and *when* your agency accepts collect calls. Do you accept *every* call that comes in – eight hours a day, five days a week – or do you establish set days/times when you accept calls?

Can individual clients call as often as they like, or are they limited to once a day, or once a week (barring true emergencies)?

These decisions must depend in part on financial resources (collect calls can get expensive) and in part on the availability of staff (whether or not a designated support worker will be in the office every day to take calls).

b) Three-way Calls

Three-way calls are very useful for prisoners to speak with people who cannot afford, or simply will not accept, collect calls. However, they also create additional expense for agencies offering the service, tie up agency

phone lines, and potentially make you a conduit for discussions which are best not associated with your agency.

Since three-way calls are so useful, you will find that prisoners commonly request that you facilitate them. Decide a consistent policy from the start and stick to it. Do you provide the service to anyone who asks? Do you provide it under limited circumstances (to facilitate calls to physicians, for example)? Do you not provide it at all? Determine a realistic policy given your agency's constraints.

c) Placing Personal Calls For Prisoners

Particularly if your agency does not provide access to three-way calls, your clients may ask you to instead place a separate call to a third party and pass on a message.

In practice, there tends to be more grey areas here than in providing three-way calls. For example, it's hard to say no when a client asks you to call her or his parents to tell them that they are OK, or that they have been arrested. However, as with three-way calls, you must decide whether you do this for everyone who asks, do it only in specific circumstances (i.e., placing calls to other professionals), or not at all.

Face-to-Face Visits

Visiting your clients in prison is another critical part of providing support services.

Not only do prison visits play an important role in building trusting relationships, they also give you an insight into the conditions under which your clients are living. Depending on the circumstances of the visit, it may also provide an opportunity for the two of you to meet privately to discuss more confidential matters.

Basic information on prison visiting options was covered in detail in *Making Decisions About Individual Counselling Services and Client Visits* in Chapter Four. *The advice in summary:*

1. Raise the Issue of Confidentiality

By going into the institution to visit a client as "the AIDS worker", you are necessarily taking the risk of disclosing your client's HIV status. Be clear with the client about this risk *before* you visit, as it may change their minds. (See also *Common Concerns of Workers New to Prison Environments: Confidentiality Risks* in Chapter Four.)

2. Consider the Different Kinds of Visits

In most provincial institutions, you have two options for visiting people. One is through the *professional visiting process* (for which you need special clearance), the other is through the *family/friends visiting process* (for which you may not require clearance).

While professional visits have the advantage of being private, they can also pose a confidentiality risk. The family/friends visiting process, while not private, *can* provide a more confidential option in those provinces that do not require security clearance for such visits.

Prison visits play an important role in building trusting relationships, and give you an insight into the conditions under which your clients are living.

Find out about the available visiting options and canvass your client's preferences *before* arranging your visit. (For more on this, see *Making Decisions About Individual Counselling Services and Client Visits* in Chapter Four.)

3. Get Your Security Clearance

All federal prisons, and some provincial systems, require security clearance of all visitors.

If you hope to have access to *professional visits* (that is, private visits) with your federally and/or provincially incarcerated clients, you will definitely need to get security clearance. (See *Making Initial Preparations: Apply for Security Clearance* and *Common Concerns of Workers New to Prison Environments: Refusal of Security Clearance* in Chapter Four.)

There are some additional things to consider when planning prison visits.

4. Find Out the Most Discreet Places to Meet Clients When Arranging Professional Visits

Meeting clients in the health unit is often the first choice for AIDS workers, but it is not necessarily the most comfortable place for prisoners. Your client may have ongoing disputes with the health unit staff around treatment issues, and so may feel uncomfortable in their space. The client may have concerns about being seen the health unit by other prisoners, fearing that it will compromise their confidentiality.

Ask the prisoner her/himself about where they would be most comfortable meeting you. You can also consult with a social worker or a Native liaison about alternative meeting spaces in the prison.

5. Check the Prisoner's Own Schedule

If you are planning to visit a client, be sure to check with them about their own schedule. The person may have a court appearance, a doctor's

appointment, or other visitors planned for the day you want to come. If this is the case, you will not be able to see them. Planning ahead will reduce the likelihood of wasted trips.

6. Don't Take Up Family Visits

In some provincial institutions and detention centres, prisoners are only allowed a limited number of visits per week.

If you want to visit the person through the *family visiting process* rather than the professional visiting process, check with the prisoner first to make sure you are not inadvertently using up one of the spaces they were saving for a family member.

Professional visits – arranged as such – do not count as family visits.

7. Follow Through on Your Appointments

Never tell a prisoner you will visit them, and then fail to show up. This is a sure breach of trust, and will reflect poorly on your agency as a whole. Prisoners look forward to their few visits, and if you do not show up on the appointed day your client will be very disappointed.

Never tell a prisoner you will visit them, and then fail to show up. This is a sure breach of trust, and will reflect poorly on your agency as a whole.

Sometimes these things are out of your control – as with illness or refusal of access by the prison. In such cases try to get word to the client as soon as possible about what has happened, and reschedule to see her/him right away.

8. Recognize That Prison Visits Take Time

Visiting a client in prison can take a long time – much longer than the length of the actual meeting itself. Travel time can be extensive, especially for more remote institutions. After you've arrived, you will often face delays: from security; in finding an available meeting room; and in arranging to have the client brought down to see you. A forty-five minute support session can therefore easily take an entire afternoon. Plan your schedule accordingly.

9. Group Your Visits Together

Given the time involved in travelling to and getting into the institution, it's useful to see as many clients as possible while there. Therefore, if you have made arrangements to visit a prisoner, try to make arrangements to visit your other clients at that institution as well. This is a good way to maximize your time.

Depending upon your client load at any given institution, it can also be useful to schedule a regular day each week or each month for visiting. Scheduling your visits in this way has many advantages. It will reduce your travel and processing time, freeing up more time for client work. It can reduce access problems with the institution, as the staff will eventually come to know you. It will also increase your accessibility for PHAs, as you will be able give them a consistent schedule of your trips to the prison, so they can prepare for your visits.

Thinking Ahead about Other Support Services, Policies, and Boundaries

Imprisoned PHAs commonly make requests for a number of other support services, in addition to counselling. Most such requests stem from the fact that they are locked up and therefore unable to do many things for themselves.

As with policies around telephone support, it is best to establish relevant policies and practices within your agency as soon as possible. This not only helps to ensure fair and consistent service, it also minimizes the potential for problems or misunderstandings later on.

Below is a listing of requests that often come up. In deciding your policies, try to balance the value of the service for your clients against the resources required, and the potential for conflicts.

a) Handling Personal Identification and Belongings

When someone is arrested, the police often confiscate and store any belongings they had with them at the time (ID, clothing, bag, etc.). Clients may ask you whether you can retrieve these items from the police station and store them until they are released.

When discussing whether this is a service your agency will provide, make sure to consider whether you have the room to store such items for long periods of time.

If you do offer to collect personal items from the police, you may also need to obtain a signed release form from your client.

b) Moving Property

When someone goes to jail, they most often lose their housing. When this happens, they need to have their furniture, clothing, etc. moved out of the residence (and presumably stored). Is your agency able to provide this ser-

vice, which requires significant staff and possibly financial commitment? If not, do you know of an agency that can?

Again, if your agency decides to offer this service, you may elect to request prior written permission from the client authorizing you to pick up and store their belongings.

c) Handling Money

Since your client is incarcerated, and obviously not able to get to a bank, you will often receive requests to handle their money – to cash cheques, to transfer money into their canteen account, or to pay bills while they are inside. A helpful service, no doubt, but one fraught with potential problems.

Think this one through carefully before committing.

If your agency decides to offer this service, a written release form from the client providing specific instructions and specific amounts is advisable.

d) Taking Personal Phone Messages

You may find clients (both while in prison and after release) requesting to use your agency's phone number as their contact number.

Again, this can be a very helpful service (particularly for clients without a home or telephone), but one which potentially places a significant burden on staff, depending upon how many clients use it – and if you do it for one client you must do it for everyone.

As a compromise, you might consider allowing clients to use your number as a contact for professionals (physicians, parole officers, welfare workers, etc.) but not for personal friends.

e) Picking Up the Client From Jail

Clients may sometimes ask you to pick them up from jail when they are released. This too can be a very helpful service, but again one that can demand significant staff and travel time (depending upon where the institution is located).

In considering your policy, make sure to also investigate the prison's responsibility to return people to their town/city of origin upon release. Most prison systems do this as a matter of policy.

That said, some clients may make the request based entirely on their need for emotional support, not logistical support.

Forming PHA Peer Support Groups in Prisons

If you find that you consistently have a number of HIV positive clients at an institution, you might also consider the idea of helping to form a peer support group.

While there are potential problems with support groups – not the least of which is that many institutions will not allow them – they can provide a very positive social support for some prisoners.

Bringing PHAs together in the institution can provide a space for them to discuss their own needs, and develop their own advocacy skills as a group. It can also provide you the opportunity to bring in outside speakers on various topics related to HIV/AIDS, harm reduction, or health promotion.

If you do help form a peer support group, you may find it useful to invite the institution's head of health care to address the group on occasion, as this can create a forum for prisoners to ask questions and raise issues of concern directly with the staff, in a supportive context.

On the other hand, support groups will not work for everyone.

By attending a support group, prisoners necessarily disclose their HIV status. While some will be comfortable with this, others will not.

The prison can also impose limits on who can attend. For example, they may restrict you from mixing people from different ranges or living units. Most prisons will not allow protective custody prisoners to mix with general population prisoners, which can also exclude some clients from participation.

Therefore, while support groups can be valuable, you should only consider them as one possible element in your broader support strategy.

For advice on considerations when running a prisoner support group, see *Basic Advice on Running Your Prison Program: Manage Group Dynamics* in Chapter Five.

ONCE YOU HAVE ESTABLISHED ways of communicating with your clients, you will come to discover that various institutional policies, practices, and oversights have negative impacts on their health. Therefore, one of the most important ways that AIDS workers can support their imprisoned clients is to advocate on their behalf.

II. Providing Support Through Advocacy

Ensuring that adequate standards of care, treatment, and support are extended to prisoners living with HIV/AIDS is crucial.

As an AIDS support worker, you not only have the responsibility to act on any denials of HIV positive prisoners' basic rights to care, you also have the ability to make a significant positive impact on the living conditions of your clients through your advocacy efforts.

If you hope to do meaningful HIV/AIDS work with prisoners, you must also learn to effectively negotiate your way through the prison system. Otherwise, you will not be able to get things done for your clients.

Remember though, the ultimate goal of your intervention is to improve conditions for all prisoners living with HIV/AIDS.

We'll start by reviewing the basics of client advocacy. Then we will review its application in the prison context.

How to Get Your Clients' Needs Met: ADVOCACY 101

The concept of advocacy is frequently misunderstood.

"Advocacy" is nothing more or less than the act of defending or *"advocating"* the rights of our clients when they are denied or jeopardized.[2]

Too often, people equate advocacy solely with confrontation. This is why many of us shy away from the idea, and why many agencies avoid any mention of advocacy in their mandates. However, advocacy can and should take many forms – each appropriate to the situation at hand.

Problems requiring advocacy can range from the relatively minor and easily resoluble (such as an HIV positive prisoner needing an extra blanket to keep warm) to the complex and potentially catastrophic (such as life-threatening gaps in prisoners' access to medical services and medications). While some situations call for a more confrontational approach, the vast majority will not. Don't be intimidated by the prospect of engaging in advocacy.

[2] For more details about the legal and human rights of prisoners to adequate care, and to basic human dignity, see *Common Myths and Facts about Prisoners' Rights and Healthcare*, and *Canadian Prisons: Systems and Structures – The Correctional Mandate: A Mandate of Care* in Chapter Two, Chapter Three, and *"Inside" Information: Grievance Procedure in the Federal Correctional Setting – An Advocate's Guide.*

Effective advocacy is ultimately about communicating. It is about communicating with those who have the power to make changes happen. Such communication can and should take many forms, both direct and subtle.

For example, simply adding the prison health unit to your organization's mailing list is a form of advocacy, as it will enhance the profile and reputation of your agency among institutional staff. Sending the prison nurses regular HIV treatment update information is a form of advocacy, as it will help them to keep their knowledge current with emerging therapeutic options. Meeting with your local parole office to promote your organization's services is a form of advocacy, as it can help sensitize and educate the parole officers to the unique needs of PHAs. Sending a letter to court on behalf of a client is a form of advocacy, as it can help inform the judge about HIV/AIDS issues. Your engagement in these more subtle forms of advocacy not only serves the purpose of communication, but can also build your credibility with the targets of your efforts, generating leverage you can stockpile for later use.

Effective Advocacy Requires Effective Communication

When advocating on behalf of a prisoner, you must always:

1. *Communicate* the specific nature and detail of the problem.
2. *Communicate* a specific solution or solutions to the problem.
3. *Communicate* the reasonable and/or crucial nature of the request.
4. *Communicate* the potential ramifications if the problem is not solved (ramifications for both individual clients and for correctional services).
5. *Communicate* with other stakeholders about the situation.

When doing prison work, there are *three primary systems* with which you may have to engage as an advocate: the *prison system*, the *parole system*, and the *court system*.

There are also *three separate levels* at which you may have the occasion to advocate.

You may be asked to engage in *individual* advocacy – to resolve a single problem affecting a single individual.

You may become involved in *institutional* advocacy – to address a problem or barrier affecting an entire institution, and all the prisoners incarcerated within.

You may also decide to engage in *systemic* advocacy – to attempt to create broad change throughout an entire prison system (federal and/or provincial), court system, parole system, or other related system.[3]

[3] Although many of the same advocacy principles outlined in this chapter also apply to system-level advocacy, an in-depth discussion of system-level advocacy is beyond the scope of this manual. If you want to initiate or join in existing systemic advocacy efforts, contact the national organizations listed under *Contact Information: Useful Community Contacts* in the *Resources* section.

There are obvious relationships and overlaps between these three levels. For example, a series of individual complaints about a similar problem may cause you to identify a broader institutional or systemic issue. On the other hand, institutional and systemic barriers will have ramifications for individual client care.

Effectively addressing individual, institutional, or systemic problems requires you to develop an appropriate advocacy strategy in each instance. This is not as complicated as it sounds, but it does require you to analyze before you proceed.

What follows is a brief guide to building an advocacy strategy, based on four simple steps: assessing the situation; targeting your intervention; choosing your tools; and taking action.

Simplified even further, you need to figure out the *"what"*, the *"who"*, and the *"how"* of your plan.

Creating an Advocacy Strategy

Assessing the Situation – The "What"

Given that advocacy is predicated on communication, in order to advocate effectively, you must first know *what* to communicate.

This means that you must clearly identify the problem you are seeking to resolve, and ensure that you have *all* the available information at your disposal.

1. Identify the Problem and its Source

Sometimes a specific client request will prompt your decision to advocate. Other times this decision may result from problems you have experienced in the course of delivering programs or services.

Whether you are responding to a phone call from a specific client, or confronting a more general problem you have identified yourself, you must first assess what is the cause of the problem. Identifying the source of the difficulty is essential in determining who in the bureaucracy has the authority to fix it.

The first question you must ask yourself is whether the problem is individual, institutional, or systemic in nature. This is critical for determining your options, and the likelihood of being able to resolve the issue in a timely fashion.

In order to establish whether the client's problem is individual, institutional, or systemic, you first need to identify whether the source of the problem is a discretionary decision or an established policy.

Ask yourself the following questions:

i) Can the problem be resolved by the discretionary decision of a staff member or doctor?

If so, it is most likely that your client's problem is individual in nature.

These are the most common problems you will encounter. Perhaps the client has missed a dose of their medications. Perhaps their prescriptions have been changed without explanation. Perhaps they are feeling ill and need to see a nurse or doctor. Perhaps they need a change of bedding or clothing. Perhaps they need a high protein diet, or nutritional supplement drinks. All of these common issues are usually within the authority of individual prison staff to resolve. *Sometimes*, such problems can be the least complicated and fastest to resolve.

Effectively addressing individual, institutional, or systemic problems requires you to develop an appropriate advocacy strategy.

ii) Is the solution to the problem outside the discretion of either individual or local staff?

If so, your client's problem would likely be either institutional or systemic in nature.

Does your client require an HIV medication that is not approved by the institution? Has s/he been cut off pain management medications because the institution has an over zealous zero-tolerance drug philosophy? Perhaps your client needs to continue or start a methadone maintenance program, but your province does not provide methadone for prisoners. Perhaps your client is an injection drug user who is concerned about transmitting HIV to her/his friends in prison, but cannot access needle exchange because no prisons in Canada offer this program.[4]

All of the above cause legitimate problems for your clients, yet individual or local prison staff are in no position to resolve them, as they are related to either institutional or system-wide policy. This is where you will need to confront institutional and systemic barriers. This can be more complicated, and can also take much longer than resolving individual problems.

If you are unfamiliar with the nuts and bolts of prison policy in your region, or the standard operating practice in your local institution, the answers to the above questions may not be obvious.

[4] Accurate at the time of publication. Hopefully no longer accurate by the time you read this.

To begin to determine the source of the problem, your client is often the best person to consult initially.

Start by asking two simple questions:

i) Is this a new problem for the client?

For example, had s/he been receiving her/his medications without incident for several months, only to run into trouble recently?

If so, there are several potential causes of the problem. It might be a simple mistake or oversight by the health unit. It might be that an individual staff member has made a discretionary decision to change treatment (perhaps with good reason) that has not been communicated to the prisoner. However, it might also be that a broader change in policy has occurred.

ii) Are other prisoners in the institution having the same problem?

For example, if other prisoners in the institution are regularly accessing pain management medications, it is obviously not prohibited by prison policy. In this case, the most likely source of your client's problem is the discretionary decision of an individual staff member. If, however, all prisoners share the same problem – whether ongoing or recent – it's more likely to be caused by policy at some level.

There are exceptions to this formula, however. Depending on the decision-making structure at an individual institution, some senior staff members may have the authority to make discretionary decisions affecting most or all prisoners. Such decisions may not always accord with official policy of the system as a whole. *Make sure to check this out.*

How do I know if a client's problem is individual, institutional, or systemic?

Individual problems are single-instance problems unique to one client or to one occasion.

Institutional problems are limited to, or pervasive within, a single institution.

Systemic problems are common to a group of institutions or a region, or to the correctional system as a whole.

You can also consult with health care staff at the institution. If the barriers rest at the institutional or systemic levels, staff will be quick to point this out as it demonstrates that the problem is not of their creation.

Through experience, and by familiarizing yourself with the relevant policies, you will develop a base of information from which to judge whether the problems themselves are individual, institutional, or systemic.

Try to be alert to any patterns you see emerging over time.

2. Collect the Needed Client Information and Documentation

If you are responding to an individual's request for help, before considering your advocacy options there are a number of other specific pieces of information and documentation you will need to obtain from the client.

i) Where is the client incarcerated?

If the client is a new intake – and if you have not done so already – you need to find out whether s/he is in a federal or provincial institution, or a detention or remand centre.

As you know from the previous material covered in this manual, the inherent differences between types of institutions will partially condition both applicable policies and your available advocacy options.

To begin to determine the source of the problem, your client is often the best person to consult initially.

ii) Does the institution know the prisoner's HIV status?

Is s/he open about being HIV positive? Is that knowledge limited only to the prison health unit, or does no one know their status?

This information is crucial, because having an AIDS worker contact the institution on the client's behalf necessarily discloses her/his HIV status. Be clear with the client about this reality before you proceed any further.

Never engage in any work on behalf of the client without their express knowledge and permission.

iii) Try to get a signed Release of Information form from the client prior to engaging in any advocacy work.

Occasionally you may have time to do this by mail, or by faxing a form to the prison health unit. However, if the situation requires immediate attention, you may find yourself in the position of having to act without documented authorization. This can be tricky. You need to determine your own practice based upon client direction, the urgency of the problem, and your own agency's policies.

If you decide to begin your advocacy on the basis of the client's verbal direction – without first obtaining a release form – make sure to fully document the verbal request for your records, including: confirmation that you received verbal authorization; the date, time, and call duration; and the exact nature of the request, for example.

Remember that while the prison will not divulge information to you without a release form, this does not stop you from contacting the prison to

notify them of the client's problem. This can start the process rolling while you arrange for your client's written release.

iv) Does the client have any related written documentation?

The client may possess related documents relevant to the issue at hand, such as correspondence with the prison administration, written copies of administrative decisions in her/his case, etc.

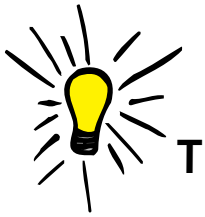
While it is infinitely preferable for you to have copies of any documents before proceeding, if time is of the essence you can get the prisoner to read you the documents (or summarize them, if long) over the phone while you take notes.

Make sure to take down the date and name of the document (if applicable), as well as the name of the signatory and their official title. You may also need to note any institutional reference numbers, including your client's prisoner number.

v) Identify any potential allies to help you in your advocacy.

Does the prisoner have a primary care physician in the community with whom s/he has an established relationship? Does s/he have a lawyer? Is s/he receiving support services from any other community-based organizations? If the answer to any of these questions is yes, it may be useful to consult these other individuals in your advocacy effort. Again, however, you will need the client's express authorization to do so.

For more advice on the mechanics of taking a prisoner complaint, see *"Inside" Information: Grievance Procedure in the Federal Correctional Setting – An Advocate's Guide.*



TIP:

Federal correctional policy (the Corrections and Conditional Release Act and the Commissioners' Directives) can be found on the CSC website (see Useful Websites *and* On-line Resources: Government Websites and Other On-line Resources *in the* Resources *section). For more on the structure of federal prison policies see* "Inside" Information: Grievance Procedure in the Federal Correctional Setting – An Advocate's Guide.

To research provincial correctional policies, you will need to contact the relevant provincial ministry (see Useful Websites and On-line Resources: Government Websites *in the* Resources *section).*

3. Identify an Acceptable Solution to the Problem

Of course, your assessment of the situation would be incomplete if you neglected to define an acceptable solution to the problem.

Once you have identified the solution you are seeking, this then becomes your *immediate objective*.

Once you have both the nature of the problem and your immediate objective clearly in mind, puzzling out the means for achieving your objective (the *"who"* and the *"how"*) becomes much easier.

Needless to say, the solution should address the problem both directly, and "to scale". In other words, if your client is cold, calling the nurse on duty

and asking for an extra blanket is a much more useful and appropriate response than holding a demonstration on Parliament Hill to protest correctional policy on institutional climate controls.

Always consult your client about an acceptable solution to the problem, and obtain their express authorization to proceed.

If the client doesn't present you with their own demands up-front, you may have to suggest and explain your assessment of possible and probable remedies.

You may find that your client demands a solution that you know from experience to be impossible within current institutional and/or correctional policies and practices. In this case, you need to work together with her/him to agree on an acceptable solution that will meet their needs *and* be possible for you to reasonably negotiate with the prison.

Once you have determined *what* the nature of the problem and its remedy are, you can decide *who* you need to communicate with to try to achieve a resolution.

Targeting Your Intervention – The "Who"

If you hope fix a problem in an expedient manner, it is essential to direct your efforts towards the person/s with the authority to make the necessary decision/s.

If you have established that an individual prison staff member *can* resolve the problem, you then need to determine which staff member to approach. There is no point in pleading your case to a person in the wrong department.

Again, your client is often the most helpful person to consult in deciding whom to call. Since your client lives in that particular prison, s/he will often know who makes what decisions in the institution. S/he will know which staff have been supportive to them, or helped them out in the past.

In general, the relevant institutional decision-making takes place in two spheres:

1. Health Care (the Institutional Physician and/or Nurse/s)

The health care staff obviously make decisions regarding access to medications – such as prescriptions, dosage amounts and times – and access to outside specialists. Health care staff can also assist your client in obtaining nutritional supplement drinks, changes of bedding and clothing, and in

some cases, changes in diet. Health care staff may also be helpful in providing access to condoms and bleach in those jurisdictions that make these materials available.

Note that *most institutions will not have a full-time physician on staff*.

In both the federal and provincial systems, doctors are often contracted from the community to either provide services on a limited basis, or to provide services on a full-time basis, but in several different prisons. This usually means that a physician may only be in the prison a couple of days a week. If you are seeking to advocate on a medical issue, this limited availability can cause real problems.

Therefore, it is generally better to try working with the nursing staff, who are in the prison every day. The Head Nurse or Healthcare Coordinator is often a good person with whom to build a relationship. If your client does not know the name of the Head Nurse, simply call the main switchboard and ask.

2. Security (the Guards/IPSOs) and Administration (the Warden, Deputy Warden, Superintendent)

Security and administrative staff make a significant number of decisions that directly affect your clients. Security and administrative personnel decide which range or living unit will house your client; whether s/he is single, double, or triple bunked; whether s/he is placed in segregation; and whether s/he is allowed a *Private Family Visit* (a "trailer visit").

Wardens set operating policies for their own institutions, in keeping with established correctional policies set at higher levels.[5]

Deputy Wardens/Superintendents are involved in community programming decisions and security clearances for visitors (both professionals and family).

Prison guards have the most face-to-face contact with the prisoners. Although their work is governed by the policies of the institution, individual guards can also exercise significant discretionary decision-making power. In some cases, this may result in behaviour that you consider inappropriate or unprofessional. If such an event occurs, *do not direct your intervention toward the guard in question*. Rather, report the issue to the prison administration, whose role is to implement and monitor institutional policy and practice.

For a break-down of decision-making structures above the institutional level, please refer to the *CSC Bureaucracy Map* and *Provincial System*

[5] For more information on the hierarchy of correctional policy-making, see *"Inside" Information: Grievance Procedure in the Federal Correctional Setting – An Advocate's Guide.*

Bureaucracy Map in *Canadian Prisons: Systems and Structures, Canada's Prisons – Two Systems, Multiple Challenges* in Chapter Two.

Having determined *what* the problem is, and *whom* you need to contact, you finally need to decide *how* you will communicate with that person.

Choosing Your Tools – The "How"

In choosing your method of communication, always maintain focus on your original objective – to create positive change in the *easiest* and *quickest* manner possible.

Broadly speaking, there are three basic advocacy tools at your disposal. We'll call these options *"the 3 Cs": Conversion, Commotion, and Coercion*.

Each of these options may or may not work, depending on the issue involved and the willingness of the institution to resolve the problem. For more on using these "3 Cs", see *Taking Action, Basic Strategic Guidelines for Advocacy*, below.

Deciding which of the 3 Cs provides the best opportunity for reaching your goal/s is part experience, part intuition, and part luck.

If you have had previous interactions with the institution or staff member in question, you will have an insight into what approach/es to use or to avoid in order to achieve results. If you have advocated on a similar problem at another institution – whether successfully or unsuccessfully – this can also inform your decision.

The urgency of the problem is another factor to consider. Is the problem of a relatively minor nature – where taking a few days to achieve a resolution is acceptable – or is it more severe, demanding immediate rectification?

Always make sure that the client authorizes both your involvement and your strategy before you take any action.

Remember that, as a prisoner, your client is in a vulnerable position. Some institutions and/or prison staff do not take kindly to prisoners approaching outsiders, and your intervention could result in negative consequences for your client.

Talk your advocacy options through with your client to make sure that they are in agreement with your ideas. Do they think a simple call placed to a friendly nurse will be sufficient? Should you contact the institution in writing instead, to create a paper trail? Should you *"cc."*[6] the letter to the warden, a lawyer, or other individual/s to try and cause a bit of commotion?

[6] *"CC"* means (to) *Copy*. Literally, (to) *"Carbon Copy"*. A *"cc." list* appears at the very end of a letter, under the signature and list of enclosures (if applicable). The cc. list indicates the recipients of a copy of the correspondence (other than the addressee), usually by name, title, and organization (if applicable), and sometimes also includes mailing address and contact number. See *Effective Letter Writing* and *Copying Correspondence* in *Taking Action: Formal Correspondence*, below.

THE 3 CS OF ADVOCACY:
Conversion, Commotion, and Coercion

1. CONVERSION

"Conversion" essentially involves convincing the person responsible that a mistake has been made, and convincing them of the need to rectify it.

This can mean making a simple phone call or writing a letter to notify a staff person of an oversight. If need be, it can mean "sweet talking" the staff member or decision maker to convince them to assist you.

This can also mean providing more systematic education, such as comprehensive or specific staff-support training, or engaging in policy advisory processes with decision-makers.

Depending on the receptiveness and responsiveness of your target, this can either be the fastest and most efficient method, or the slowest and least efficient method.

2. COMMOTION

"Commotion" is about just that – making noise and causing a fuss. It attempts to pressure or embarrass the person/s responsible into rectifying the problem. Creating a commotion can be accomplished in many ways, and to many degrees.

Options (in approximate order of confrontational magnitude) include:

- Phone calls
- Letters
- Mobilizing other allies in cooperation
- Filing complaints with the Ombudsman (for provincial corrections)
- Filing complaints with the Correctional Investigator (for federal corrections)[7]
- Media work/press releases
- Demonstrations
- Participating in Coroner's Inquests (which investigate all deaths in custody)

3. COERCION

"Coercion" refers to legal remedies, such as launching lawsuits or other legal actions.

While the legal avenue is often the first option that springs to the minds of both prisoners and community-based workers to effect change, it should *never* be considered as the option of *first* resort because of the time, resources, and uncertainty involved.

While appropriate in some cases, it is seldom useful for accomplishing easy and quick change.

Once you have determined the *what*, the *who*, and the *how* – and have received your client's authorization – it is now time to *act* on your advocacy strategy.

Taking Action

By far the vast majority of your advocacy efforts will involve making phone calls and writing letters.

The centrality of phone calls and letter writing to prison advocacy warrants them a little more attention here.

Phone Calls

If you have decided that the problem is best addressed by a quick telephone call to a prison staff member, call the main switchboard and ask to speak to the person in question (Head Nurse, Deputy Superintendent, etc.).

After your call is patched through, introduce yourself and your agency, and ask for assistance with the problem. Don't forget to follow the guidelines for effective communication highlighted earlier in this chapter, under *How to Get Your Clients' Needs Met: Advocacy 101*.

Calling a staff person on an individual basis is the "softest" approach. This advocacy option is least likely to cause undue fallout for your client, as it can usually be accomplished in a friendly and casual manner.

However, phone calls don't leave a formal record. Since there is no documentation of the exchange, it is easier for your concerns to be dismissed, ignored, misunderstood, or forgotten. It is then difficult to hold people accountable for any verbal commitments made to rectify the problem.

However, just because the institution will have no formal record of the call does not mean that you should not document it yourself. Remember to make a note of the date, time, staff member/s reached, and any commitments made. The phone call is frequently just the first step in a longer advocacy chain, and the documentation you keep at this stage can help form the basis for later advocacy efforts.

Formal Correspondence

If you have decided that the problem requires firmer action, or if a phone call has failed to resolve the issue, you may choose to notify the institution in writing. Again, call the main switchboard, and ask for the name and fax number of the appropriate staff member. Write that person a letter docu-

[7] For more information on grievance procedure, see *"Inside" Information: Grievance Procedure in the Federal Correctional Setting – An Advocate's Guide*.

Keys To An Effective Advocacy Letter

1. *IDENTIFY THE INDIVIDUAL CONCERNED*
2. *ESTABLISH YOUR CREDIBILITY* by explaining the mandate of your organization.
3. *IDENTIFY YOUR RELATIONSHIP WITH THE INDIVIDUAL*
4. *IDENTIFY AND EXPLAIN THE PROBLEM*
5. *PROPOSE A SOLUTION* that would meet the needs of your client.
6. *MAKE YOURSELF AVAILABLE* to assist with the solution in an appropriate way.
7. *INDICATE THAT YOU WILL FOLLOW UP* on the letter, and specify how and when.
8. *LIST CCs* – indicate the other players who will receive a copy of this correspondence, if applicable.

menting your client's concerns, following the guidelines for effective letter writing below.

Writing a formal letter to staff is more likely to generate a response of some kind. By beginning a paper trail, you create a situation where the staff *must* respond to you in some way, either to fix the problem or explain why it cannot be fixed.

Effective Letter Writing

Letters can be a very effective means of advocating for your client at all levels of the criminal justice system.

Naturally, a well-articulated letter will have a much greater impact with decision-makers than will a quickie, off-the-cuff effort. Therefore, you should devote the time and thought necessary to compose a letter that will generate maximum impact, and leave the least amount of wiggle room for reluctant recipients.

Above is an eight-step guide to crafting an effective letter. An example is provided on the facing page.

Note the similarity to the principles of effective communication outlined in *Advocacy 101* earlier in this chapter. Your letter need not be lengthy – in fact, it *shouldn't* be long – but, at minimum, it should include all of the components 1 – 7 above, and component 8 if applicable.

Copying Correspondence

If you want to be *sure* of receiving a response, it is wise to *"cc."*[8] the correspondence further up the bureaucratic chain to the person/s to whom that staff member reports (the Warden, the Regional Director of Health Services for Corrections, the Solicitor General, etc.).[9] You could also cc. the correspondence to your client's outside community supports, such as their physician, lawyer, and/or support worker/s. Sending a copy of the letter to government watchdogs such as the Ombudsman's Office (for provincial corrections) or the Correctional Investigator (federal corrections) is another option.

[8] See definition at footnote 7 earlier in this chapter.

[9] For an overview of the corrections hierarchy, see the *CSC Bureaucracy Map* and *Provincial System Bureaucracy Map* found in *Canadian Prisons: Systems and Structures, Canada's Prisons – Two Systems, Multiple Challenges* in Chapter Two.

Example of an Effective Advocacy Letter

(ORGANIZATIONAL LETTERHEAD) (Date)

(Name of Specific Individual)
Superintendent
(Name of Correctional Centre)
(Address)

DELIVERED VIA FAX

Dear (Name of Specific Individual):

1 Re: Mr. John Doe

I am writing on behalf of PASAN to request your assistance with Mr. John Doe, who is currently incarcerated at your institution.

2 PASAN is a community-based network of prisoners, ex-prisoners, organizations, activists and individuals working together to provide advocacy, education, and support to prisoners on HIV/AIDS and related issues. We are the only organization in Canada working specifically to provide HIV/AIDS education and support to prisoners, ex-prisoners, and young offenders.

3 Mr. Doe has been a client of ours since 1994, 4 and it has recently come to our attention that he is being held in punitive segregation following an incident with a correctional officer. It is our experience that people held in segregation often have difficulty accessing adequate bedding and blankets, and we understand that this is now the situation facing Mr. Doe. For a person living with HIV/AIDS, such conditions obviously pose an unnecessary and unacceptable risk to his health, and we request your assistance to ensure that Mr. Doe's health needs are met during his time in segregation.

While we understand the responsibility of the institution to ensure a safe environment for staff and prisoners, and that segregating individuals for disciplinary reasons is sometimes part of that mandate, we are also adamant that such disciplinary measures must not compromise the fragile health of prisoners living with HIV/AIDS. We believe that even the small step of providing adequate bedding and blankets during segregation will help to ensure that Mr. Doe's health is not further jeopardized.

5

6 If you have any questions, please don't hesitate to contact me. 7 I will telephone you this afternoon to discuss the situation.

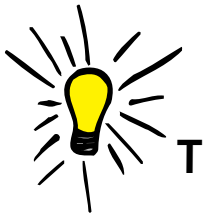
Thank you very much for your attention in this matter. Your cooperation and assistance is greatly appreciated.

Yours truly,

(Your name and Position)

8 cc. *(Name of Specific Individual), Ombudsman*

Remember that while copying the correspondence to others will definitely earn your letter a response, it is also likely to anger the person to whom the letter is addressed. The more important the people *cc.'d*, the angrier the recipient is likely to be. *This is not a reason to avoid this strategy*. To the contrary, a recipient's anger shows that you have successfully forced them to take your letter seriously. Still, it *is* a reason to consider your strategy carefully, and proceed thoughtfully.



TIP:

If your fax is urgent, be sure to mark it "URGENT".

You also want to avoid overusing this escalation tactic at the outset of your efforts. For example, if you cc. your *first* letter to everyone under the sun – and your client's problem remains unremedied – you have inadvertently eliminated your avenues for increasing pressure through follow-up advocacy.

YOU HAVE NOW BEEN introduced to the basic process of advocating for prisoners with the institution. To complete your introduction to advocacy, below are some proven effective guidelines to keep in mind when planning your advocacy, and throughout the process.

Basic Strategic Guidelines for Advocacy

1. Familiarize Yourself With Policy

Gaining an understanding of prison policy and practice is essential before embarking on a course of advocacy. This knowledge will help clarify which options for resolution are open, and which are closed to you. In addition, demonstrating specific knowledge will significantly increase your credibility when intervening.

2. Clarify Your Immediate Objective

Limited objectives are always more achievable.

Of course, you should not ignore (nor do anything to undercut) your long-term objective – to improve conditions for *all* imprisoned PHAs. However, do not be afraid to set more limited, short-term objectives as well, related strictly to the immediate problem at hand. *Limited objectives are not a "cop-out".* Rather, a succession of limited victories can get you closer to your longer-term goals than will a string of ambitious failures.

3. Relate Your Means to Your Ends

Assess the available advocacy options in relationship to your desired outcome. Just as you must be realistic in clarifying your immediate objective,

you must likewise use good judgement to assess the quickest and most effective way to reach that goal. Be sure to choose the right tool for the job.

4. Have a "Plan B" (and C)

Depending upon the severity of the problem, you may or may not be able to resolve it with a single phone call, or piece of correspondence. Therefore, when creating your advocacy strategy, it is best to *assume that your first communication will fail*. In this way, if your first approach is successful, it is good news for everyone. However, if your first approach is unsuccessful, you have already planned out your next move/s, and have laid groundwork for follow-up advocacy at higher levels.

5. Use a Calculated Escalation of Pressure

An incremental approach is usually better than going straight to the top of the decision-making chain.

Target your efforts first at an institutional level, then move up to the regional/national headquarters level, and then on to the political level.

Structuring your escalation in this manner gives the prison an opportunity to resolve the problem "in-house" – that is, without being embarrassed at higher levels. This leaves room for goodwill in your relationship.

Should you need to escalate further, it will also allow you to build a stronger and more compelling case at each stage up the ladder. For example, it allows you to argue that you are *forced* to write directly to the Commissioner of Correctional Services, because the institution has ignored your previous appeals for assistance, or otherwise failed to resolve the problem.

6. Increase Your Leverage

One of your greatest sources of advocacy leverage is your *credibility* – with prisoners, with the institution, with the corrections bureaucracy, and with the outside community. Therefore, your reputation will be a factor influencing the success or failure of present and future client advocacy efforts.

Ultimately, to increase your advocacy leverage you need to demonstrate your willingness to take matters to higher authorities, but in a thorough, responsible, and well-documented fashion. If you can earn a reputation as an agency which acts thoughtfully, yet with strong conviction, you may find that a problem which took three letters to resolve the first time can be fixed with a single well-placed phone call the next time (or later down the road).

TIP:

Despite its convenience and apparent speed, don't assume that email will serve the same purpose as a mailed or faxed letter. Generally, email is still too informal, and is less of a permanent record than a hard copy of a letter appearing on organizational stationery.

Remember too, not everyone checks their email on a daily basis, whereas a faxed letter will be delivered to an individual's desk by clerical staff.

Therefore, while your immediate priority is always to assist your individual client, keep in mind that the advocacy process also involves building your agency's reputation with both the individual institution and the prison system as a whole. Remember: *any move that does not enhance your credibility, detracts from it.* Always conduct yourself professionally in all advocacy efforts, as this will ultimately increase your advocacy leverage.

Other sources of increased advocacy leverage include bringing other allies (individuals, agencies, or networks) on-side in a cooperative effort; and generating publicity. Usually these latter two options should be saved for situations requiring further escalation.

7. Follow Through

Don't leave the outcome hanging, or release the pressure on staff or decision-makers before the change has actually taken place.

Unfortunately, commitments alone are no guarantee of results. Allow a reasonable amount of time to elapse, then follow up your last contact. Plan this follow-up ahead of time, and write it into your schedule.

8. Analyze the Outcome

It is important for you to evaluate and learn from the advocacy experience, and build upon it for next time. What worked and what didn't? Which staff were helpful to you, and which were not? Are there people you could involve in the advocacy effort next time to strengthen your case? Are there avenues for pressure that you did not try that might be useful next time?

9. Follow Up With the Client

Make sure that your client is satisfied with the results of your efforts. Did the problem get fixed? Did it get fixed in a way that s/he can live with? If not, then further follow-up with the institution may be required.

Even if your efforts were unsuccessful, it is still essential to follow-up with the client and explain what has happened. It is important that your client knows that you tried your best, and didn't just ignore their request for help.

10. Follow Up With the Institution

If your advocacy successfully resolved the problem, then a thank-you to the staff person/s who assisted you is appropriate. A quick thank you phone call will go a long way towards building your agency's reputation with the prison staff.

A formal written thank you is especially important if you have cc'd an advocacy letter higher up the prison bureaucracy. It is only fair that the same people who were notified of the problem are also told that it has been rectified. If you have been working through the Head Nurse to resolve the issue, for example, send them a letter thanking them for their help, and send copies to the same people who received your previous letter/s. This is both respectful of the staff attention given to resolving the matter, and useful in demonstrating your willingness to recognize and reward any assistance prison staff lend to outside community agencies.

11. Don't Despair

Some of the above follow-up tips are based upon the assumption that you are able to resolve the issue successfully. However, the reality of doing prison support work is that you will never be able to fix every problem. Ultimately, the prison controls what goes on within its walls. In many cases, you can do everything right and still fail to get the problem solved.

If there is no policy in place at a federal or provincial level to address your client's particular need, you will have no ability to resolve it in the short term. *This does not mean you are a bad advocate.* Likewise, if the institution digs in its heels and refuses to address your concerns, there is not really anything you can do about it, other than use the experience to inform broader systemic advocacy initiatives and campaigns.

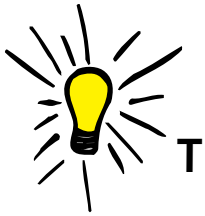
Distilling the intricacies of successful advocacy into one short chapter is impossible. So many of the nuances and subtleties used by skilful advocates only develop through experience, and through a detailed understanding of their particular working environment. This is not to say categorically that you cannot advocate successfully without such detailed knowledge. However, the better your understanding of the relevant policies, the institutional systems and cultures in your region, and the personalities involved, the more easily you will recognize the most effective options when faced with an advocacy issue.

Effective advocacy is about knowing what buttons to push to resolve your problem, when to push them, and how hard. Different approaches work better for different people, for different institutions, for different issues, and at different moments in time. Through experience, you will learn to assess which approaches offer the best opportunity for a speedy resolution of any given problem.

WE HAVE BEEN LOOKING at advocacy as it applies to interactions with the institutions and with prison and government bureaucracies. However, you may also be called upon to provide client support through another form of advocacy: by providing testimony at various types of hearings.

Providing Support through Courtroom Advocacy

When working with people living with HIV/AIDS who are in conflict with the law, there may come a time when you are asked to provide support for a client appearing before court. You may be asked to write a letter on behalf of the client, but you may also be asked to appear in court and testify.



TIP:

It is useful to decide ahead of time two or three key points you want to emphasize in your testimony. This will make it easier for you to maintain focus under questioning, and ensure that your answers always reinforce these key themes. If you are able to keep your testimony coming back to these two or three key points, you are more likely to impress these points on the judge.

Unlike television courtroom dramas, where everything is nicely wrapped up in an hour, the real court process can drag on for months or even years. The defendant has to appear in court multiple times for various bail hearings, administrative hearings, and evidentiary hearings before ever reaching trial. If the individual is not granted bail and released pending trial, s/he will have to spend all of this time a detention or remand centre. This is called *"dead-time"*. The threat of spending months or even years in an over-crowded and under-serviced detention centre while awaiting trial leads many defendants to plead guilty to charges – such is their desperation to get transferred to a less crowded institution (and begin serving their sentences).

Testimony in court can take place at various stages of the process. While everyone is familiar with trial testimony, when witnesses get up and answer questions about the crime, there are other times when the judge may consider verbal testimony or written submissions from people who are not witnesses to the crime itself. This occurs at *bail hearings* (held after a person has been arrested but before s/he comes to trial), and at *sentencing hearings* (held after a person has been convicted, when the judge is determining an appropriate sentence). Such hearings present opportunities for HIV/AIDS workers to advocate on behalf of clients.

Whether you are writing a letter or providing verbal testimony, you have two main advocacy objectives:

1. *To educate the judge about the negative effects of incarceration on people living with HIV/AIDS, and why that should be taken into account in deciding your client's bail or sentence.*

2. *To present the court with a support plan for your client, should s/he be released back into the community.*

"Support plans" relate to the provision of post-release housing, counselling, drug treatment, family support, and medical care, etc. for your client. The more comprehensive the plan, the greater the likelihood of your client's *"success in the community"*. High potential for "success in the community" is what you will need to prove to the judge. Note that the judge will equate potential for "success" with her/his assessment of the client's risk of re-offending.

If you are providing a letter of support, please refer to the earlier section of this chapter on writing effective letters. Verbal testimony is discussed in detail below.

When providing either written or verbal evidence to the court, always remember that your reputation, and that of your agency, is also being examined. It is essential that you are as accurate and credible as possible in all information you provide.

Stick to providing information *only* on those issues on which you have expertise and credibility – HIV/AIDS – and *do not* allow yourself to be drawn into offering opinions on other topics. The further you allow yourself to veer outside of your area of knowledge, the weaker the credibility and impact of your information.

If you present yourself and your evidence well, it will have a positive impact on your credibility in later cases.

Testifying in Court

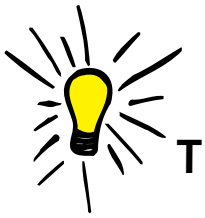
If you have elected to testify in person, below are some tips to help familiarize you with the players and the process, and advice on being an effective witness.

HALCO's Witness Tips

Ruth Carey, Executive Director of the *HIV & AIDS Legal Clinic Ontario (HALCO),* was kind enough to provide her four tips for being an effective witness.

1. **Listen very carefully to each question.** Before answering, repeat the question again to yourself in your head to be sure you understand it.
2. **Never answer unless you're absolutely sure of what you are being asked.** If you have *any* doubt, state that you do not understand the question, and ask that it be restated.
3. **Unless you are 100% sure that the answer you are giving is true, you should qualify your answer.**

   This concept is best described using an example. Suppose you are asked, "Did you move into your new apartment on January 1st?" Unless you are ABSOLUTELY positive that you *did* move on *January 1st*, it's wiser to qualify your answer by saying "I moved *on or about* January 1st. It might have been a day earlier or a day later," rather than just saying "Yes." This way, you don't look like you are making a mistake or evading the question if the crown has evidence that you actually moved on January *2nd*.
4. **Show respect for the proceeding.**



TIP:

One common cross-examination tactic the Crown will use to try and throw you off is to examine your client's criminal record in detail while you are on the stand.

A standard piece of Crown theatre is to ask you things such as "Did you know Mr. Smith was convicted of armed robbery in 1992? Did you know Mr. Smith was convicted of aggravated assault in 1995? Do you think Mr. Smith should be allowed to go free simply because he has AIDS?"

The purpose of this line of questioning is to obscure your client's health issues behind their criminal record. It is also an attempt to paint you as a naïve "do-gooder" rather than a knowledgeable witness, and to draw you away from testifying in your area of knowledge.

The best way to subvert this tactic is to maintain strict and disciplined focus on your own area of expertise – HIV and AIDS. Your client's criminal record is irrelevant to the credibility of your particular piece of evidence, so don't allow yourself to be baited into this trap.

When the Crown asks "Did you know Mr. Smith was convicted of armed robbery in 1992?" you answer "I'm sorry, I don't un-

The Crown Prosecutor (The "Crown")

Make no mistake, as a community-based professional appearing in court on behalf of your client *you are entering an adversarial process*. You will be questioned and challenged by a Crown whose job it is – at least from your client's point of view – to put your client in prison for as long as possible.

The Crown's job is to rigorously test your evidence. They do this by *"cross-examining"* you.

This process can often feel like a personal attack – like the Crown is trying to insult you and/or discredit your experience and training. It is precisely because cross-examination can feel like a personal attack that it is essential for you to keep in mind that it is *not*. For you to advocate most effectively – and thereby serve your client well – it is crucial that you not allow yourself to be baited into responding to cross-examination as if it were a personal attack.

The Crown will likely try to provoke you, because drawing you into a personal confrontation is to their advantage. The more effective they are at getting you upset – and possibly flustered – the less effective you are in presenting your client's case.

Do not ever insult the Crown, even if you feel they are insulting you. If you do get angry (and you might), focus that anger into calmly and clearly advocating for your client. Maintaining your professionalism and focus is of paramount importance in making your case to the judge.

Besides, being an effective witness for your client is the best revenge.

The Defence Counsel

In an ideal world, your client's defence counsel will have spoken with you ahead of time to assist you in preparing your evidence. Through that consultation, the defence will have logically determined the best questions to ask you in order to bring out your strongest testimony. Do not assume we live in an ideal world, however.

While some defence counsels will ensure that such preparation is done properly, just as many will not bother. *Do not assume the defence counsel is knowledgeable on HIV/AIDS*. Some are, some are not. Unless you have specifically consulted with the defence counsel prior to the court date, you should assume that you are going to be on your own in presenting your client's case (regarding HIV/AIDS).

If this occurs, there is no need to panic. Even a poorly prepared defence counsel will not question you in the same adversarial manner as the Crown. However, it *is* likely that an unprepared defence counsel will not know the best questions to ask in order to elicit your best testimony. In this event, *you* should take the initiative during your time on the witness stand. Testify about what *you* think are the most important issues. Don't be shy. If you are an articulate advocate for your client's case, the defence counsel will not stop you from expanding the boundaries of their questioning.

The Judge

The judge will make the decision in your client's case, and it is their opinion alone that matters in the end.

For this reason, it is very useful for you to direct your testimony to the judge, rather than to the Crown or defence counsels.

Directing your answers to the judge also provides you with a useful safeguard. If you direct your answers solely to Crown, you are more likely to be drawn into some sort of back and forth argument. Directing your answers to the judge (without even looking at the Crown) is an effective way of stepping outside of a counterproductive confrontational dynamic.

Make eye contact with the judge, as this can be an effective way of making your points with clarity and conviction. It can also help you collect your thoughts, control your emotions, and maintain your focus on your number one priority – impressing the judge.

Remember that the judge can also ask you questions at any time during your testimony. If the judge does ask you a question, make *sure* you address your answer directly to her/him.

Parole Hearings

Whether federally or provincially incarcerated, everyone who is in prison will have the right to apply for *parole*, and have their application considered at a *parole hearing*.

Parole hearings are another common venue where HIV/AIDS workers engage in client advocacy.

Parole hearings occur automatically after the prisoner has served a set proportion of their sentence (which varies by jurisdiction). For example, provincially sentenced prisoners in Ontario have the right to a parole hearing after completing one third of their sentence.

derstand what that has to do with his HIV status?"

When the Crown asks "Did you know Mr. Smith was convicted of aggravated assault in 1995?" you answer "Mr. Smith's criminal record is fair to discuss, and it is your responsibility and that of the defence counsel to examine that record carefully. My responsibility, on the other hand, is to discuss Mr. Smith's medical record, not his criminal record."

When the Crown asks "Do you think Mr. Smith should be allowed out simply because he has AIDS? " you answer "That is not for me to decide. That is for the judge to decide, and I have every confidence in the ability of Her/His Honour to make a fair judgement, based upon all the evidence. My role here is to assist the court by providing a piece of that evidence, namely the negative health effects of incarceration on people living with HIV/AIDS. I for one would certainly not make statements to the court outside of my area of expertise, nor would I be so presumptuous as to tell Her/His Honour what her/his decision should be."

Answers such as these go far in establishing your professional credibility with the court. Once the Crown realizes that this tactic is not going to work to draw you off topic, they will soon drop it.

Prisoners also have the right to waive their parole hearing, and many choose to exercise this option if they feel they will be denied parole anyway.

Parole applications are heard by *parole boards*, which are panels appointed by the federal or provincial governments.

The mandate of the parole board is public safety and security. Therefore, parole boards are most interested in whether the individual is at risk to re-offend if released, and/or violate the provisions of her/his parole. To determine this, the parole board looks primarily at the person's prior criminal record. The longer their record, the less likely the board will be to grant them parole. The board also tends to be particularly harsh in their decision if the individual has previously violated parole or bail conditions, or has failed to appear at court hearings.

The parole hearing takes place inside the prison. When a prisoner comes up for a parole, the parole board interviews the individual, and also considers written submissions from various sources (correctional, community, family, etc.).

The parole hearing is another instance where a well-written letter can help your client's chances.[10] Although parole boards rarely give much weight to compassionate or health-related circumstances, it is still important to articulate the negative effects of incarceration on people living with HIV/AIDS. As with submissions to court, think of your letter as a chance to educate the parole board about HIV/AIDS issues.

Also take the opportunity to detail the supports, which will be available from your agency when the parole applicant, your client, is released. This is a specific area that can impress parole boards. You should make sure to emphasize that your client's access to regular, structured support in the community (via counselling, support groups, volunteering with your agency, etc.) is something concrete that can help reduce their risk of re-offending.

In rare circumstances, you may be invited to attend a parole hearing. While the prisoner is allowed to have a lawyer and/or supporter attend on her/his behalf, the supporter is not generally invited to speak directly to the parole board. If you *are* asked to attend a hearing, be sure to find out if you will be expected to answer questions from the board members, so that you can prepare as necessary. While the parole hearing is not technically an adversarial process, the parole board members will need to be "convinced" that your client should be released. The previous advice in this section should help you to shape your testimony before the parole board.

[10] Once again, refer to the subsection *Effective Letter Writing*, earlier in this chapter.

Parole boards have been known to use an individual's HIV positive status as a *negative* factor in assessing their risk to the community. In this sense, AIDS-phobia has found a home among many parole board members. For example, it is a common experience for prisoners living with HIV/AIDS applying for parole to be asked questions such as *"How can we be sure that if you're released you won't go around intentionally infecting people?"*

The limitations of appealing for compassionate consideration from parole boards of this mind set are obvious. Still, it is critical that community-based HIV/AIDS workers intervene in this process to help provide a counter to discriminatory attitudes.

Detention Review Hearings

A second type of parole hearing that you may encounter is a *detention review hearing*. This is a hearing unique to the federal system.

In the federal prison system, prisoners are eligible for *"statutory release"* after serving two-thirds of their sentence. This means that they are released from the penitentiary, and serve the final third of their sentence in the community, under some sort of supervision (reporting to a parole officer, living in a halfway house, undergoing random urinalysis, etc.).

In some cases, however, CSC will recommend that an individual be *"gated"*. This means that the person will have their statutory release revoked prior to being released, and will therefore serve their entire sentence in the penitentiary. This is usually done when individuals are considered to be at high risk of re-offending, and/or have convictions for violent crimes. Before the prisoner can be "gated", however, s/he is entitled to a detention review hearing, where the parole board will consider CSC's request to withhold statutory release.

As with other parole hearings, you can make written submissions to the board on behalf of your client. Again, refer to the section on *Effective Letter Writing* earlier in this chapter.

Compassionate Release Hearings

A final type of parole hearing is the *compassionate release hearing*.

While these hearings are often termed "compassionate", they are actually regular parole hearings, and are heard by regular members of the parole board.[11]

TIP:

The courts are notoriously crowded and slow. If you do offer to appear in court for a client, you should be prepared to spend your whole day there. Individual court appearances are rarely on an exact schedule, so while you will know the date and the room where the hearing will be held, you will probably not be given an accurate starting time.

This means that you will need to arrive at the courthouse in the morning when court opens, and wait until you are called. If you are lucky, your client's case may be heard in the first hour. If you are unlucky, it may not come up until after lunch. If you are very unlucky, her/his case might not come up at all, and be rescheduled for the next day. Be prepared to wait, and bring a good book or other work to do.

[11] In the federal prison system, such hearings are officially called *"parole by exception"*

Rather than being designed to consider cases on medical grounds, these hearings are instead conducted as standard parole hearings where the prisoner's parole eligibility date has been moved forward due to their failing health.

This is important to understand for two reasons. First, the board members considering the application have no training in medical issues, either generally, or on HIV/AIDS specifically. Second, the parole board's primary concern remains public safety, security, and the prisoner's risk of re-offending. They are not required to consider medical conditions at all in their decision.

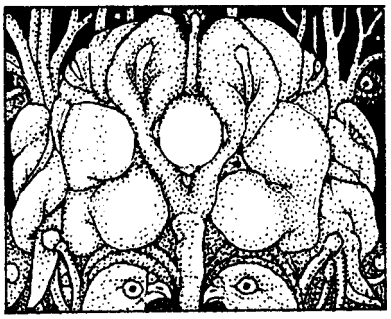
This reality can and does lead to horrible and heartbreaking situations, where terminally ill people are denied release based solely upon their past criminal records.

No one should die from HIV/AIDS alone in prison, and the urgent nature of compassionate release situations compels you to intervene as an advocate. If you are invited to make oral or written submissions on your client's behalf, follow the advocacy and testimony guidelines elaborated earlier in this chapter.

It is important to fight the good fight in these situations, but be prepared that these hearings are very stressful and emotional. More often than not, compassionate release applications are refused.

HAVING REVIEWED the support and advocacy processes relevant during an HIV positive client's imprisonment, we have now come to the final phase during which you may be called upon to provide support to imprisoned PHAs: the release process.

III. Providing Support During the Release Process



When you get the good news that your client is being released, you may think that their worst troubles are over.

However, release from prison can be a terrifying experience, particularly for someone who has been incarcerated for a long period of time. The prospect can very easily cause a person to panic, and the days and weeks leading up to your client's release date can therefore actually be a period of high anxiety.

Most likely, your client will need your support now as much as ever.

Imagine the changes your client faces.

While the client's old environment was completely structured and controlled, her/his new one is comparatively wild and chaotic. Where the prison environment was slow moving and excruciatingly boring, the outside world can seem too fast, and over-stimulating.

In prison, the client was told when to get up, when to eat, when to take medications, and when to go to sleep. S/he was housed, food was prepared, and medicines were provided. Now s/he must find a place to live, cook for her/himself, remember her/his own medications, and keep appointments. If the client will be returning to a city, s/he must get used to being in huge crowds and to riding public transit. If the client was incarcerated for many years, s/he may never have seen a bank machine, let alone a looney or a tooney. Many other changes and responsibilities may confront and confuse your client.

The client's social life will change completely, as once again s/he separated from the support of an established circle of friends left behind in prison. The social codes s/he grew accustomed to on the inside don't always apply on the outside. The individual who may have been a "big man" or "big woman" in prison is now just one of a thousand people on the street.

The shock to the system can be almost as great as when entering prison for the first time.

With the stresses of managing HIV infection piled on top of all these adjustments, things can easily spin out of control.

When someone is released from prison, the first 24 to 48 hours is often the most stressful and chaotic time. Even once that period is over, however, it can take weeks, months, or even years for people to resettle themselves comfortably on the outside. Some people never do, and enter the "revolving-door" of going to prison/getting out of prison/going back to prison for many years.

As support workers, there are a number of services we can provide to people as they approach their release date to help make those first few days a bit less stressful, and their transition more comfortable. There are also things that agencies can do to make themselves more accessible to the unique needs of people who have been incarcerated, and thus to facilitate their continued use of your services.

The measures that will help imprisoned PHAs during the release process are discussed below.

Pre-release Planning

Pre-release planning is one of the most important ways that community workers can help smooth a PHA's transition from prison to the community.

By putting concrete support structures in place for the client prior to their release – such as housing, financial support, and medical support – you can significantly increase the structure, security, and stability of their daily lives.

While pre-release planning *should* be the responsibility of the prison system itself, few jurisdictions provide sufficient resources to do this work comprehensively. Some institutions do pre-release planning on a piecemeal basis. Others do not provide the service at all. In such instances, planning ahead for the client's release often falls primarily or solely upon community workers (both AIDS workers and others).

For those institutions that *do* incorporate pre-release planning into their mandate (such as those in the federal system), correctional staff are often not familiar with the specific needs of, and services available to, people living with HIV/AIDS. In these cases, community-based AIDS support workers also have an important contribution to make.

If you have a client who is nearing a release date, ask them what their plans are for when they get out. The sooner you have this conversation the better, as some pre-release work – such as securing housing – can often take many weeks or months.

Your client can tell you whether or not there is someone in the institution assisting them (i.e., a parole officer, pre-release planning officer, Native liaison worker, etc.). If someone else is already working on their case, ask your client if you can call them and offer to assist. *Be sure to find out first whether the client has disclosed her/his status*. If it is all right with your client, then simply give the staff member a call, introduce yourself, and ask if you can be of any help. Most correctional staff charged with pre-release planning are quite open to working with community-based groups, and will likely be grateful for your involvement – and particularly for your HIV/AIDS expertise.

Whether you and the client are working on your own, or in conjunction with correctional staff, the necessary elements of a pre-release plan are the same.

Elements of a Pre-release Plan

1. Housing

Housing is always the primary issue facing people when they get out. Many prisoners may have been homeless or under-housed prior to their arrest. Some may have been renting an apartment or house, which they had to give up while incarcerated. Some may have been living with partners or families – or in communities – who don't want them back. Some clients may have been living in environments that led directly to their incarceration (with drug using friends, for example), and to which they would prefer not to return.

High demand for HIV-supportive housing, public housing, and rent-geared-to-income housing, means that waiting lists for places can sometimes be very long, particularly in urban centres. Therefore, it's never too early to begin looking for housing for clients, filling out applications, and getting them placed on waiting lists.

When making housing applications, be sure to find out whether the client's criminal history or parole status (if on parole) will be a barrier, as some places are reluctant to take in ex-prisoners. Transsexual and transgendered ex-prisoners often face additional barriers to housing, as many residences (including correctional halfway houses) are single gender facilities. In either of these situations, some advocacy may be required.

If the client is being released from a federal prison, the local federal parole office will have to do a *"community assessment"* on the address where your client is planning to live. This can sometimes create problems if your client is moving in with friends or family with past convictions, or into neighbourhoods that are assessed as having a big drug scene.

Be aware of these potential problems *before* doing lots of leg-work to secure a space in a particular residence. If you have a specific address in mind, talk with your client's parole officer or case management officer *before* starting a long application and intake process. This can help save you unnecessary work, and/or provide the opportunity to advocate with the parole officer about the benefits of a particular housing arrangement.

2. Clothing

Some jurisdictions will release people with only the clothes they were wearing when arrested. If they were arrested in August – wearing shorts and a T-shirt – and are being released in February, this creates an obvious problem. Ask your client about this ahead of time, as you may need to arrange to get her/him clothes to wear when s/he gets out.

Call the jail and find out their procedure. If your agency has access to clothes or a clothing bank, you can usually bring the clothes in to the client yourself. If not, the chaplain and/or the Salvation Army (who often work in the jails) can usually help on this issue.

3. Money

Financial support is another key need after clients are released.

Most often, people are turned onto the street with no money at all in their pockets. This is an urgent problem, particularly if the person lacks housing as well. It means they are unable to rent a room, or buy a meal. You will also find that people are commonly released on a Friday, but cannot hope to get anything from a welfare office before Monday. Even when people are released mid-week, it can often take 24-48 hours to process a request for an emergency welfare cheque. This is a long time when you're flat broke.

In some cases, you may be able to pre-arrange a welfare appointment for the person on the morning or afternoon they are released. If you are fortunate enough to know a helpful welfare worker, your advocacy can sometimes encourage them to make the necessary arrangements to have a cheque issued that same day. While this is not a standard procedure, it *can* be done.

If your agency provides emergency financial assistance to people living with HIV/AIDS, consider giving grants to your clients upon their release. Even a few dollars can help them get through a day or two until they can pick up their first cheque.

4. ID

Most prisoners have their ID confiscated – and then promptly lost – by the police when they are arrested. Therefore, most people are released without birth certificates, SIN cards, and health cards. This obviously poses enormous problems for PHAs trying to get access to social assistance, health care, etc. when they get out. This is another area where you can be a big help.

Find out whether your client has any ID. If they tell you the police have it, assume it's gone.

If the client needs new ID, they can begin the process of getting it replaced while still inside. Again, this process again can take a few weeks, so begin as soon as possible.

Birth certificates and SIN cards are the first step. Find out the process for replacing them in your province, obtain the forms, and then mail or bring them in for your client to fill out. If the client needs additional help filling out the forms, you can usually ask a prison social worker, chaplain, or Native liaison to assist them. The client can either have the new ID mailed back to them at the prison, or to your office for them to pick up later.

There is usually a fee associated with replacing birth certificates and SIN cards. If your agency provides financial assistance to PHAs, this is a useful grant to make.

This same problem applies to health cards. In some provinces, a person can begin the process of replacing lost health cards while still incarcerated. In others, this can only be done in person at designated offices. Provincial policies also change quite regularly, so it is useful to keep up with any new legislation.

TIP:

If your client approves, try to involve other organizations in building a pre-release plan. While some of the elements are specifically related to health, many others are not, and may be taken on by other community-based groups. Do not try to do it all on your own.

5. Medications

If your client is on any HIV-related medications, it is important that their release not cause an interruption in their therapies. Contact the prison health care unit to ensure that the person will be released with several days' supply of their medications.

More and more prison health units are now doing this as a matter of routine for PHAs. Still, it's best to check up just to be safe.

Note that the prison will not provide the client with pain medications. Therefore, if your client is on significant pain medications, you will need to arrange a doctor's appointment on the day they are released in order to get a prescription.

6. A Doctor

Once you've arranged for the client to be released with a small supply of HIV medications, it's important that they see a doctor *before* that supply runs out.

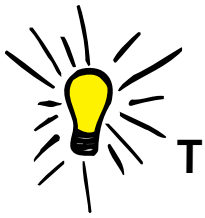
If your client already has a doctor in the community, call ahead and make them an appointment for as soon as possible after their release. If the client does not have a doctor, set up an appointment with a local HIV specialist. It's important to explain the client's situation, and to brief the doctor on the urgency of the case. *Make sure that you have your client's permission to do this.*

If possible, try to arrange for the jail to send a copy of the client's prescriptions to the doctor, as this will increase the continuity of care (particularly if the person is seeing a new doctor).

A further note on pain medications. Some physicians are very reluctant – or even refuse – to prescribe pain medications to current or former drug users. Those that *are* willing to do so are unlikely to agree to make that prescription on a patient's first visit.

If your client is on pain medications, find out the physician's policy beforehand. The last thing your client needs is to walk into the doctor's office, already stressed out and probably going through withdrawal, only to be told they can't get their pain medications.

If the doctor refuses to make the prescription, try to get the medical file released from the prison health unit, if you have not done so already. If the doctor continues to refuse, consider finding another doctor.



TIP:

It is useful to identify physicians and/or community health centres in your region that are willing to see patients without health cards, or while health cards are being processed.

If your client has an appointment to see a doctor upon release, but has no health card, be sure to communicate this with the physician's office ahead of time to ensure that the doctor will still see the patient. If not, you will need to arrange an appointment with another doctor or clinic that <u>will</u> accept your client without a health card, at least as an interim measure.

7. A Buddy System

Having a "buddy" to act as a guide or helper in the first 24 to 48 hours after release can be an incredible support. The buddy can help the client get to appointments and generally get around, as well as provide moral support during this most difficult period of the transition.

If a staff member or volunteer with your agency can provide this service, great. If not, ask your client if they have any friends or family members whom they would trust to fill this role.

Providing Support for Staying Out

You may find that many of the clients with whom you had regular contact while they were inside prison will lose contact with your agency after they are released. This is a common experience.

In some cases, the individual's needs change after their release, and they no longer feel it necessary to access specific AIDS services. For some people, the very fact of being out increases their options for obtaining support services, and they may choose to access other community and family resources. Some people will go back to chaotic drug use and life on the street, cutting ties to your organization in the process. In other cases, community-based agencies are just not very welcoming or accessible to ex-prisoners. It is often a combination of these and other factors that result in clients losing contact.

While community-based agencies have little control over most of these factors, one thing we *can* influence is the degree to which our agencies are able to meet the specific needs of ex-prisoners.

Adapting your services to meet their needs encourages ex-prisoners to maintain contact with your agency. This sustained contact can play an important positive role – not only in their health, but also in providing structures and supports that may assist them to stay out of prison for the medium and longer term.

Below are some common difficulties affecting ex-prisoners, and some suggestions to help make your agency more accessible to them.

Common Adjustments for Ex-Prisoners and/or their Support Agencies

1. Keeping Appointments

You may find that ex-prisoners have real difficulties in keeping set appointments with you. If one of your recently released clients misses their appointment, don't automatically assume they have done so intentionally. You may find that they turn up later in the day, or at the correct time on a different day.

Since prisoners' daily lives are so completely structured by the institution, creating and managing their own daily routines after release is a gradual process. For this reason, it is important that agencies make extra efforts to make their services accessible to people as they are getting reacquainted with managing their own time.

TIP:

Women ex-prisoners may have additional support needs when they are released from prison. Many find themselves back in abusive relationships with male partners, and this can also make negotiating safer sex practices more difficult for them. Such clients may therefore need support and advice around negotiating safer sex, as well as around other issues arising from their abusive relationship.

It is useful to develop contacts with groups providing support for women who are survivors of violence. This will assist you in making appropriate referrals for women ex-prisoners who need support in addressing issues of past violence, or for those currently involved in abusive relationships.

If your client is having trouble in this regard, talk to her/him about strategies that might make it easier for them to remember their appointments. If your agency has set days or times for drop-in, you might suggest that the client try to come during that time, as it will allow them more flexibility on arrival time.

2. Taking Medications

Remembering to take medications on time is a daily struggle for all PHAs. However, this is often *more* difficult for people when they first get out of prison. Most institutions do not allow prisoners to manage their own medications. Instead, nurses come around at set times to dispense prescriptions, or prisoners have to go to the health unit at certain times to pick them up. When people get out, they are immediately thrown into managing their own medications – seeing the doctor to get the prescription, getting the prescription filled at the pharmacy, and then taking the medications as prescribed (including any dietary and other considerations).

Be aware of this issue, and prepare your client ahead of time. Discuss strategies to help them remember to take their medications, and ways that you and/or your agency can help.

3. Needing to Make Phone Calls from Your Agency

When people are first released from prison, the telephone is a crucial organizational tool for them. They need to get information from government offices on things like ID replacement. They need to make appointments with doctors, welfare workers, and parole officers. Yet many people who are released do not have housing, let alone a telephone.

If your agency can provide access to a free phone – even only on set days and times – this will be of great help. Try to make the phone area as comfortable and confidential as possible, as clients may need to spend some time waiting to have their calls returned by various agencies and professionals.

4. Needing Peer Support

Many ex-cons are not comfortable in more general support groups. Some feel unfairly judged by other group members because of their incarceration history. Others find that they have life experiences that are so unlike those of many of the other participants, that this makes it difficult to access true "peer" support.

If you have a significant number of ex-prisoners accessing your agency, starting a peer support group exclusively for them can help to address some of these barriers.

An ex-prisoners' peer support group can play a role in building a broader network of support and knowledge on the outside and (should any members of the group get rearrested) on the inside as well. Such a group can be particularly helpful to newly released clients, as they will then have the opportunity to access real life expertise from their peers who have also been through the stresses of getting out and staying out.

Should you wish to incorporate peers into your HIV prevention education prison programs, an ex-prisoner group could also provide a pool of potential recruits.

5. Providing Peer Support: Volunteering Opportunities with Your Agency

Some clients may also be interested in providing peer support, and so may inquire about opportunities to volunteer at your agency after their release.

Even a couple of hours a week as a volunteer can provide some structure and purpose in the client's new routine. Volunteering can provide a boost to their self-esteem, and can also provide another outlet for them to access regular peer support from other PHAs.

If your agency is able to offer such volunteer opportunities, ex-prisoners can play a very strong supportive role in helping their peers adjust to life on the outside. As such, they can be a great help with ex-prisoner peer groups. Some may also be interested in working as peer educators. (For more on using peers in your programs, see *Basic Advice on Running Your Prison Program: Use Peers* in Chapter Five.)

In addition, ex-prisoner volunteers can make a valuable contribution to the development and review of your agency's prison-specific programs and materials, and can help review the agency's accessibility issues.

Going Back to Jail

Finally, it is not uncommon to have clients who cannot stay out of prison for more than a week or two at a time over the course of several years.

If your client gets released, only to be arrested again shortly thereafter, is that "failure"? Absolutely not.

One reality of working with prisoners is that many people continue to go in and out of the system over the course of many years. This happens despite the best intentions of the individuals, and the best efforts of their support workers. It is essential that we recognize this struggle within its proper social context, and continue to maintain supportive and non-judgemental relationships with our clients, whether inside or out.

As community workers, we cannot focus on the perceived "failure" of being arrested again. For the individual who has never been out for more than a period of days at a time, struggling and succeeding in staying out for a few months is an incredible achievement. We must focus on the fact that the client stayed out for as long as they did. We should not underestimate or diminish the courage and determination it took that individual to accomplish that much. If this is recognized and supported as a major step in that person's life, it can be significant in helping them to stay out longer the next time.

One reality of working with prisoners is that many people continue to go in and out of the system over the course of many years. This happens despite the best intentions of the individuals, and the best efforts of their support workers.

We must be also be aware of the dangers of judging our own effectiveness as workers by the perceived "successes" and "failures" of our clients.

This is a common – but unproductive – tendency. First, it places unnecessary and undeserved pressures on our clients, which can ultimately lead to poisoning our relationships with them. Second, it can lead to worker frustration and burn out. If we set unattainable goals for our clients, and then decide we are ineffective workers when they fail to meet those expectations, it is no wonder that so many of us end up feeling frustrated and cynical.

Far too often, breaking the law is trivialized as simply "being bad" or "misbehaving". However, as discussed in Chapters One and Two, people usually come into conflict with the law as a result of deeper personal issues and broader social determinants. Getting released from prison does not mean that those personal pains have been resolved, nor that those broader determinants have disappeared. Therefore, it should come as no surprise that many people must struggle to remain out of prison – sometimes throughout their entire lives.

People heal themselves on their own, based upon their own needs and timetables, and through their own personal struggle. It is our job to assist our clients in that healing process as best we can, rather than judge them for their perceived "failures."

IV. Conclusion

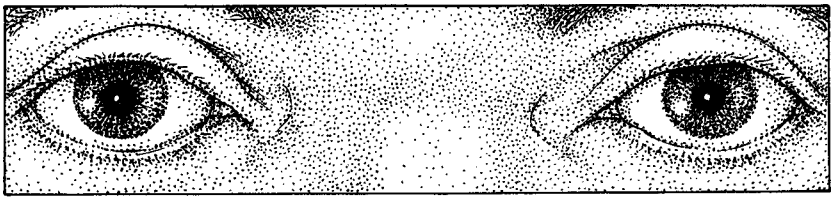
As AIDS workers, providing support for, and promoting the health of, people living with HIV/AIDS is our primary responsibility.

Given the unique barriers and struggles that *incarcerated* PHAs must endure, delivering this support and advocacy is not only more challenging, but also absolutely critical to defending their rights to care.

This chapter has given you some guidance on providing concrete support services to PHAs in prison, and advice on negotiating and advocating on behalf of your imprisoned clients.

For further assistance, the *Resources* section provides detailed contact information for every adult prison in Canada, as well as for key organizations involved in systemic advocacy initiatives.

"INSIDE" INFORMATION



Grievance Procedure in the Federal Correctional Setting: An Advocate's Guide

by Michael Linhart, Coordinator, Prison Outreach Project, BC Persons With AIDS Society, Vancouver, B.C.

WITHIN THE FEDERAL PRISON SYSTEM there is a mechanism for prisoners to attempt to address treatment that they believe to unfair, inappropriate and/or contrary to their rights as a Canadians and as prisoners. The mechanism is officially called the *Grievance Process.* Any prisoner who feels they have not been treated fairly, is free to begin seeking redress through this process.

Grievance procedure is a multi-level process that can often be confusing and frustrating, and therefore prisoners frequently need outside help. Since lawyers may be unwilling, or their fees prohibitive, such requests for assistance frequently fall to community-based advocates like you and me.

When a prisoner feels that they have something to grieve, they can file a *complaint form*. This is the basic first step in the process. The supervisor in charge of the area where the alleged event occurred must respond to the complaint.

If the supervisor's response does not effectively deal with the issue to the satisfaction of the prisoner, they can file a *first level grievance* that goes directly to the Warden. If there is still no action or acceptable solution, the prisoner can then file a *second level grievance* for response by the Regional Deputy Commissioner (actually it's usually a delegate). If after receiving this response the prisoner still feels there has not been an acceptable resolution, they have the right to file a *third level grievance* directly to the Commissioner. The Commissioner will typically delegate someone to look into the issue and provide a response. Upon receipt of the Commissioner's reply, if the prisoner remains dissatisfied and feels that the injustice is important enough, they have the right to take the matter to the *Correctional Investigator*.

The Correctional Investigator is pretty much the federal counterpart to a provincial Ombudsman (or to be politically correct Ombudsperson). The Correctional Investigator is *not* a Correctional Service of Canada (CSC) employee, and is charged with conducting investigations into complaints that have been through the complete

grievance procedure. *Unless all levels of the grievance process have been completed, the Correctional Investigator does not have the authority to act on the matter in question.*

The Correctional Investigator has the power to investigate and make recommendations as a result of the investigation's findings. However, the Correctional Investigator *cannot* effect policy change, or overturn legislation, and/or any decisions of the Warden or Parole Board where such decisions were made within the framework of existing CSC policy or directives.

There are also some things CSC simply classes as "non-grievable". Typically these are things such as incidents that did not happen directly to the person filing the complaint, and issues specifically covered by CSC policies and/or Directives.

Thus, whenever you are doing advocacy for aggrieved federal prisoners, someone will invariably refer to either a "Commissioner's Directive", a "Regional Instruction", or an "Institutional Standing Order". It is important to understand what these different Corrections documents are, and how they relate to the law, and to the grievance procedure.

Every single document associated with federal prison policy must be based on two key pieces of legislation: the *Canadian Charter of Rights and Freedoms* ("the Charter") and the *Corrections and Conditional Release Act* (CCRA). The Charter sets out what is fair and reasonable treatment for every human being in Canada, based on the principles of human dignity. The CCRA is the legislation that outlines the treatment of prisoners in Canada, and the authority of the federal Correctional Service. The drafters of the CCRA had to ensure that it did not violate the principles of fundamental human rights, as outlined in and protected by the Charter. The rights of prisoners are set out in these two legal documents.

The CCRA sets out the parametres that the Commissioner of the CSC uses to develop the *Commissioner's Directives (CDs)* that stipulate guidelines for the treatment of all federal prisoners regarding virtually everything concerned with managing the prisoners' custody and behaviour. There are also specific CDs which establish standards governing the behaviour of CSC staff, and they manner in which they are to conduct business. In turn, each CSC Region's Deputy Commissioner uses the CDs as the basis for their *Regional Instructions (RIs)*. Likewise, each institution's Warden develops *Standing Orders (SOs)* based on existing CDs and RIs. RIs and SOs must cover the issues outlined in the appropriate CD, and may only make changes that are necessarily specific to the Region or Institution. (For example, security levels differ between institutions, and therefore some SOs within the same region will vary with the institution's security rating.)

In theory, CDs, RIs, and SOs all follow the spirit of the two principal pieces of legislation, the Charter and the CCRA. In practice, however, you will discover that CDs, RIs, and SOs seldom take into consideration specific medical, spiritual, gender, and cultural differences. They are usually generic, open to interpretation, and written for the segment of the prison population without special needs. *When prison policy as set out in CDs, RIs, and SOs contradicts the Charter and CCRA, this can constitute grounds for a prisoner launching a formal grievance, citing Charter violations, or citing violations of, or inconsistency with, the CCRA guarantees.*

Knowledge of the contents of the relevant CDs, RIs and SOs – as well as the Charter and the CCRA – is critical for knowing how to proceed when a prisoner ap-

proaches you for help with a grievance. Your policy knowledge will help you navigate as an advocate.

In my experience as a prisoner advocate, I have developed some standard procedures for assisting prisoners with their grievances.

The first and most important step is to get as much information as possible from all parties concerned, including any documents, and witnesses. Always make sure you have full information before proceeding.

When talking with the aggrieved prisoner, write down all of the information they give you, then repeat the information back to them. Ask if you have understood them correctly, and clarify any questions you have. Thank them for trusting you with the information, and reassure them that the information is confidential, and that you will only use it to help them.

You may need to get the prisoner to sign a *Release of Information (ROI)*. This allows the prisoner to give you the legal right to ask questions on their behalf, and compels CSC to provide you with answers *(except when the issue relates to institutional security and/or when the issue or individual concerned is the subject of an ongoing investigation).*

Discuss with the prisoner what they think is a reasonable solution to the problem, and what they would be prepared to accept if it is not possible to get exactly what they want. If the prisoner is not willing to accept anything less than their way, explain that this could prove problematic, but assure them you will do what you can.

You will find that you do not always get the complete story, or an accurate account of the events from prisoners. There are several reasons for this. Sometimes the prisoner may not have all of the information, and can only pass on what they have been given. Some prisoners have language barriers, lower literacy and/or comprehension levels, and may not understand the situation fully. Other prisoners are very angry with the system, and when something does not go the way they want or think it should, they get mad and don't hear anything that is being said by others. None of this is to say that you should not believe prisoners, nor to say that you should automatically trust that a staff member is telling you the full truth. However, there are two sides to every story. Good advocacy in prisons requires finding out as much as possible about both sides.

If you have been able to build good working relationships with staff in the institution/s, they can often help clarify situations for you, or direct you to who can. Call the staff member concerned and ask them for their perspective (if they will talk to you). Once again, write down what they have to say, feed it back, and clarify any questions.

If the issue is a minor one, you can often reach suitable solutions at this point. If so, thank the staff member for their cooperation. Follow this up by sending a letter thanking them again for taking the time to answer your questions and concerns, and outline the points of the conversation as you understood them. This can be very useful later, as it's not unheard of for staff or prisoner stories to change.

If a phone call to the staff member concerned has not resolved the issue satisfactorily, the second step is to determine whether the prisoner's issue is "grievable" or not.

You must first ascertain whether the situation as you understand it *is* in fact contrary to the CDs/CCRA/Charter. If so, then it is grievable. If you are unfamiliar with the relevant CDs/RIs/SOs, look them up.

In the course of your advocacy ef-

forts, you may be told that something is "policy", but that you are not entitled to review a copy of that policy. You *can* legally obtain these policies through a *Freedom of Information Act* (FOI) request. However, FOI requests are time consuming and can be costly. If you believe that an FOI request is necessary, make sure you have organizational authorization before you initiate the request.

If something going on is clearly outside of the CDs/CCRA/Charter, there are several remedial steps available that stop short of filing a formal complaint. You should try these first.

You can notify the staff person concerned that you are aware that they are not following the CDs, and insist that they make the change or the matter will go to their supervisor. Every single correctional employee has a supervisor. Even the Commissioner must answer to the Solicitor General.

If this does not generate the change, find out who the supervisor in charge of the staff person is and contact them. Explain that the issue has been brought to your attention and that you want to try to resolve it as quickly and fairly as possible. Begin by outlining the concerns of the prisoner. Outline your own concerns, pointing to what you believe is contrary to the relevant CD and/or CCRA/Charter provisions. Suggest several possible resolutions.

When talking to the supervisor responsible for the area where the problem exists, approach the issue in a manner that is non-accusatory and open. If you approach them in an aggressive manner, they may shut down before you have even had a chance to talk about the issue. If the issue is something that appears to be the result of a lack of information (about medical issues, for example) offer to assist by providing the information.

When the situation is a matter of (federal, regional, or institutional) policy, however, there may be nothing you can do to resolve it for the prisoner short of filing a formal grievance and taking it as far as necessary.

It is always best to empower the prisoner to complete their own grievance. However, there are times when issues such as literacy can prevent them feeling confident enough to file a complaint or grievance without assistance.

If you are working with a prisoner who has filed or will be filing a complaint or grievance, *it is crucial that you have them keep copies of every stage of the process.* If possible, have them also provide copies to you, to help build a paper trail that will be useful if the court process becomes necessary.

If the prisoner wants help filing a formal complaint or grievance they have two options. First, each institution is supposed to have an Inmate Grievance Clerk, and part of their job is to assist prisoners in filing grievances. However, this may not always be the case, and so the prisoner you are dealing with may seek other outside assistance – possibly yours.

If you are assisting the prisoner, follow the intake procedures described above. Then have the prisoner obtain a complaint form from the prison. This form is blue and should be easy for any prisoner to access, and *must be provided by staff when requested.* Fill out the form with all of the necessary information, and as much detail as possible. Don't hesitate to use additional sheets of paper if needed. File the completed form with the prison, according to its stated procedure.

This process will be the same for all additional grievance steps, except that for the next steps the grievance form is yellow,

with sections for the first, second, and third level grievances all included within the one form.

It is generally *not* a good idea to introduce new information or details when taking the issue to higher levels. The best you can do is continue to argue how the previous level decision does not fall within the CDs, CCRA, or Charter. Always ensure that you keep copies of every level you grieve, and the response, for future reference or action.

If the prisoner has already filed a formal complaint or grievance on their own, ask them to get you copies of all the relevant documents, including the responses they have received. This way, you will be able to know where to begin your follow-up advocacy efforts. For example, if the response to date indicates that the solution is outside the jurisdiction of the Warden, Deputy Commissioner and/or Commissioner, then you would begin by going directly to the Correctional Investigator.

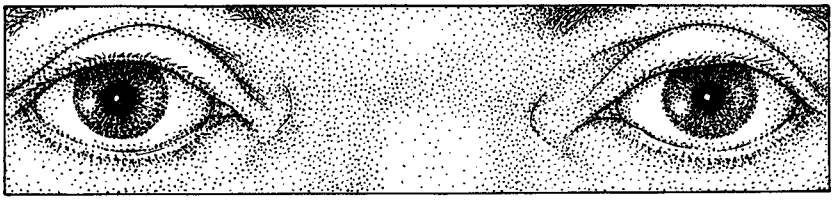
Despite our reliance on the protections provided to prisoners under the CCRA, there have been times when parts of the CCRA itself have been challenged in court as violating the Charter. It is possible that at some point in your work with prisoners, you may believe that such a violation has happened, or may be happening. This is considerably more serious and requires more complex action than just filing a grievance. In such instances, you should consult a lawyer familiar with both pieces of legislation.

One of the resources you can use when you encounter such problems is the network of other HIV/AIDS organizations working on prison issues. Perhaps the best resource for a community worker or volunteer dealing with grievances regarding HIV/AIDS in prisons is the Canadian HIV/AIDS Legal Network (CHALN). CHALN has worked on issues around HIV/AIDS in our prisons, and they are interested in hearing of any major problems or discriminatory practices of CSC. If we all document these types of problems as they occur, eventually there may be enough evidence to pursue a court challenge.

Grievances and complaints do not always bring about the changes the prisoner is looking for. However, they do serve to bring CSC's attention to areas where there may be problems, such as policy violations, or staff acting inappropriately.

If you are wondering whether there is any point to pursuing grievances, consider this. The Charter, CCRA, and CDs all outline treatment and codes of conduct that respect basic human rights. When CSC staff find prisoners not abiding by these, they are quick to take action. If prisoners are expected to comply, then surely we must also expect CSC to follow their own rules.

Prisoners have rights. As an advocate you can use these tools to hold CSC staff accountable for their actions or inactions, and thereby help ensure that these rights are upheld.



Supporting Pain Management for HIV Positive Women in Prison[1]

by Anne Marie DiCenso, Women's Programs Coordinator,
Prisoners' HIV/AIDS Support Action Network, Toronto, Ontario

WOMEN LIVING WITH HIV/AIDS often experience pain related to their disease. This pain can vary from the uncomfortable to the debilitating, and from the sporadic to the chronic. For many women PHAs such pain becomes part of their daily lives.

Different women cope with HIV-related pain in different ways. Some can effectively manage their pain using relaxation, meditation, massage, diet, exercise, and/or alternative medicines. For others, however, these strategies are not possible, effective, or desired. In many cases, their pain is best managed by using prescribed medication or street drugs.

For most women living with HIV/AIDS, using prescribed pain management medication is seen as a reasonable and necessary option for coping with HIV-related pain. Few medical professionals, social workers, or AIDS counsellors would take issue with this. The need for pain management frequently becomes obscured, however, when the PHA in question is either a street drug user, in prison, or both.

For many medical and social service providers, drug use and/or incarceration changes their perception of the woman's pain, and often restricts the options they make available to her for pain relief. These are problems I frequently confront as a counsellor working with HIV positive incarcerated women – many of whom are drug users.

Many clients come to me for help because medical staff are not taking them seriously. One client's story illustrates the potential for catastrophe when prejudice against drug users clouds medical judgment.

This woman PHA was back on the street. She was using heavily, but was still feeling severe pain. No matter how much she self-medicated with street drugs, she could not block out the pain she was in. After a few weeks she finally decided to go to the emergency room of her local hospital. She was seen by a nurse who looked at her arms and saw needle marks. The nurse told her to lay off the drugs and she would be fine. Without further examination she was told to *"go home and sleep it off"*.

The woman tried to stay away from drugs, believing that maybe she *had* been using too much, and that was the cause of her problems. She worried that she was doing damage to her immune system and be-

lieved the break from drug use would do her good. But the pain persisted and she was unable to cope with it. She went back to the hospital and was told the same thing. *"Stop using and you'll be fine."* She explained that she hadn't used in four days and could not stand the pain. She told them she was HIV positive, and felt unable to eat, was nauseous, and had night sweats. The hospital staff insisted it was just withdrawal and sent her home again.

The woman's roommate came home to find her unconscious and called an ambulance. She was finally diagnosed with PCP pneumonia, and a viral infection in her intestines that had gone untreated for months. Despite having sought medical attention twice, this woman might have died had she not had a caring roommate to come to her assistance.

I believe the fact that this woman PHA was a drug user led medical staff to make incorrect assumptions about her symptoms, and prevented them from treating her seriously. Unfortunately, misdiagnosis and dismissal of HIV positive drug users in pain is not unusual in my experience.

Another reason clients frequently come to me for help is that needed prescription pain management medication is being withheld from them. I believe that this too is often the result of prejudices about drug users in general, rather than objective and considered medical judgment in individual cases.

Medical professionals are often reluctant to prescribe narcotics to drug users because they fear that these women are more likely to become "addicted" to pain medication, or because they assume the patient is fabricating or exaggerating her pain in an attempt to secure drugs to get high.

Many doctors who see a woman when she is going through withdrawal also refuse to prescribe pain medications on the grounds that the withdrawal phase will pass, and because they view getting the patient off drugs as a priority over pain management.

The treatment decisions resulting from these pre-judgments force these HIV positive women to either continue to self-medicate with street drugs, or else live with unrelenting pain.

These common assumptions about drug users and pain management medication do not stand up to scrutiny, however.

People who use drugs are not necessarily "addicted" to them. It is therefore incorrect to conclude that drug users are more prone to dependency on prescription pain management medications than non-drug users. In fact, a person who has a history of using street drugs *without* developing a dependency may be *less* likely to become "addicted" to prescription narcotics than a person who is a non-user (and who therefore has no drug using history to evaluate). Use of other drugs is not a valid reason to deny needed pain medications.

Those drug users who *are* dependent (or "addicted") generally stick to a particular "drug of choice". If such a user also seeks prescription pain management medication from a physician, this usually indicates that the street drugs she is using are not helping to manage her pain – this may be because she has developed a tolerance to the street drug, or it may be because her condition has worsened. Again, dependence on another drug is not a valid reason to deny needed pain medications.

Finally, withdrawal itself is a *very* painful and stressful process, and can be even more so for HIV positive people. Even if the physician believes that it is in the pa-

tient's best interest to stop using street drugs, this is not a valid reason to deny needed pain medications, especially when withdrawal compounds preexisting HIV-related pain. In fact, such a decision is more likely to lead the woman to return to self-medication to manage her pain.

The problems of pain misdiagnosis and refusal of needed pain medications are difficulties common to women PHA drug users, both on the outside and while in prison. However, when an HIV positive woman drug user is imprisoned, the issue of pain management becomes even more urgent. Withdrawal is almost inevitable, her access to non-drug avenues of pain relief is limited or non-existent, and her ability to select a doctor who is more sympathetic to the needs of drug users is negligible.

The perception of "drug-seeking behavior" is the most significant barrier confronting women prisoners living with HIV/AIDS, and a difficult prejudice for many medical and social service professionals to overcome. There is a common scenario that serves to reinforce this idea.

While incarcerated, a woman's access to her street drug of choice will most likely be reduced, sporadic, or eliminated completely (depending upon the availability of street drugs in the prison). This can create a dual pain issue. Not only may she be facing the pain of withdrawal, but *she also may be experiencing new HIV-related pain which had gone previously unnoticed because of her use of the street drugs*. These two factors can combine to *increase* her need for pain management medications.

If a woman's use of street drugs *has* effectively masked her HIV related pain, she is unlikely to have visited a community doctor for pain relief – or other treatment. For this reason, prison can be the first time many women living with HIV/AIDS seek medical treatment for HIV-related pain. This point is particularly crucial, since prison doctors often question the legitimacy of requests for pain medication *specifically* because the woman has not previously sought pain medication on the outside.

In the face of persistent pain, it is natural to try to find avenues for pain relief. In prison, however, women PHAs usually cannot access the non-narcotic options. Alternative medicines, massage, stress reduction and relaxation exercises are generally out of the question – either because prisoners have no means of learning the techniques or acquiring the tools, or simply because they don't have access to private, quiet space. In this context, it is simply wrong to deny them access to prescription pain management medications as well.

It may be true that *some* drug users seek pain management drugs in order to get high. However, this does not absolve doctors of the responsibility to examine the individual, determine if there is any HIV-related pain, and prescribe treatment and/or pain management medication as needed. In fact, with the rigorous precautions standard to prison settings, it is difficult to understand why doctors continue to deny pain medication to HIV positive prisoners. In prisons, pain medication is distributed in a monitored setting and must be taken in front of health care professionals. It is only given out as prescribed by a doctor, and the amount cannot be changed without the doctor's agreement. The logical conclusion is that continued denial of treatment is rooted in persistent – perhaps unconscious – prejudice against drug users and stereotyping of women prisoners.

In truth, it is difficult for most of us to see the need for compassion for drug users. An inherent judgment that *"it's their own fault"* makes even the most compassionate

person feel that drug users just need to tough it out regardless of pain or distress. The concepts of recreational drug use, of drug use as self-medication, and the principle of harm reduction all continue to be contentious in the fields of medicine and social work. Yet we cannot deny that the belief that everyone in pain has a right to pain management medication *except* drug users constitutes discrimination.

Prejudices against drug users intersect with stereotypes of women in prison. Women prisoners are generally assumed to be selfish and irresponsible – otherwise how could they have abandoned their family responsibilities, or put their own drug-using desires first? An HIV positive woman prisoner's attempts to secure pain medication in order to care for herself are therefore suspect if she is a drug user: *"well, she doesn't seem to care enough about her health or her children to stop using drugs."* It automatically brings us to the conclusion that her request for pain meds must be a ruse to get more drugs. Very rarely are such requests understood as what they most often are: pleas made by women in pain who need help in making the pain go away.

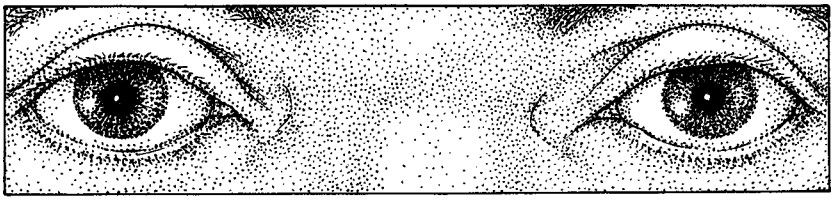
How *does* a woman access pain medication in prison when she is HIV positive and a drug user? Faced with issues of prejudice, suspected of trying to scam drugs from the health unit, and threatened with either intolerable pain or denial of privileges, she is often in a no-win situation that leads her back to covert self-medication.

This problem can only be reduced through education of prison health staff and health care providers in the community, by challenging prejudice and by promoting the principles of harm reduction.

As AIDS workers, our response needs to be based on health promotion and not on moralistic grounds. This can be difficult for many health care providers whose primary aim may be to get people off street drugs. Nevertheless, acceptance of HIV positive drug users and a willingness to listen to them is the key to negotiating a treatment and pain management plan that is acceptable to both the health care provider and the client.

When our clients are denied needed pain management medications, we need to be able to make effective arguments on their behalf – either to the prison health unit, to the client's community doctor, or both. We need to recognize the common barriers encountered by our clients. We need to understand the bases for doctors' negative decisions – and be equipped to counter them. Most of all, we need to confront our own prejudices against drug users and be sure that these do not hinder our ability to support our HIV positive clients, and advocate for their right to pain management.

[1] Although my observations and arguments are based on my experiences with HIV positive women, most would apply equally to male or transgendered HIV positive drug users in prison.



Supporting the Families of Prisoners Living with HIV/AIDS

by Holly Wiggins,
Winnipeg Chapter, John Howard Society of Manitoba, Winnipeg, Manitoba

I HAVE BEEN WORKING in Stony Mountain Penitentiary (a men's prison) with the John Howard Society since 1989. During this time, one of my concerns has been the needs of the families of prisoners infected with HIV.

In many cases, a prisoner is inside when he finds out he is HIV positive. Sometimes he was positive before he came in. Sometimes he has been infected while in prison. In these situations, not only does the prisoner not have access to the support of his family, but the prisoner's family can also be left out of the support process.

Many of the family members I have spoken to have hesitations about attending support groups in the outside community. They see themselves as different from other families affected by the disease. The majority have brothers or partners who were infected by dirty needles or tattoos, rather than by unsafe sex. Many of these families feel that the stigma attached to prisoners and drug users makes it hard for them to seek the support of other community-based groups.

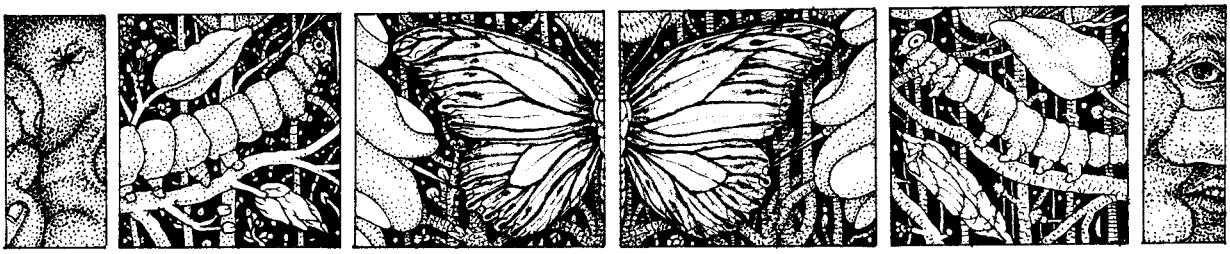
Given that their infected loved ones are incarcerated, HIV positive prisoners' families also have unique needs and concerns. Things that are taken for granted in the community – specialized doctors and clinics, food supplements, access to the latest prescription medications – are all things that are often not available for people in prison. These families also often feel helpless to assist their loved ones in any manner. Family members may be afraid to start any political action or advocacy on the prisoner's behalf, for fear that the prison will retaliate against their loved one. They fear that their brother/son/partner may be shipped out to a prison miles away from them because he/they are seen as trouble makers. They fear that their efforts to advocate for the prisoner's health care may result in him being transferred out of province, to the regional medical unit in Saskatchewan. At a time when the family should be pulling together to support each other and their infected loved one, they feel unable to do so because Corrections is in control. These unique stressors further separate the prisoners' families from the more general support groups.

Over the last year I have been trying to form a support group specifically for fami-

lies with incarcerated loved ones infected with HIV. Of the twelve families I am in contact with, nine have voiced interest in support from others in the same situation. In an attempt to bring these families together for mutual support during the Christmas season, I organized a Christmas dinner with an informal meeting after. Once the families were all there, and a few began sharing stories, they soon discovered they were not alone. The discussion ended up going well beyond what was initially planned, and was a good start towards future work.

Please pray for these families and myself, to give us the wisdom and strength for us to follow the right path in the coming months.

Migwitch.



CONCLUSION

Ploughing the Ground

THIS BRINGS US TO THE CONCLUSION of *Pros & Cons*. We hope you found it a useful and informative manual, and that you continue to use it as a resource as you develop your own work with prisoners.

Pros & Cons has provided PASAN the opportunity to share with you many of the lessons we've learned over the past nine years. Yet for us, undertaking this project has always represented a starting point, rather than an end point.

While we have reached the end of the book, we are still at the beginning of the work.

It's true that the needs of prisoners are now talked about more often in the AIDS movement. However, the unfortunate reality is that there are still far too few of us meaningfully engaged in this crucial work with prisoners. Our numbers are too small. Our programs are too few. Our voices are too quiet.

Your work can help change this.

We hope that this manual will encourage more of you to take on prison work, and encourage greater networking and cooperation between all of our agencies.

For those of you new to the field, we hope that you will be able to take some of our ideas, and use them to initiate and inspire your own HIV/AIDS work with prisoners.

For those of you already engaged in this work – at whatever stage – we hope this manual provides guidance enough to help you expand and improve your efforts.

As has been stated throughout this manual, there is a public health crisis in Canadian prisons. Change is essential.

While the community has a responsibility to provide services for prisoners, this does not negate or replace the responsibility of government to provide services for prisoners as well. Without adequate access to the tools to prevent HIV infection, without adequate access to HIV specialists and proper medications, all of our combined community-based efforts will necessarily be of limited efficacy.

If our governments are not prepared to act on their responsibility, it is our responsibility to hold them accountable. It is our responsibility to work to ensure that the rights of people in prison, the rights of people living with HIV/AIDS, are recognized and respected. This effort is of equal importance to providing direct AIDS services.

As repeated throughout: within the prison context, education, support, and advocacy efforts are integrally linked. Each necessarily supports the goals of the others. All three together act as ploughing the ground for the seeds of change.

We encourage you to keep in touch with PASAN, and with the other community-based agencies listed in the *Resources* section, all of whom have been leaders in the effort to promote health care rights for prisoners.

As you move forward in developing your own work with prisoners, remember:

Listen to the voices of prisoners and people living with HIV/AIDS, as their experiences must guide our work.

Invent your own creative approaches to HIV/AIDS work in prisons.

Encourage your agency to take a stand on HIV/AIDS and prison issues.

Document the experiences of prisoners living with HIV/AIDS in your region, and share them with others.

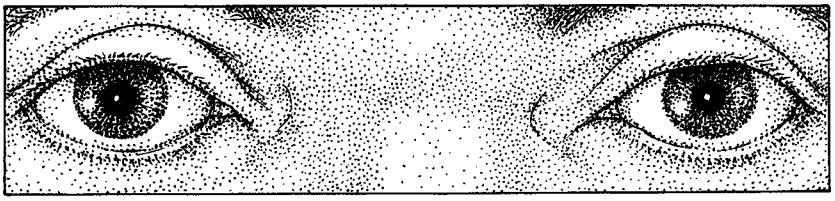
Fight every day for the rights of people in prison, and of all people living with HIV/AIDS.

Join us.

SECTION C

Resources

RESOURCES



RESOURCES

I. Further Readings

Useful Publications

Canadian HIV/AIDS Legal Network (CHALN). *HIV/AIDS in Prisons: Info Sheets 1-13.* 1999.

—— *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*. November 1999.

Community AIDS Treatment Information Exchange (CATIE). *Managing Your Health: A Guide for People Living with HIV or AIDS*. 1997.

Correctional Service of Canada (CSC). *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons*. February 1994.

Jürgens, Ralf. *HIV/AIDS in Prisons: Final Report*. The Joint Project on Legal and Ethical Issues Raised by HIV/AIDS (a project of the Canadian AIDS Society and the Canadian HIV/AIDS Legal Network). September 1996.

Prisoners' HIV/AIDS Support Action Network (PASAN). *HIV/AIDS in Prisons: A Comprehensive Strategy*. June 1992.

—— *HIV/AIDS in Youth Custody Settings: A Comprehensive Strategy*. June 1996.

—— *HIV/AIDS in the Male-to-Female Transsexual and Transgendered Prison Population: A Comprehensive Strategy*. May 1999.

White, Cheryl. *The Virus in the Steel: HIV/AIDS in Prisons*. Kingston AIDS Project. March 1994.

Useful Periodicals

Canadian HIV/AIDS Policy and Law Review. Published quarterly by the Canadian HIV/AIDS Legal Network. For subscription information contact CHALN (see *Contact Information* below), or go to www.aidslaw.ca.

CELL COUNT: Bulletin of PASAN. Published quarterly by Prisoners' HIV/AIDS Support Action Network. For subscription information contact PASAN (see *Contact Information* below), or go to www.interlog.com/~pasan.

II. Useful Websites and On-line Resources

Community Websites (National Level)

Canadian Aboriginal AIDS Network
www.caan.ca

Canadian AIDS Society
www.cdnaids.ca

Canadian Association of Elizabeth Fry Societies
www.web.apc.org/~kpate/caefs_e.htm

Canadian HIV/AIDS Legal Network
www.aidslaw.ca

Community AIDS Treatment Information Exchange
www.catie.ca

Hepatitis C Society of Canada
www.hepatitiscsociety.com

John Howard Society of Canada
www.johnhoward.ca

Prisoners' HIV/AIDS Support Action Network
www.interlog.com/~pasan

Government Websites

Federal Government

Solicitor General of Canada
www.sgc.gc.ca

Canadian Department of Justice
http://canada.justice.gc.ca

Correctional Service of Canada
www.csc-scc.gc.ca

Provincial and Territorial Governments

Alberta Justice
www.gov.ab.ca/just

British Columbia Ministry of the Attorney General
www.gov.bc.ca/ag

Manitoba Justice
www.gov.mb.ca/justice

New Brunswick Attorney General and Ministry of Justice
www.gov.nb.ca/justice

Newfoundland and Labrador Department of Justice
www.gov.nf.ca/just

Government of the North West Territories
www.gov.nt.ca

Nova Scotia Justice
www.gov.ns.ca/just

Government of Nunavut
www.gov.nu.ca

Ontario Ministry of Correctional Services
www.corrections.mcs.gov.on.ca

Government of Prince Edward Island
www.gov.pe.ca/government

Québec Ministry of Public Security
www.msp.gouv.qc.ca

Government of Saskatchewan
www.gov.sk.ca

Other On-line Resources

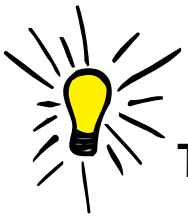
Canadian Charter of Rights and Freedoms
www.laurentia.com/ccrf

Corrections and Conditional Release Act
laws.justice.gc.ca/en/C-44.6

CSC Commissioner's Directives and Standard Operating Practices
www.csc-scc.gc.ca/text/legislat_e.shtml

HIV and the Law: Advocates' Manual *(published by the HIV and AIDS Legal Clinic Ontario)*
www.halco.org/ham.htm

UNAIDS
www.unaids.org



TIP:

Please note that the locations for the above on-line resources were accurate at the time of writing. Websites are frequently changed and updated, however. By the time you read this, some of these resources may be found at different locations on the website/s, or may have been removed from the website/s altogether. If you have trouble locating a specific item, please contact the website's administrator/s.

III. Contact Information

Useful Community Contacts (National Level)

Canadian Aboriginal AIDS Network (CAAN)
251 Bank Street, Suite 602,
Ottawa, Ontario, K2P 2H7
Phone: (613) 567-1817 or 1-800-285-2226
Fax: (613) 567-4652
www.caan.ca

Canadian AIDS Society (CAS)
309 Cooper Street, 4th Floor,
Ottawa, Ontario, K2P 0G5
Phone: (613) 230-3580 Fax: (613) 563-4998
www.cdnaids.ca

Canadian Association of Elizabeth Fry Societies (CAEFS)
151 Slater Street, Suite 701,
Ottawa, Ontario, K1P 5H3
Phone: (613) 238-2422 Fax: (613) 232-7130
www.web.apc.org/~kpate/caefs_e.htm

Canadian HIV/AIDS Legal Network (CHALN)
417 rue Saint-Pierre, Suite 408,
Montréal, Québec, H2Y 2M4
phone (514) 397-6828 FAX (514) 397-8570
www.aidslaw.ca

Community AIDS Treatment Information Exchange (CATIE)
505 Richmond Street West, Suite 555, Box 1104,
Toronto, Ontario, M5V 3B1
Phone: (416) 203-7122 or 1-800-263-1638
Fax: (416) 203-8284
www.catie.ca

Hepatitis C Society of Canada (HCSC)
3050 Confederation Parkway, Suite 301B,
Mississauga, Ontario, L5B 3Z6
Phone: (905) 270-1110 or 1-800-652-4372
Fax: (905) 270-1277
www.hepatitiscsociety.com

John Howard Society of Canada (JHSC)
771 Montreal Street,
Kingston, Ontario, K7K 3J6
Phone: (613) 542-7547 Fax: (613) 542-6824
www.johnhoward.ca

Prisoners' HIV/AIDS Support Action Network (PASAN)
489 College Street, 5th floor,
Toronto, Ontario, M6G 1A5
Phone: (416) 920-9567 Fax: (416) 920-4314
www.interlog.com/~pasan

Federal Correctional Headquarters

CSC National Headquarters
Sir Wilfrid Laurier Building
340 Laurier Avenue West
Ottawa, Ontario K1A 0P9
Phone: (613) 992-5891
Fax: (613) 996-5049

CSC Regional Headquarters (Atlantic Region)
1045 Main Street, 2nd floor
Moncton, New Brunswick E1C 1H1
Phone: (506) 851-6313
Fax: (506) 851-2418

CSC Regional Headquarters (Québec Region)
3 Place Laval, Floor 2
Chomedy, City of Laval, Québec H7N 1A2
Phone: (450) 967-3333
Fax: (450) 967-3326

CSC Regional Headquarters (Ontario Region)
440 King Street West, P.O. Box 1174
Kingston, Ontario K7L 4Y8
Phone: (613) 545-8211
Fax: (613) 545-8684

CSC Regional Headquarters (Prairie Region)
2313 Hanselman Place, P.O. Box 9223
Saskatoon, Saskatchewan S7K 3X5
Phone: (306) 975-4850
Fax: (306) 975-4435

CSC Regional Headquarters (Pacific Region)
32560 Simon Avenue, Floor 2, P.O. Box 4500
Abbotsford, British Columbia V2T 5L7
Phone: (604) 870-2501
Fax: (604) 870-2430

Federal Institutions by Region

ATLANTIC REGION

Atlantic Institution *(Max.)*
13175 Route 8, P.O. Box 102
Renous, New Brunswick E9E 2E1
Phone: (506) 623-4000
Fax: (506) 623-4017

Dorchester Penitentiary *(Med.)*
4902 Main Street
Dorchester, New Brunswick E4K 2Y9
Phone: (506) 379-2471
Fax: (506) 379-4189

Nova Institution for Women *(Multi.)*
180 James Street
Truro, Nova Scotia B2N 6R8
Phone: (902) 897-1750
Fax: (902) 897-1788

Springhill Institution *(Med.)*
330 McGee Street, P.O. Box 2140
Springhill, Nova Scotia B0M 1X0
Phone: (902) 597-8651
Fax: (902) 597-3952

Westmorland Institution *(Min.)*
4902A Main Street
Dorchester, New Brunswick E4K 2Y9
Phone: (506) 379-2471
Fax: (506) 379-4629

QUÉBEC REGION

Archambault Institution *(Med.)*
242 Montée Gagnon
Sainte-Anne-des-Plaines, Québec J0N 1H0
Phone: (450) 478-5960
Fax: (450) 478-7655

Cowansville Institution *(Med.)*
P.O. Box 5000
Cowansville, Québec J2K 3N7
Phone: (450) 263-3073
Fax: (450) 263-0325

Donnacona Institution *(Max.)*
1538 Highway 138
Donnacona, Québec G0A 1T0
Phone: (418) 285-2455
Fax: (418) 285-2027

Drummond Institution *(Med.)*
2025 Jean-de-Brébeuf Street
Drummondville, Québec J2B 7Z6
Phone: (819) 477-5112
Fax: (819) 477-9893

Federal Training Centre *(Min.)*
6099 Lévesque Boulevard
City of Laval, Québec H7C 1P1
Phone: (450) 661-7786
Fax: (450) 661-9485

Joliette Institution for Women *(Multi.)*
400 Marsolais Street
Joliette, Québec J6E 8V4
Phone: (450) 752-5257
Fax: (450) 752-2823

La Macaza Institution *(Med.)*
321 Chemin de l'Aéroport
La Macaza, Québec J0T 1R0
Phone: (819) 275-2315
Fax: (819) 275-3079

Leclerc Institution *(Med.)*
400 Montée Saint-François
City of Laval, Québec H7C 1S7
Phone: (450) 664-1320
Fax: (450) 664-6719

Montée Saint-François Institution *(Min.)*
1300 Montée Saint-François
City of Laval, Québec H7C 1S6
Phone: (450) 661-9620
Fax: (450) 661-7449

Port-Cartier Institution *(Max.)*
Chemin de l'Aéroport, P.O. Box 7070
Port-Cartier, Québec G5B 2W2
Phone: (418) 766-7070
Fax: (418) 766-6258

Regional Reception Centre *(Max.)*
246 Montée Gagnon
Sainte-Anne-des-Plaines, Québec J0N 1H0
Phone: (450) 478-5977
Fax: (450) 478-7661

Sainte-Anne-des-Plaines Institution *(Min.)*
244 Montée Gagnon
Sainte-Anne-des-Plaines, Québec J0N 1H0
Phone: (450) 478-5933
Fax: (450) 478-7077

ONTARIO REGION

Bath Institution *(Med.)*
P.O. Box 1500
Bath, Ontario K0H 1G0
Phone: (613) 351-8346
Fax: (613) 351-8039

Beaver Creek Institution *(Min.)*
P.O. Box 1240
Gravenhurst, Ontario P1P 1W9
Phone: (705) 687-6641
Fax: (705) 687-5010

Collins Bay Institution *(Med.)*
455 Bath Road, P.O. Box 190
Kingston, Ontario K7L 4V9
Phone: (613) 545-8598
Fax: (613) 545-8824

Fenbrook Institution *(Med.)*
P.O. Box 5000
Gravenhurst, Ontario P1P 1Y2
Phone: (705) 687-6641
Fax: (705) 687-1896

Frontenac Institution *(Min.)*
455 Bath Road, P.O. Box 7500
Kingston, Ontario K7L 5E6
Phone: (613) 536-6000
Fax: (613) 545-8823

Grand Valley Institution for Women *(Multi.)*
1575 Homer Watson Blvd.
Kitchener, Ontario N2P 2C5
Phone: (519) 894-2011
Fax: (519) 894-5434

Isabel McNeil House *(Women's)*
525 King Street West
Kingston, Ontario K7L 2X9
Phone: (613) 545-8845
Fax: (613) 547-7724

Joyceville Institution *(Med.)*
Highway 15, P.O. Box 880
Kingston, Ontario K7L 4X9
Phone: (613) 536-6400
Fax: (613) 536-6434

Kingston Penitentiary *(Max.)*
555 King Street West, P.O. Box 22
Kingston, Ontario K7L 4V7
Phone: (613) 545-8460
Fax: (613) 545-8826

Millhaven Institution *(Max.)*
Highway 33, P.O. Box 280
Bath, Ontario K0H 1G0
Phone: (613) 351-8000
Fax: (613) 351-8136

Pittsburgh Institution *(Min.)*
Highway 15, P.O. Box 4510
Kingston, Ontario K7L 5E5
Phone: (613) 536-6400
Fax: (613) 536-6389

Regional Treatment Centre *(Max.)*
555 King Street West, P.O. Box 22
Kingston, Ontario K7L 4V7
Phone: (613) 545-8460
Fax: (613) 545-8826

Warkworth Institution *(Med.)*
County Road #29, P.O. Box 760
Campbellford, Ontario K0L 1L0
Phone: (705) 924-2210
Fax: (705) 924-3351

PRAIRIE REGION

Bowden Institution *(Med.)*
P.O. Box 6000
Innisfail, Alberta T4G 1V1
Phone: (403) 227-3391
Fax: (403) 227-6022

Drumheller Institution *(Med.)*
P.O. Box 3000
Drumheller, Alberta T0J 0Y0
Phone: (403) 823-5101
Fax: (403) 823-8666

Edmonton Institution *(Max.)*
21611 Meridian Street, P.O. Box 2290
Edmonton, Alberta T5J 3H7
Phone: (780) 472-6052
Fax: (780) 495-6036

Edmonton Institution for Women *(Med./Min.)*
11151 - 178th Street
Edmonton, Alberta T5S 2H9
Phone: (780) 495-3657
Fax: (780) 495-2266

Grande Cache Institution *(Min.)*
Bag 4000
Grande Cache, Alberta T0E 0Y0
Phone: (780) 827-4200
Fax: (780) 827-2984

Grierson Centre *(Min.)*
9530 - 101 Avenue
Edmonton, Alberta T5H 0B3
Phone: (780) 495-2157
Fax: (780) 495-4755

Okimaw Ohci Healing Lodge *(Women's)*
P.O. Box 1929
Maple Creek, Saskatchewan S0N 1N0
Phone: (306) 662-4700
Fax: (306) 662-3555

Pê Sâkâstêw Centre *(Min.)*
P.O. Box 1500
Hobbema, Alberta T0C 1N0
Phone: (780) 585-4104
Fax: (780) 585-3588

Regional Psychiatric Centre (Prairies) *(Multi.)*
P.O. Box 9243
Saskatoon, Saskatchewan S7K 3X5
Phone: (306) 975-5400
Fax: (306) 975-6024

Riverbend Institution *(Min.)*
15th Street West, P.O. Box 850
Prince Albert, Saskatchewan S6V 5S4
Phone: (306) 765-8200
Fax: (306) 765-8220

Rockwood Institution *(Min.)*
P.O. Box 72
Stony Mountain, Manitoba R0C 3A0
Phone: (204) 344-3435
Fax: (204) 344-7107

Saskatchewan Penitentiary *(Max./Med.)*
15th Street West, P.O. Box 160
Prince Albert, Saskatchewan S6V 5R6
Phone: (306) 765-8000
Fax: (306) 765-8073

Stony Mountain Institution *(Med.)*
P.O. Box 4500
Winnipeg, Manitoba R3C 3W8
Phone: (204) 344-5111
Fax: (204) 344-7100

Willow Cree Healing Lodge *(Min.)*
P.O. Box 520
Duck Lake, Saskatchewan S0K 1J0
Phone: (306) 467-1200
Fax: (306) 467-1210

PACIFIC REGION

Elbow Lake Institution *(Min.)*
Harrison Mills,
British Columbia V0M 1L0
Phone: (604) 796-1650
Fax: (604) 796-8431

Ferndale Institution *(Min.)*
33737 Dewdney Trunk Road, P.O. Box 50
Mission, British Columbia V2V 4L8
Phone: (604) 826-5410
Fax: (604) 826-5519

Kent Institution *(Max.)*
4732 Cemetery Road, P.O. Box 1500
Agassiz, British Columbia V0M 1A0
Phone: (604) 796-2121
Fax: (604) 796-4500

Matsqui Institution *(Med.)*
33344 King Road, P.O. Box 2500
Abbotsford, British Columbia V2S 4P3
Phone: (604) 859-4841
Fax: (604) 850-8228

Mission Institution *(Med.)*
8751 Slave Lake Road, P.O. Box 60
Mission, British Columbia V2V 4L8
Phone: (604) 826-1231
Fax: (604) 820-5801

Mountain Institution *(Med.)*
4830 Cemetery Road, P.O. Box 1600
Agassiz, British Columbia V0M 1A0
Phone: (604) 796-2231
Fax: (604) 796-1450

Regional Health Centre *(Max.)*
33344 King Road, P.O. Box 3000
Abbotsford, British Columbia V2S 4P4
Phone: (604) 870-7700
Fax: (604) 870-7746

William Head Institution *(Med.)*
William Head Road, P.O. Box 4000, Station A
Victoria, British Columbia V8X 3Y8
Phone: (250) 391-7000
Fax: (250) 391-7055

Provincial and Territorial Ministries of Corrections and Institutions

ALBERTA

Director of Corrections
Adult Centre Operations Branch
Correctional Services Division
Alberta Department of Justice
John E. Brownlee Building, 10th floor
10365-97 Street
Edmonton, Alberta T5J 3W7
Phone: (780) 427-4703
Fax: (780) 427-1904

Bow River Correctional Centre
P.O. Box 3250, Station B
11333 - 85 Street NW
Calgary, Alberta T2M 4L9
Phone: (403) 239-7232
Fax: (403) 297-4377

Calgary Correctional Centre
P.O. Box 3250, Station B
11808 - 85 Street NW
Calgary, Alberta T2M 4L9
Phone: (403) 239-0010
Fax: (403) 297-4577

Calgary Remand Centre
c/o Silver Springs, Box 71056
12200 - 85 Street NW
Calgary, Alberta T3B 5K2
Phone: (403) 241-4411
Fax: (403) 241-4363

Edmonton Remand Centre
9660 - 104 Avenue
Edmonton, Alberta T5H 4B5
Phone: (780) 427-1600
Fax: (780) 427-1352

Fort Saskatchewan Correctional Centre
7802 - 101 Street, Bag 10
Fort Saskatchewan, Alberta T8L 2P3
Phone: (780) 992- 2424
Fax: (780) 992-2526

Kainai Community Correctional Centre
(Contracted)
P.O. Box 530
Stand Off, Alberta T0L 1Y0
Phone: (403) 737-2666
Fax: (403) 737-2000

Lethbridge Correctional Centre
P.O. Bag 3001
Coaldale Road
Lethbridge, Alberta T1J 3Z3
Phone: (403) 329-9414
Fax: (403) 317-7506

Medicine Hat Remand Centre
874 - 2 Street SE
Medicine Hat, Alberta T1A 8H2
Phone: (403) 529 - 2111
Fax: (403) 529-3132

Peace River Correctional Centre
P.O. Bag 900-40
Peace River, Alberta T8S 1T4
Phone: (780) 624-5480
Fax: (780) 624-5807

Red Deer Remand Centre
4720 - 49th Street, Bag 5017
Red Deer, Alberta T4N 6A1
Phone: (403) 340 - 3200
Fax: (403) 340-7170

BRITISH COLUMBIA

Director, Adult Custody
1001 Douglas Street, 7th floor
Victoria, British Columbia
Phone: (250) 387-5097
Fax: (250) 952-6883
Mailing Address: P.O. Box 9278, Stn. Prov. Govt.
Victoria, British Columbia V8W 9J7

Alouette River Correctional Centre
P.O. Box 1000
Maple Ridge, British Columbia V2X 7G4
Phone: (604) 463-8891
Fax: (604) 467-6945

Bear Creek Correctional Centre
Wells Gray Park Road
Clearwater, British Columbia V0E 1N0
Phone: (250) 674-3256
Fax: (250) 674-2431
Mailing Address: Box 1761, R.R. #1
Clearwater, British Columbia V0E 1NO

Burnaby Correctional Centre for Women
7900 Fraser Park Drive
Burnaby, British Columbia V5J 5H1
Phone: (604) 436-6020
Fax: (604) 660-9724
Fax Records: (604) 660-6258

Burnaby Open Living Unit
7900 Fraser Park Drive
Burnaby, British Columbia V5J 5H1
Phone: (604) 436-5390
Fax: (604) 436-5302

Burnaby Sentence Management Unit
7900 Fraser Park Drive
Burnaby, British Columbia V5J 5H1
Phone: (604) 436-6020
Fax: (604) 660-6258

Chilliwack Community Correctional Centre
45914 Rowat Avenue
Chilliwack, British Columbia V2P 1J3
Phone: (604) 795-8305
Fax: (604) 795-8463
Mailing Address: P.O. Box 365
Chilliwack, British Columbia V2P 6J4

Chilliwack District
53033 Chilliwack Lake Road
1Chilliwack, British Columbia V4Z 1A7
Phone: (604) 824-2204
Fax: (604) 858-8470
Mailing Address: P.O. Box 365
Chilliwack, British Columbia V2P 6J4

Chilliwack Forest Camp/
Chilliwack Support Services
P.O. Box 365
Chilliwack, British Columbia V2P 6J4
Phone: (604) 824-2240
Fax: (604) 858-8470

Chilliwack Sentence Management Unit
53033 Chilliwack Lake Road
Chilliwack, British Columbia V4Z 1A7
Phone: (604) 824-2211
Fax: (604) 824-2264
Mailing Address: P.O. Box 365
Chilliwack, British Columbia V2P 6J4

Ford Mountain Correctional Centre
57657 Chilliwack Lake Road
Chilliwack, British Columbia V4Z 1A7
Phone: (604) 824-2223
Fax: (604) 824-2245
Mailing Address: P.O. Box 365
Chilliwack, British Columbia V2P 6J4

Fraser Regional Correctional Centre
13777 - 256th Street
Maple Ridge, British Columbia V2X 0L7
Phone: (604) 462-9313
Fax: (604) 462-5186
Mailing Address: P.O. Box 1500
Maple Ridge, British Columbia V2X 7G3

Fraser Sentence Management Unit
13777 - 256th Street
Maple Ridge, British Columbia V2X 0L7
Phone: (604) 462-5156
Fax: (604) 462-5187
Mailing Address: P.O. Box 1500
Maple Ridge, British Columbia V2X 7G3

Hutda Lake Correctional Centre
Bag 9600
Prince George, British Columbia V2L 5J9
Phone: (250) 964-0504
Fax: (250) 964-0262

Kamloops Regional Correctional Centre
2250 West Trans Canada Highway
Kamloops, British Columbia V2C 5M9
Phone: (250) 372-7202
Fax: (250) 374-9237
Mailing Address: P.O. Box 820
Kamloops, British Columbia V2C 5M9

Kamloops Sentence Management Unit
Box 820
Kamloops, British Columbia V2C 5M9
Phone: (250) 372-7202
Fax: (250) 374-9583

Maple Ridge Support Services
Box 1000
Maple Ridge, British Columbia V2X 7G4
Phone: (604) 463-8891
Fax: (604) 463-3821

Mount Thurston Correctional Centre
53033 Chilliwack Lake Road
Chilliwack, British Columbia V4Z 1A7
Phone: (604) 824-2220
Fax: (604) 824-2252
Mailing Address: P.O. Box 365
Chilliwack, British Columbia V2P 6J4

Nanaimo Correctional Centre
3945 Biggs Road
Nanaimo, British Columbia V9R 5N3
Phone: (250) 756-3300
Fax: (250) 758-1964 Fax Nurse: (250) 756-3322
Mailing Address: Bag 4000
Nanaimo, British Columbia V9R 5N3

New Haven Correctional Centre
4250 Marine Drive
Burnaby, British Columbia V5J 3E9
Phone: (604) 660-5945
Fax: (604) 660-5995

North Fraser Pretrial Centre
1451 Kingsway Avenue
Port Coquitlam, British Columbia V5J 3E9
Phone: (604) 468-3500
Fax: (604) 468-3556

Prince George Regional Correctional Centre
795 Highway 16 East
Prince George, British Columbia V2L 5J9
Phone: (250) 960-3001
Fax: (250) 960-3021
Mailing Address: P.O. Box 4300
Prince George, British Columbia V2L 5J9

Rayleigh Correctional Centre
P.O. Box 820
Kamloops, British Columbia V2C 5M9
Phone: (250) 578-7244
Fax: (250) 578-8594

Slave Lake Correctional Centre
P.O. Box 1000
Maple Ridge, British Columbia V2X 7G4
Phone: (604) 462-7233
Fax: (604) 462-0465

Surrey Pretrial Services Centre
14323 - 57th Avenue
Surrey, British Columbia V3X 1B1
Phone: (604) 599-4110
Fax: (604) 572-2101
Fax Health Care: (604) 572-2161

Terrace Correctional Centre
3120 Braun Street
Terrace, British Columbia V8G 5N9
Phone: (250) 638-2171
Fax: (250) 638-2176

Vancouver Island Regional Correctional Centre
4216 Wilkinson Road
Victoria, British Columbia V8Z 5B2
Phone: (250) 479-1621
Fax: (250) 727-5001
Fax Health Care: (250) 727-5043
Mailing Address: P.O. Box 9224, Stn. Prov. Govt.
Victoria, British Columbia V8W 9J1

Vancouver Pretrial Services Centre
275 East Cordova Street
Vancouver, British Columbia V6A 3W3
Phone: (604) 775-3800
Fax: (604) 775-3804

MANITOBA

Executive Director of Corrections
Manitoba Justice
810-405 Broadway
Winnipeg, Manitoba R3C 3L6
Phone: (204) 945-7283
Fax: (204) 945-5537

Brandon Correctional Institution
375 Smithfield Road
Brandon, Manitoba R7A 5Y5
Phone: (204) 725-3532
Fax: (204) 727-3961

Dauphin Correctional Institution
114 River Avenue West
Dauphin, Manitoba R7N 0J7
Phone: (204) 622-2083
Fax: (204) 638-9809

Egg Lake Rehabilitation Camp
P.O. Box 659,
The Pas, Manitoba R9A 1K7
Phone: (204) 682-7466
Fax: (204) 623-7774

Headingly Correctional Institution
6030 Partage Avenue
Headingly, Manitoba R4H 1E8
Phone: (204) 831-4600
Fax: (204) 889-3033

Milner Ridge Correctional Centre
Provincial Building
20 First Street South
Beausejour, Manitoba R0E 0C0
Phone: (204) 268-4011
Fax: (204) 452-0375

The Pas Correctional Institution
P.O. Box 659,
The Pas, Manitoba R9A 1K7
Phone: (204) 627-8480
Fax: (204) 623-7774

Portage Correctional Centre
329 Duke Avenue
Portage la Prairie, Manitoba R1N 0S4
Phone: (204) 239-3389
Fax: (204) 239-3397

Winnipeg Remand Centre
141 Kennedy Street
Winnipeg, Manitoba R3C 4N5
Phone: (204) 945-3541
Fax: (204) 948-2217

NEW BRUNSWICK

Deputy Commissioner of Corrections
1045 Main Street, 2nd Floor
Moncton, New Brunswick E1C 1H1
Phone: (506) 851-6377
Fax: (506) 851-2418

Bathurst Detention Centre
242 St. Patrick Street, P.O. Box 5001
Bathurst, New Brunswick E2A 1E1
Phone: (506) 547-2156
Fax: (506) 547-2961

Dalhousie Provincial Jail
426 William Street
Dalhousie, New Brunswick E8C 2X5
Phone: (506) 684-7517
Fax: (506) 684-7519

Madawaska Regional Correctional Centre
15 Fournier Street
St-Hilaire, New Brunswick E3V 4T9
Phone: (506) 737-4510
Fax: (506) 737-4520

Moncton Detention Centre
125 Assumption Boulevard, P.O. Box 5001
Moncton, New Brunswick E1C 1A2
Phone: (506) 856-2311
Fax: (506) 856-2895

Saint John Regional Correctional Centre
930 Old Black River Road
Saint John, New Brunswick E2J 4T3
Phone: (506) 658-5400
Fax: (506) 658-6632

NEWFOUNDLAND/LABRADOR

Corrections and Community Services Division Headquarters
P.O. Box 8700
St. John's, Newfoundland A1B 4J6
Phone: (709) 729-3880
Fax: (709) 729-4069

Bishop's Falls Correctional Centre
P.O. Box 880
Bishop's Falls, Newfoundland A0H 1C0
Phone: (709) 258-6966
Fax: (709) 258-5484

Clarenville Correctional Centre for Women
P.O. Box 1030
Clarenville, Newfoundland A0E 1J0
Phone: (709) 466-3101
Fax: (709) 466-3664

Corner Brook City Lockup
P.O. Box 2006
Corner Brook, Newfoundland A2H 6J8
Phone: (709) 634-4140
Fax: (709) 634-0658

Her Majesty's Penitentiary
P.O. Box 5459
St. John's, Newfoundland A1C 5W4
Phone: (709) 729-2978
Fax: (709) 729-0409

Labrador Correctional Centre
P.O. Box 1240, Station B
Happy Valley/Goose Bay, Labrador A0P 1E0
Phone: (709) 896-3327
Fax: (709) 896-3329

Salmonier Correctional Institution
P.O. Box 5459
St. John's, Newfoundland A1C 5W4
Phone: (709) 229-1985
Fax: (709) 229-7154

St. John's City Lockup
P.O. Box 5459
St. John's, Newfoundland A1C 5W4
Phone: (709) 729-0396
Fax: (709) 729-0376

West Coast Correctional Centre
P.O. Box 660
Stephenville, Newfoundland A2N 3B5
Phone: (709) 643-5601
Fax: (709) 643-3707

NORTH WEST TERRITORIES

Director of Corrections
Department of Justice, Box 1320
Yellowknife, North West Territories X1A 2L9
Phone: (867) 873-7212
Fax: (867) 873-0299

River Ridge Secure Facility (Fort Smith)
Box 388
Fort Smith, North West Territories XOE OPO
Phone: (867) 872-7367
Fax: (867) 872-3060

South MacKenzie Correctional Centre
34 Studney Drive
Hay River, North West Territories XOE OR6
Phone: (867) 874 2798
Fax: (867) 874-2953

Territorial Women's Correctional Centre
Box 5
Fort Smith, North West Territories XOE OPO
Phone: (867) 872 7361 Fax: (867) 872-5800

Yellowknife Correctional Centre
Box 278
Yellowknife, North West Territories X1A 2N2
Phone: (867) 669-8600 Fax: (867) 873-5841

NOVA SCOTIA

Director of Corrections
P.O. Box 968, Station M
Halifax, Nova Scotia B3J 2V9
Phone: (902) 424-6290
Fax: (902) 424-0692

Antigonish Correctional Centre
68 Court Street, P.O. Box 1748
Antigonish, Nova Scotia B2G 2M5
Phone: (902) 863-2527
Fax: (902) 863-7483

Cape Breton Correctional Centre
136 Gardiner Road
Sydney, Nova Scotia B1M 1A1
Phone: (902) 563-2114
Fax: (902) 563-3636

Colchester Correctional Centre
215 Queen Street, P.O. Box 921
Truro, Nova Scotia B2N 5G7
Phone: (902) 893-3120
Fax: (902) 893-6120

Cumberland Correctional Centre
1 Lawrence Street
Amherst, Nova Scotia B4H 3G4
Phone: (902) 667-2320
Fax: (902) 667-5533

Guysborough Correctional Centre
Church Street Ext., P.O. Box 209
Guysborough, Nova Scotia B0H 1N0
Phone: (902) 533-3903
Fax: (902) 533-2558

Halifax Correctional Centre
189 Cobequid Road, P.O. Box 10
Lower Sackville, Nova Scotia B4C 2S8
Phone: (902) 865-8391 /
Female Unit (902) 865-0353
Fax: (902) 864-4386

Kings Correctional Centre
1303 County Home Road, P.O. Box 124
Waterville, Nova Scotia B0P 1V0
Phone: (902) 538-3138
Fax: (902) 538-8153

Lunenburg Correctional Centre
R. R. #2
Lunenburg, Nova Scotia B0J 2C0
Phone: (902) 634-4421
Fax: (902) 634-9570

Yarmouth Correctional Centre
459 Main Street
Yarmouth, Nova Scotia B5A 1G9
Phone: (902) 742-4211
Fax: (902) 742-0680

ONTARIO

Assistant Deputy Minister of Correctional Services
25 Grosvenor Street, 16th Floor
Toronto, Ontario M7A 1Y6
Phone: (416) 327-9911
Fax: (416) 327-3849

Brantford Jail
105 Market Street
Brantford, Ontario N3T 6A9
Phone: (519) 752-6578
Fax: (519) 752-7461

Brockville Jail
10 Wall Street
Brockville, Ontario K6V 4R9
Phone: (613) 342-1456
Fax: (613) 342-0962

Burtch Correctional Centre
P.O. Box 940
Brantford, Ontario N3T 5S6
Phone: (519) 484-2461
Fax: (519) 484-2587

Central North Correctional Centre
1501 Fuller Avenue
Penetanguishene, Ontario L9M 2G2
Phone: (705) 549-9470
Fax: (705) 549-0634

Chatham Jail
17 Seventh Street
Chatham, Ontario N7M 4J9
Phone: (519) 352-0150
Fax: (519) 351-3578

Cornwall Jail
7 Water Street West, Box 1418
Cornwall, Ontario K6H 5V5
Phone: (613) 932-5720
Fax (613) 932-9461

Elgin-Middlesex Detention Centre
711 Exeter Road
London, Ontario N6E 1L3
Phone: (519) 686-1922
Fax: (519) 686-5265

Fort Frances Jail
310 Nelson Street, Box 189
Fort Frances, Ontario P9A 3M6
Phone: (807) 274-7708
Fax (807) 274-3304

Guelph Correctional Centre
785 York Road, Box 3600
Guelph, Ontario N1H 6P3
Phone: (519) 822-0020
Fax: (519) 822-0591

Hamilton-Wentworth Detention Centre
165 Barton Street East
Hamilton, Ontario L8L 2W6
Phone: (905) 523-8800
Fax: (905) 529-0977

Kenora Jail
1430 River Street
Kenora, Ontario P9N 1K5
Phone: (807) 468-2871
Fax: (807) 468-2876

Lindsay Jail
50 Victoria Avenue North
Lindsay, Ontario K9V 4G3
Phone: (705) 324-3792
Fax: (705) 328-1656

Maplehurst Complex
661 Martin Street, P.O. Box 10
Milton, Ontario L9T 2Y3
Phone: (905) 878-8141
Fax: (905) 878-1572

Metro Toronto East Detention Centre
55 Civic Road
Scarborough, Ontario M1L 2K9
Phone: (416) 750-3513
Fax: (416) 750-3345

Metro Toronto West Detention Centre
P.O. Box 4950.
111 Disco Road
Rexdale, Ontario M9W 5L6
Phone: (416) 675-1806
Fax: (416) 675-9942

Millbrook Correctional Centre
Box 300, King Street West
Millbrook, Ontario LOA 1GO
Phone: (705) 932-2624
Fax: (705) 932-2962

Mimico Correctional Centre
P.O. Box 75, Station N
130 Horner Avenue
Toronto, Ontario M8V 3S9
Phone: (416) 314-9600
Fax: (416) 314-9606

Monteith Correctional Centre
Junction Hwy 11 & 577, Box 90
Monteith, Ontario POK 1PO
Phone: (705) 232-4092
Fax: (705) 232-4206

Niagara Detention Centre
Highway 58, P.O. Box 1050
Thorold, Ontario L2V 4A6
Phone: (905) 227-8021
Fax: (905) 227-0032

North Bay Jail
2550 Trout Lake Road
North Bay, Ontario P1B 7S7
Phone: (705) 472-8115
Fax: (705) 472-3803

Northern Treatment Centre
800 Great Northern Road, P.O. Box 1510
Sault Ste. Marie, Ontario P6A 6N3
Phone: (705) 946-0995
Fax: (705) 946-4047

Ontario Correctional Institution
109 McLaughlin Road South, Box 1888
Brampton, Ontario L6V 2P1
Phone: (905) 457-7050
Fax: (905) 452-8606

Ottawa-Carleton Detention Centre
2244 Innes Road
Ottawa, Ontario K1B 4C4
Phone: (613) 824-6080
Fax: (613) 824-1297

Owen Sound Jail
1237 Third Avenue East, Box 517
Owen Sound, Ontario N4K 5R1
Phone: (519) 376-0435
Fax: (519) 376-7927

Pembroke Jail
297 Pembroke Street East
Pembroke, Ontario K8A 3K2
Phone: (613) 735-0647
Fax: (613) 735-2741

Quinte Detention Centre
89 Richmond Boulevard, Postal Bag 3060
Napanee, Ontario K7R 3S1
Phone: (613) 354-9701
Fax: (613) 354-9114

Rideau Correctional Centre
County Road 2, Box 100
Merrickville, Ontario KOG 1BO
Phone: (613) 269-4771
Fax: (613) 269-3583

Sarnia Jail
700 Christina Street North
Sarnia, Ontario N7V 3C2
Phone: (519) 337-3261
Fax: (519) 336-6505

Sault Ste. Marie Jail
145 McNabb Street, Box 340
Sault Ste. Marie, Ontario P6A 5L8
Phone: (705) 254-6817
Fax: (705) 256-3028

Stratford Jail
30 St. Andrews Street
Stratford, Ontario N5A 1A3
Phone: (519) 271-2180
Fax: (519) 273-1938

Sudbury Jail
181 Elm Street West
Sudbury, Ontario P3C 1T8
Phone: (705) 675-4150
Fax: (705) 564-4157

Thunder Bay Correctional Centre
Hwy 61 South, Box 1900, Station F
Thunder Bay, Ontario P7C 4Y4
Phone: (807) 475-8401
Fax: (807) 475-9240

Thunder Bay Jail
285 MacDougall Street, Box 2806
Thunder Bay, Ontario P7B 5G3
Phone: (807) 345-7364
Fax: (807) 345-4595

Toronto (Don) Jail
550 Gerrard Street East
Toronto, Ontario M4M 1X6
Phone: (416) 963-2880
Fax: (416) 325-8616

Vanier Centre for Women
205 McLaughlin Road South, Box 1150
Brampton, Ontario L6V 2M5
Phone: (905) 459-9100
Fax: (905) 452-8522

Walkerton Jail
209 Caley Street, Box 429
Walkerton, Ontario NOG 2VO
Phone: (519) 881-3448
Fax: (519) 881-2182

Whitby Jail
220 Victoria West
Whitby, Ontario L1N 6G3
Phone: (905) 668-7791
Fax: (905) 668-8388

Windsor Jail
378 Brock Street, Box 38
Windsor, Ontario N9C 3Y6
Phone: (519) 254-2891
Fax: (519) 973-1376

PRINCE EDWARD ISLAND

Director, Community and Correctional Services
Office of the Attorney General, ACCESS PEI
120 Harbour Drive, P.O. Box 2063
Summerside, Prince Edward Island C1N 5L2
Phone: (902) 432-2850
Fax: (902) 432-2851

Prince Correctional Centre
P.O. Box 2710
Charlottetown, Prince Edward Island C1A 8C3
Phone: (902) 368-4590
Fax: (902) 368-5834

Provincial Correctional Centre
108 Central Street
Summerside, Prince Edward Island C1N 3L4
Phone: (902) 888-8209
Fax: (902) 888-8222

QUÉBEC

Deputy Minister of Public Security
2525, boulevard Laurier, 5e étage
Tour des Laurentides
Sainte-Foy, Québec G1V 2L2
Phone: (418) 643-3500
Fax: (418) 643-0275

Amos Detention Centre
851, 3e rue Ouest
Amos, Québec J9T 2T4
Phone: (819) 444-5222
Fax: (819) 444-5298

Baie-Comeau Detention Centre
73, avenue Mance
Baie-Comeau, Québec G4Z 1N1
Phone: (418) 294-8646
Fax: (418) 294-8853

Chicoutimi Detention Centre
237, rue Price Est
Chicoutimi, Québec G7H 2E5
Phone: (418) 698-3838
Fax: (418) 698-3845

Havre-Aubert*
C.P. 25
Îles-de-la Madeleine, Québec GOB 1JO
Phone: (418) 937-2550
Fax: (418) 937-5480

Hull Detention Centre
75, rue St-François
Hull, Québec J9A 1B4
Phone: (819) 772-3065
Fax: (819) 772-3963

Longueuil Palais de justice*
1111, boulevard Jacques-Cartier Est
Longueuil, Québec J4M 2J6
Phone: (450) 647-4401
Fax: (450) 647-1635

Montréal Detention Centre
800, boulevard Gouin Ouest
Montréal, Québec H3L 1K7
Phone: (514) 336-7700
Fax: (514) 873-4605

Montréal – Maison Tanguay
555, boulevard Henri-Bourassa Ouest
Montréal, Québec H3L 1P3
Phone: (514) 337-9450
Fax: (514) 873-7871
Montréal Palais de justice*
10, rue Saint-Antoine Est, bureau 14.10
Montréal, Québec H2Y 1A2
Phone: (514) 393-2807
Fax: (514) 873-0044

New-Carlisle Detention Centre
87, rue Principale, C.P. 9
New-Carlisle, Québec GOC 1ZO
Phone: (418) 752-6637
Fax: (418) 752-2909

Québec Detention Centre – Men's Sector
500, de la Faune, C.P. 7130
Québec, Québec G1G 5E4
Phone: (418) 622-7100
Fax: (418) 643-3332

Québec Detention Centre – Women's Sector
500, de la Faune, C.P. 7130
Québec, Québec G1G 5E4
Phone: (418) 622-7125
Fax: (418) 622-7125

Rimouski Detention Centre
200, rue des Négociants, C.P. 490
Rimouski, Québec G5L 7C5
Phone: (418) 727-3547
Fax: (418) 727-3799
Rivière-des-Prairies Detention Centre
11 900, rue Armand-Chaput
Rivière-des-Prairies, Québec H1C 1S7
Phone: (514) 494-3930
Fax: (514) 494-1423

Roberval Detention Centre
756, boulevard St-Joseph
Roberval, Québec G8H 2L5
Phone: (418) 275-0207
Fax: (418) 275-4349

Saint-Jérôme Detention Centre
40, montée Meunier, C.P. 513
Saint-Jérôme, Québec J7Z 5V3
Phone: (450) 436-8144
Fax: (450) 436-8444

Sept-Îles Detention Centre
425, boulevard Laure
Sept-Îles, Québec G4R 1X6
Phone: (418) 968-8632
Fax: (418) 964-8147

Sherbrooke Detention Centre
1055, rue Talbot
Sherbrooke, Québec J1G 2P3
Phone: (819) 820-3100
Fax: (819) 820-3964

Sorel Detention Centre
75, boulevard Poliquin, C.P. 529
Sorel, Québec J3P 5N9
Phone: (450) 742-0471
Fax: (450) 742-4067

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* *These places of confinement are only prison quarters, and are not considered as prisons* per se.

Trois-Rivières Detention Centre
7600, boulevard Parent
Trois-Rivières, Québec G9A 5E1
Phone: (819) 372-1311
Fax: (819) 371-6979

Valleyfield Detention Centre
75, rue Montcalm
Valleyfield, Québec J6T 2C8
Phone: (450) 370-6814
Fax: (450) 370-6825

SASKATCHEWAN

Executive Director of Corrections
1874 Scarth Street, 7th Floor
Regina, Saskatchewan S4P 3V7
Phone: (306) 787-3573
Fax: (306) 787-8084

Battleford Community Correctional Centre
P.O. Box 996
North Battleford, Saskatchewan S9A 3E6
Phone: (306) 446-7800
Fax: (306) 446-7851

Buffalo Narrows Community Correctional Centre
P.O. Box 340
Buffalo Narrows, Saskatchewan S0M 0J0
Phone: (306) 235-1756
Fax: (306) 235-4656

Pine Grove Correctional Centre
1700 - 7th Avenue NE, P.O. Box 3002
Prince Albert, Saskatchewan S6V 6G1
Phone: (306) 953-3100
Fax: (306) 953-3108

Prince Albert Provincial Correctional Centre
P.O. Box 3002
Prince Albert, Saskatchewan S6V 6G1
Phone: (306) 953-3000
Fax: (306) 953-3030

Regina Provincial Correctional Centre
P.O. Box 617
Regina, Saskatchewan S4P 3A6
Phone: (306) 924-9000
Fax: (306) 787-0432

Saskatoon Provincial Correctional Centre
910 - 60th Street East
Saskatoon, Saskatchewan S7K 2H6
Phone: (306) 956-8800
Fax: (306) 931-0811

YUKON

Director of Community and Correctional Services
P.O. Box 2703
Whitehorse, Yukon Y1A 2C6
Phone: (867) 667-8294
Fax: (867) 393-6326

The Whitehorse Correctional Centre
25 College Drive
Whitehorse, Yukon Y1A 5B6
Phone: (867) 393-7200
Fax: (867) 393-6208

IV. Glossary of Common Language and Terminology

AASO – Aboriginal AIDS Service Organization

AIDS – Acquired Immune Deficiency Syndrome

ASO – AIDS Service Organization

Bale – slang for an order of tobacco.

Big house – slang for federal penitentiary.

Bit – slang for prison sentence, as in *"an 8-year bit"*.

Bleach kit – harm reduction kit for cleaning drug injecting equipment, usually comprising small bottles of both bleach and distilled water.

Brotherhood – short for Native Brotherhood. A type of Aboriginal prisoners' organization.

Bucket – slang for local jail/detention centre.

Bug – pejorative slang for a person with a mental illness.

Bug range – pejorative slang for a unit where mentally ill prisoners are housed.

Camp – minimum security institution.

Canteen – prison "store", where prisoners can purchase (limited) consumer goods through the prison.

Cc – Copy. Literally, *"Carbon Copy"*. A shorthand term for indicating that you have sent copies of your correspondence to those recipients listed under *"cc."* at the end of the letter. An advocacy trick for upping the ante.

CCRA – *Corrections and Conditional Release Act*. Legislation governing federal correctional services.

CDs – Commissioner's Directives. Policies governing federal prison rules and practices, based on the CCRA (see above).

CHIPs – Choosing Health In Prison. Federal prison health education programs run by the prison health units.

Classification (to be classified) – the process through which a prisoner's security rating is assessed. This is usually done to determine the type of institution (maximum security, medium security, etc.) in which an individual will serve their sentence.

CMO – Case Management Officer

Cocktail/Drug cocktail – medical slang for an HIV therapy regime involving three or four drugs used in combination.

Committee – short for ***Inmate Committee*** (see below).

Community Assessment – a term for corrections' process for assessing the suitability of a prisoner's post-release living arrangements. Usually done by a case management officer or parole officer as part of a parole application.

Con – short for convict (prisoner). A term preferred by many prisoners over "inmate" or "offender".

Contraband – any item or substance prohibited by the institution (usually used in reference to drugs and weapons).

Copper – slang for guard.

CPIC – Canadian Police Information Check. A security check conducted by prison authorities on visitors and non-correctional professionals.

CRF – Community Residential Facility. A supervised living facility, most often used to house prisoners during their parole/reintegration process. In most CRFs, prisoners can go into the community unescorted during the day, but must return to the facility at night. Also known as a ***halfway house*** (see below).

CSC – Correctional Service of Canada (federal prison system)

Dead-time – slang for time served in prison while awaiting trial.

(A) Deuce less – slang for a sentence of two years less a day. The maximum possible sentence for someone housed in a provincial institution.

Dirty piss test – slang for a positive result in a random urinalysis test for the presence of drugs in a prisoner's system.

Down below – slang for federal prison, as in *"I'm going down below."*

Double-bunking – the practice of housing two prisoners in a cell designed for only one.

Dumptruck – pejorative slang for a lawyer who consistently has their clients plead guilty, rather than defend their cases.

ETA – Escorted Temporary Absence of a prisoner from an institution. A stage of release prior to the granting of parole, whereby the prisoner is allowed to leave the institution for a set period of time, under the supervision of an escort authorized by the institution (usually, but not necessarily, correctional staff).

Fit – slang for syringe.

(To) Gate – a term for the process initiated by federal corrections to prevent an eligible prisoner from receiving ***statutory release*** (see below). In some cases, an eligible individual may be "gated" – that is, have their statutory release revoked prior to being released. Individuals who are gated must serve their entire sentence in the penitentiary. Prisoners are usually gated when they are considered to be at high risk of re-offending, and/or have convictions for violent crimes.

Goof – very pejorative label, one of the worst things one prisoner can call another. *Community workers should avoid using this term, as it does <u>not</u> have the same meaning in prison as it does outside prison.*

Halfway house – a supervised living facility, most often used to house prisoners during their parole/reintegration process. In most halfway houses, prisoners can go into the community unescorted during the day, but must return to the facility at night. See also ***CRF*** (Community Residential Facility), above.

HIV – Human Immunodeficiency Virus

The Hole – slang for the segregation cells used as punishment.

Hooping – slang for the act of smuggling drugs or other contraband items into the prison by inserting them into the anus or vagina.

House – slang for cell.

IDU – Injection Drug Use/User

Inmate Committee – an elected committee of prisoners who represent the prisoner population in dealings with the administration (in the federal prison system).

Ion scan – a test for the presence of drug residues on hands, clothing, or ID. A test conducted on prison visitors in some instances. A positive result on an ion scan is grounds for barring the subject from the institution.

IPSO – Institutional Preventive Security Officer

Joint – slang for prison, institution.

Keep six – slang meaning "to keep watch", as in *"keep six for me."*

Lifer – slang for a prisoner serving a life sentence.

Lockdown – a time when all prisoners are locked in their cells, and no visitors or programs are allowed. Usually a punitive action after a disturbance or a death. Also used to facilitate an institution-wide search.

The Man – slang denoting the correctional system.

Methadone – prescription medication intended as a replacement for opiates in heroin and morphine users.

MMT – Methadone Maintenance Therapy

NEP – Needle Exchange Program

NG – No Good. Pejorative prison slang used to describe an untrustworthy individual.

OD – Overdose

PASAN – Prisoners' HIV/AIDS Support Action Network

PC – Protective Custody

PFV – Private Family Visit. Also known as a ***Trailer visit*** (see below) or "conjugal visit".

Pen – short for penitentiary/federal prison.

Perc – short for Percoset. A type of pain medication.

PHA – Person Living with HIV/AIDS

PO – Parole Officer

Primary care physician – HIV/AIDS specialist

Range – cell block/living unit comprised of a group of cells.

Rape hound – pejorative slang for rapist.

Rat – pejorative slang for "stool-pigeon". One who gives evidence against another prisoner. Someone who is untrustworthy.

(On) Remand – to be incarcerated while awaiting trial.

RIs – CSC Regional Instructions. Policies developed in each CSC region, based upon the national Commissioner's Directives (see ***CDs***, above).

Rig – slang for syringe.

Screw – slang for guard.

Seroprevalence – term denoting rate of infection.

Sharp – slang for a sharp object (i.e., a piece of glass) used to intentionally "slash" or cut one's own flesh (see ***Slash***, below).

SHU *(pronounced "shoe")* — Special Housing Unit. A "control unit" or super-maximum security unit where prisoners are locked up 23-24 hours a day.

Sisterhood – short for Native Sisterhood. A type of Aboriginal prisoners' organization.

Skin beef – pejorative slang for sexual offense, as in *"he's in on a skin beef."*

Slash – to intentionally cut one's own flesh. A form of self-injury used to release stress, anxiety, or anger; for relief of deep emotional pain or trauma; and as a way to feel "alive" within the numbing prison environment. A particularly common practice in women's prisons.

SOs – CSC Institutional Standing Orders. Policies developed in each federal prison based upon the Commissioner's Directives and Regional Instructions (see ***CDs*** and ***RIs***, above).

Solid – a prisoners' term of respect, denoting trustworthiness and reliability.

Stand-up – a term describing a trustworthy and straightforward individual, as in *"he's a stand-up guy."*

Statutory release – a form of parole. Under statutory release provisions, all federal prisoners must be released after serving two-thirds of their sentence (unless they are ***gated***, see above). The final one-third of the prisoner's sentence is served in the community, under supervision.

Suitcasing – slang for the act of smuggling drugs or other contraband items into the prison by inserting them into the anus or vagina.

Trailer visit – slang for ***PFV***, see above.

UTA – Unescorted Temporary Absence of a prisoner from an institution. A stage of release prior to the granting of parole, whereby the prisoner is allowed to leave the institution, without escort, for a set period of time.

Works – slang for injecting equipment.

YO – Young Offender