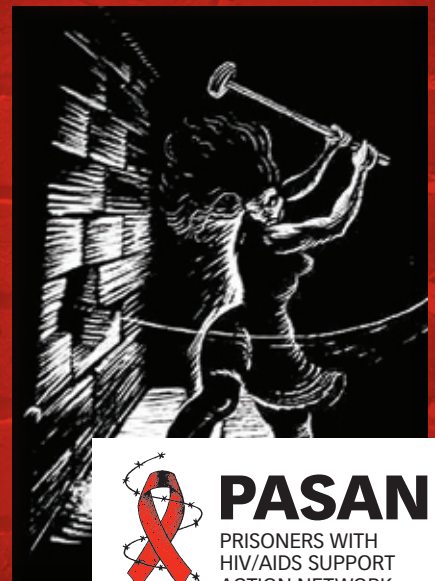
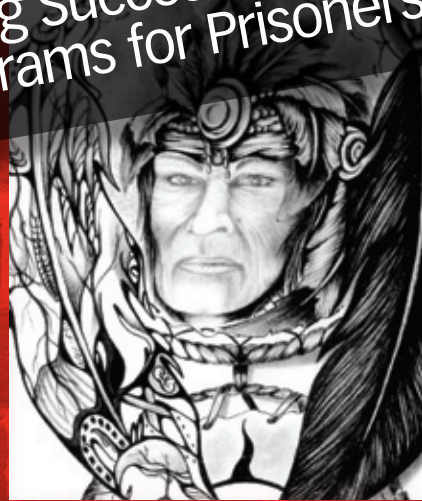
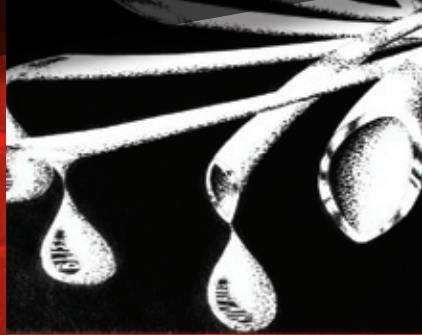




PROS & CONS

A Guide to Creating Successful Community-Based HIV and HCV Programs for Prisoners (Second Edition)



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

Second Edition, 2011

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ABOUT PASAN

PASAN is a community-based prisoners' rights organization that strives to provide advocacy, education and support to prisoners and ex-prisoners in Ontario on HIV, HCV and other harm-reduction issues. Established in 1991, PASAN is the only community-based organization in Canada exclusively providing HIV and HCV prevention, education and support services to prisoners, ex-prisoners, youth in custody and their families.

DEDICATION

This book is dedicated to all the HIV- and HCV- positive prisoners in Canada.

And, to our beautiful sister and leader LaVerne Monette, who left this life on December 1, 2010. LaVerne was the executive director of the Ontario Aboriginal HIV/AIDS Strategy and was also a member of the board of directors of PASAN. We thank the Creator for our time with LaVerne. She inspired us, gave us hope and taught us how to make a difference in this life.

Meegwetch.

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– Tracy Campbell, March 4, 2011

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PROS & CONS

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SECOND EDITION

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Introduction

THIS SECOND EDITION OF PROS AND CONS was written by PASAN to synthesize the experience the organization has gained over many years and is intended to provide readers with new ideas and lessons to help others implement PASAN's vision of comprehensive community-based HIV and HCV services for prisoners.

HIV and hepatitis C (HCV) continue to be challenging public health issues. In Canadian correctional facilities, the unique socio-demographic risk profile of prisoners and the nature of incarceration itself present specific challenges for HIV and HCV prevention, education, management, support, advocacy and harm reduction. 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 community-based workers who can act as advocates to ensure that their basic human rights and health-care needs are safeguarded.

If you are already involved in this work, this manual may reinforce some of your own conclusions and also give you some new ideas to incorporate into your services and programs. If you've never worked with HIV - and HCV- positive prisoners, knowing where to begin can be overwhelming considering the layered complexities and multiple nuances of gaining access to prisoners and developing programs that meet the wide-ranging needs of specific prisoner populations. As you begin your preparation for this work you will also need to be aware that the policies and practices in force at provincial and federal correctional facilities present significant barriers for prisoners who need access to and consistently use harm-reduction materials, such as sterile

Tracy Campbell works with AIDS service organizations to provide management and human resources consulting for capacity building, training, policy and organizational development and project management. This second edition is a revision of the original work written by Rick Lines. Rick researched and wrote the first Pros & Cons in 2002. Many of Rick's original ideas are reflected throughout this second edition. At the time of writing, Rick Lines was the executive director of the International Harm Reduction Association. Rick has been working in HIV and AIDS, harm-reduction policy and advocacy for more than 15 years and is known for his leading work in the areas of HIV and AIDS in prisons, human rights and drug policy.

needles; tattooing, piercing and drug preparation equipment; safer inhalation equipment; and condoms.

Providing support to your imprisoned clients and promoting the physical, emotional, spiritual and mental well-being of HIV- and HCV- positive prisoners should be your primary focus as an HIV/HCV worker. Given the unique barriers and daily struggles that prisoners must endure, delivering ongoing support, services, programming and advocacy is absolutely critical. Prison is an environment where adequate and consistent access to specialized health care is difficult and where maintaining confidentiality about one's HIV and HCV status is a daily struggle. Under these conditions, the risk of unnecessary or accelerated health decline – or death – is ever-present.

This manual is intended to be a resource and reference guide to provide HIV and HCV programming within prisons. Whether you are new to prison work or want to expand your knowledge, this manual will also guide your efforts for building relationships and trust, facilitating discussions, advocating for your clients and supporting them with pre- and post- release planning. Before you begin to plan your program, however, your first step will be to ensure that your organization is not only fully committed to this work but that it also has the capacity to develop and deliver your programs.

It is our hope that this book will provide you with new ideas and guidance on how to provide education programming, support services, care and treatment to prisoners, and advice on negotiating and advocating on behalf of your imprisoned clients. To obtain training, support or more information about the topics in this manual please contact PASAN.

How to Use this Manual

This manual is presented in a “how-to” format beginning with initial preparations. Each of the following sections and chapters are placed in what we think is an effective order and will be most useful for someone who is new to this type of work, walking the reader through each step. Throughout this manual you will see that we've included tools, tips, checklists, formats for programming, etc. However, we've also included advice and guidance on how to develop and use the “softer” skills, which are equally as important. Knowing how to develop trust, credibility and relationships are examples of these softer skills and they are critical for this work. You will also need to be an effective listener and be able to pay acute attention to the non-verbal cues and nuances of the prison environment.

We've started this manual with a section on building relationships, because without this you will have great difficulty in your work. Trust is the cornerstone of prison work and it is not given easily by prisoners or by prison workers for that

matter. If you are not trusted or considered to be “solid” by prisoners to whom you are providing services, you may as well pass the prison portfolio over to someone else in your organization. We cannot stress enough the importance of developing and maintaining appropriate and effective relationships and trust with prisoners, your clients.

The other key element in doing effective prison programming is flexibility and adaptability. As a worker hoping to do HIV and HCV 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 in this manual. If that opportunity seems to be 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 you and share it with others.

The same goes for the content and structure of your programs. View these 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 this manual as a template to create your own unique educational tools, and let us know about them.

Many topics covered in this manual are presented only as examples of some of the issues that are common to the prison system as a whole. You should therefore seek out specific knowledge and training from other established organizations that do HIV and HCV prison work, such as PASAN, HIV/AIDS Regional Services (HARS) and Positive Living BC or organizations that provide HIV and HCV programming to specific populations such as the Black Coalition for AIDS Prevention (Black CAP), the Canadian Association of Elizabeth Fry Societies (CAEFS) and the Ontario Aboriginal HIV and AIDS Strategy (OAHAS). We also recommend that you access the Correctional Service Canada (CSC) Web site or the Web site for provincial Corrections to obtain the most current information about the prison structures and systems for your region. This manual should not be considered a substitute for training.

If you are new to HIV and HCV prevention and education, you should contact a local AIDS service organization to arrange for “HIV and HCV 101” training. Throughout this manual hepatitis C is referred to as HCV, which is the acronym for the hepatitis C virus. If you require more information on HIV and HCV please contact CATIE online, www.catie.ca or hepCinfo.ca, or by phone 1-800-263-1638.



CHAPTER 1

Preparing for Prison Work

WORKING WITH PRISONERS AND EX-PRISONERS can pose a unique challenge. Unlike working with some other populations where testing HIV- or hepatitis C-positive (HCV) is often a defining moment in a person's life, for many prisoners and ex-prisoners their HIV or HCV status is not their biggest concern. For ex-prisoners worried about where their next meal, next bed or next fix is coming from, it is understandable that HIV and HCV infections may fall low on their list of priorities. For those struggling to deal with histories 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 test can be subsumed by other, deeper personal pains. This is an essential context to understand. Just because your main concerns are HIV and HCV does not mean that your imprisoned client's main concerns are HIV and HCV.

Building Relationships – The Foundation of Prison Work

In order to be effective with your prison work, you must be willing and able to work with prisoners and ex-prisoners on their own terms. Working with HIV- and HCV-positive prisoners can be a very different experience. Prisoners obviously don't have access to the same types of multi-level supports that are available in the general community. Therefore, HIV/HCV workers often find themselves filling many different counselling or support roles. Similarly, HIV/HCV prevention educators should anticipate spending much of their time in a prison workshop facilitating discussions of issues ranging from drug use to general frustrations about prison health care.

For many HIV- and HCV- positive prisoners, 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. You should therefore expect that, often, little or no time in a given session will be devoted to specific discussions of HIV or HCV issues. A client may instead need to discuss sexual abuse issues, drug-use issues or institutional frustrations or just have a friendly face or voice to talk to about everyday mundane things. 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.

Chapter Overview:

This chapter will provide you with the necessary groundwork before you set foot in a prison. It will help you understand the various relationships at play, how to build trust, the provincial and federal prison systems and the needs of the diverse prison populations for which you will be developing your programs.

Trusting relationships between you and 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. At a most basic level, doing HIV/HCV work in prisons is about building relationships:

1. **Between yourself and prisoner/s** – Individual professional relationship/s between yourself as a worker and prisoner/s for whom you provide services are based on trust.
2. **Between your agency and the institution** – A professional relationship between the agency or organization you represent and the institution is based on mutual convenience.
3. **Amongst prisoners** – You play a key facilitation role in these relationships, which are based on common interests.

Building Relationships – Between Yourself and Prisoners

One of the essential elements of being effective in your work is knowing how to effectively build relationships and trust. Your goal will be to cultivate and develop trust with prisoners with whom you work. People in prison, however, do not give their trust easily. This is often because prisoners have had trust violated in their lives – in family, schools, church and in the judicial system. It’s understandable, therefore, that trust is not given freely, but must be earned by community workers.

Being Solid

In prison, you are 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.

TIP: Someone who is considered solid is trustworthy and is often described as:

- Person who maintains confidentiality and privacy;
- Person who won’t collaborate with the staff or betray any information about another prisoner to the institution;
- Person who won’t give information against another con to the police to save their own skin; and
- Person who won’t back down on those principles, even when tempted with rewards or threatened with punishment.

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 (see tip box below). You must abide by those same principles in order to be successful. If you are fortunate enough to earn trust, it is crucial that you not violate it. To violate it 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 similar work. Always remember, while community workers can rarely expect to be considered solid in the same manner as a prisoner, they can definitely be judged to be not solid. If you are judged to be not solid, you may as well give up the prison portfolio in your agency to someone else.

Define Your Boundaries

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 of your own or topics you may be uncomfortable discussing. If you feel compromised by hearing about a client’s criminal history or being told of illegal activities such as drug trafficking within the prison, be upfront about it. In defining your boundaries from the outset, you are giving 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.

Building Relationships – Between Your Agency and the Institution/s

Agency and 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. Working with prison staff is necessary, because you have to go through the staff in order to get access to prisoners. Having cooperative relationships with the staff can help facilitate that access. While you 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 prisoners.

The relationship between your agency and the institution is essentially one based on mutual convenience:

1. Your agency is mandated to provide HIV and HCV services to prisoners.

- Prisons are mandated to provide health services to prisoners, and your agency can help them do that without increased burden on their staff.

As a service provider, you are able to provide an important 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 support to both prisoners and prison staff alike. 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 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. Do not underestimate the real risk that being perceived as “too friendly” with prison staff poses to your credibility with prisoners. Why should prisoners trust you if you are chummy with their keepers? This goes to questions of funding as well. If your agency accepts funding from correctional 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. “Who pays you?” is often one of the first questions prisoners ask in any workshop.

TIP: 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 illness
- literacy issues
- drug use
- homelessness
- institutionalization
- other medical concerns such as tuberculosis (TB)

Building Relationships – Amongst Prisoners Themselves

If done effectively and carefully from the onset, your work can also foster constructive relationships between prisoners themselves. HIV and HCV cut across racial, ethnic and other divisions within the prison. Health programs 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 or HCV status.

TIP: What NOT to do when you set out to develop relationships:

- Do not ask prisoners what they are doing time for.
- Never ask a prisoner about another prisoner.
- Do not seek advice from prison authorities without prisoner consent.
- Never make promises that you can’t keep.
- Do not reinforce penal authority or speak “down” to a prisoner.
- Never rationalize punishment or assist in the control of a prisoner.
- Do not impose your views, moral standards or judgments.
- Avoid “isms” including: racism, sexism, homophobia, transphobia and Islamophobia.

What You Need to Know about Prisons

Before you begin your prison work, you should have a basic understanding of the Canadian prison system and its populations. You will also need to understand the key issues that affect HIV and HCV prevention, care and treatment in prison (Please refer to the HIV and HCV in Prisons section, Chapter 3). As a prison worker, 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 from doing local work, local consultation and local investigation.

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 and HCV 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;
- be used to justify the neglect of prison health issues by provincial and federal governments;
- influence the moral and financial support our programs can expect from the broader community; and

- even negatively affect the way prison work is viewed by our colleagues in community-based HIV/HCV organizations and sometimes by co-workers within our own agencies.

Common Myths and Facts – Prisoners’ Rights and Health Care

1. **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 people enter 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. 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.

2. **MYTH: Prisoners should expect substandard healthcare.** Particularly in a climate where all Canadian citizens fear cutbacks in health services, people often assume that adequate health care 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 healthcare services that “shall conform to professionally accepted standards¹.” 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 and HCV.

3. **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 people who use drugs, 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 healthcare issues – possibly more so than most other audiences encountered by a community health worker. The success of prisoner-initiated peer health and peer counselling programs in many institutions provides an example of this motivation and interest. In PASAN’s experience, there are several explanations for prisoners’ interest in healthcare issues.

1. Prisoners usually recognize that their living conditions enhance their vulnerability to infectious diseases (although awareness about HIV and HCV infection itself may not be a primary concern).
2. Given the high rates of HIV, HCV and TB infection 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.
3. 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/HCV as do those of us in the general Canadian population.

4. **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. 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/HCV prevention and treatment programs in Canadian prisons is an urgent public health concern – one that demands immediate attention from the federal and provincial governments.

Canadian Prisons: Systems and Structures

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

1. The police make arrests.
2. The judiciary tries, prosecutes and imposes sentences.
3. The prison 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 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 and HCV. 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.

Federal and Provincial Prisons – What’s The Difference?

Policies and procedures with regards to the management of HIV- and HCV- positive prisoners vary considerably between federal and provincial institutions. Health and wellness programs offered by the institutions can also differ considerably (in content and in access) from region to region.

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. The federal prison system is administered by Correctional Service Canada (CSC), which is accountable to the federal minister of Public Safety. CSC’s National Headquarters is in Ottawa, but administration from

province to province is coordinated on a regional basis, under various Regional Headquarters:

1. Atlantic Region (Newfoundland, Nova Scotia, Prince Edward Island, New Brunswick)
2. Québec Region
3. Ontario Region
4. Prairie Region (Alberta, Saskatchewan, Manitoba, Northwest Territories, Northwestern Ontario)
5. Pacific Region (British Columbia, Yukon)

Security classifications in the federal system can present significant challenges for an agency wishing to deliver effective HIV and HCV programs and supports. It is important for you to understand that access to bleach, condoms and dental dams is sometimes impossible for those prisoners in higher security facilities compared to prisoners in minimum security prisons. There are also fewer programs and supports being offered in higher security facilities, which for a prisoner means there is significantly less to do in maximum security settings. Boredom and sensory deprivation can lead to violence, self harm and an oppressive, depressing environment.

The Provincial System

Individuals sentenced to less than two years (often referred to as “two-years-less-a-day”) are the responsibility of the provincial and territorial governments. Additionally, the provinces and territories are responsible for adults who are ordered to be held in custody before or during their trial (i.e. remand or pre-trial detention) and other forms of temporary detention (i.e. immigration holds). The provincial systems incarcerate prisoners in two different types of institutions: correctional centres and remand centres.

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

Remand centres are also known as detention centres, pretrial centres and local jails. Remand centres 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. 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 (e.g. less than 30 days) will actually serve their time in the remand centre.

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 across Canada. 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. Provincial prisons (correctional centres, detention centres, jails and treatment centres) will vary with regard to how prisoners spend their time. Prisoners are confined to different areas in the prison including segregation, protective custody (PC), general population, etc. The area in which a prisoner is being held will determine his or her access to programs and supports within the prison. It is important to understand your regional structure and the various levels of access before you begin your work within the provincial system.

Youth in Custody Facilities

Provincial governments also have the responsibility to house young prisoners. Please note that the issues and regulations for youth in custody facilities completely differ from those pertaining to adult prisoners and institutions. Such discussions are beyond the scope of this manual.

Community Residential Facilities (CRFs) /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 sentences, 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, when they are subject to supervision.

Common Structures of the Canadian Prison Environment

Gender Segregation

Male and female prisoners can be gender segregated. 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 can be housed in separate sections of men’s penitentiaries. Transsexual and transgen-

dered prisoners are housed based upon their biological sex, rather than their gender identity.

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 maximum). 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 confront.

The security level indicates:

1. the security classifications of prisoners within the institutions, which are often but not necessarily related to the nature of the conviction and length of sentence.
2. 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.

Physical Structures

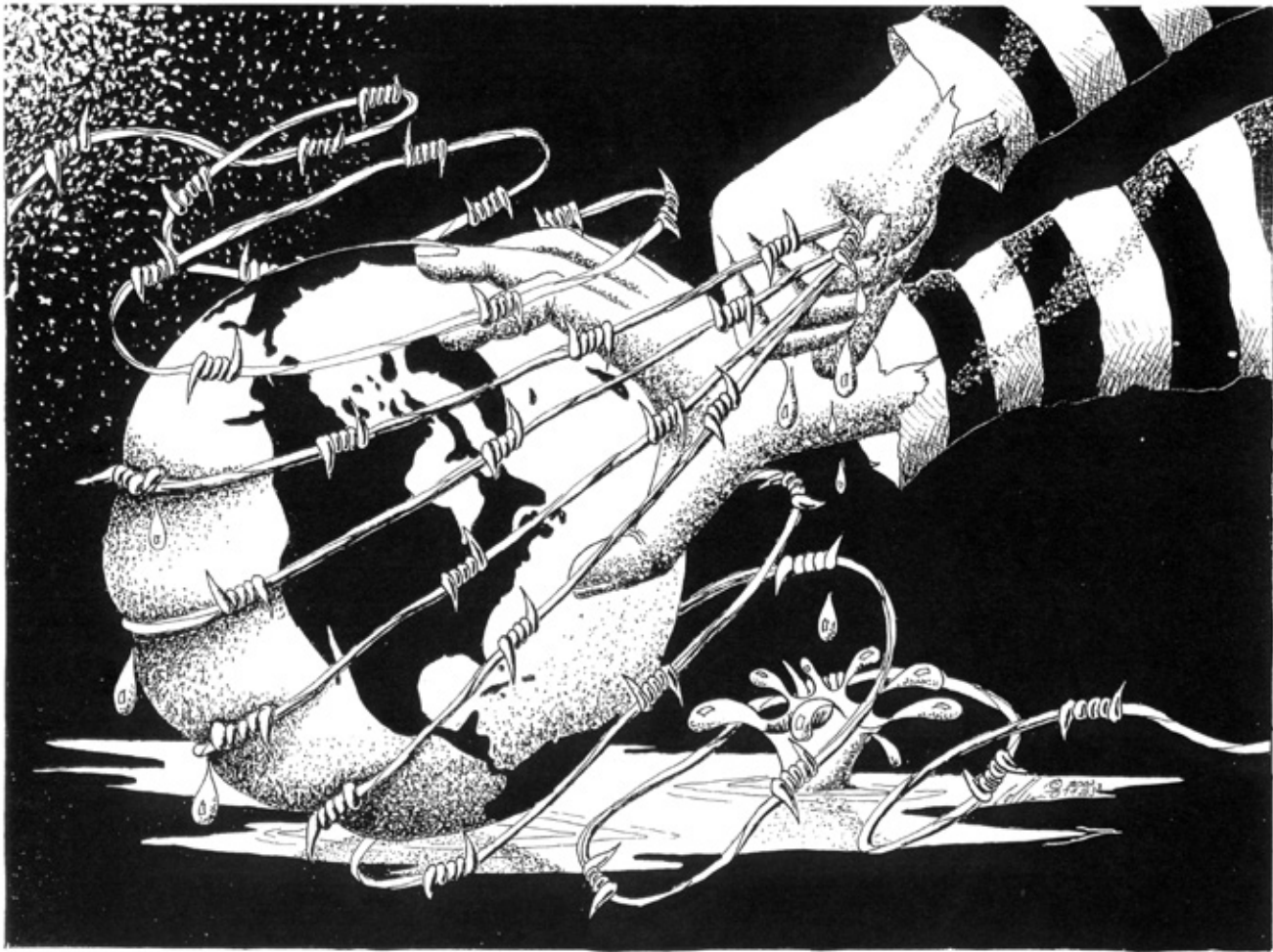
Ranges

The basic unit in any prison’s physical structure is the range (or “cell block”). The range is a self-contained living unit in which prisoners are housed. Ranges are comprised of a group of cells (usually between 20 and 40) and a common living area (that will usually have tables, benches, a television and shower/toilet facilities). Depending on the size of the institution, there may be only a few ranges or several dozen.

Protective Custody Range

Every prison will have at least one range that is designated PC. The PC section houses prisoners who are thought to be unsafe in the “general population”. In some cases, when people fear for their 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 PC.



Peter Collins

- People who are testifying against other prisoners are also usually held in PC.
- People who have developed large drug debts within the prison are usually held in PC.
- 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.

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.

Freedom of Movement and Security Ratings

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 determines the amount of freedom of movement prisoners 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

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 (IPSOs) who are in charge of internal prison security
2. **Supervision/parole staff** – case management officers, parole officers
3. **Healthcare 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)

- spiritual
- peer health education
- peer support counselling
- athletics
- 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. Feedback from prisoners, obtained during the writing of this manual, indicated that institution-run programs in British Columbia and Québec were more progressive and supportive of prisoner needs as compared to institution-run programs in other provinces. Budgetary constraints will also affect the availability of programs and services.

Programs and Services

Programs and services of various types are often available to prisoners. In many cases, participation in these programs is a mandatory part of an individual’s correctional plan and will be a factor in assessing 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.

1. **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
 - work training (often as part of prison industry)
2. **Types of programs run by community groups and volunteers can include:**
 - literacy
 - cultural (for Aboriginal prisoners or Black prisoners, for example)
 - spiritual
 - Alcoholics Anonymous
 - Narcotics Anonymous
 - health promotion and education (including HIV and HCV)
 - creative/art/music
 - social support groups
3. **Types of programs run by prisoners can include:**
 - social support
 - cultural

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 or early parole. In others, they are more informal, such as relaxed surveillance or “less hassle” from staff. Never underestimate the punitive effects of informal disciplinary actions in the prison environment.

While formal disciplinary sanctions are always damaging, particularly towards an individual’s application for parole, informal ones can be equally or more detrimental. And, 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 charge
- solitary confinement
- transfers to higher security institutions

In other cases, they are informal, such as:

- increased surveillance from guards
- more frequent cell searches
- more “hassle”

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.

Prisoners' Social Response, Norms and Codes

Prisoners respond to the realities of their environment in a variety of ways, as do many socially and economically marginalized populations. Prisoners 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 situations. Having knowledge of these responses, norms and codes can help you enhance your prison programs and services.

Prisoners have long had their own subculture 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 PC and being convicted of crimes against women or children (particularly true in, but not limited to, male institutions.)

TIP: When developing prison programs, especially in federal institutions, it is important that you seek out the support of "solid" cons and respected prisoner organizations, 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. Prisoner-run groups are facilitated by prisoners themselves, sometimes with support from community volunteers. These organizations fall into five general categories and most are active in federal prisons:

1. Elected/administrative bodies

These can include Inmate Committees, Range Reps and 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. 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. It 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 ethno-cultural 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/HCV 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. Together, these organizations will constitute your prison community partners, and working with them will significantly enhance your prison programming and service provision.

- 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 you are 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 coun-

try. Working with these groups can be potentially problematic, but they do provide an opportunity to reach prisoners. You will find that interest in HIV/HCV varies in accordance with the personalities of the individuals involved.

Prisoner Economies and Commodities

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

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.

1. It is the culture and society in which they feel most secure.
2. It is where their friends are and where they may enjoy a level of respect and recognition.

TIP: When released, one of the most difficult struggles for prisoners to overcome is the effects of institutionalization. Institutionalization reduces a person's ability to function in the outside world. Thus, for some people, the effects of institutionalization contribute to cycles of re-arrest and re-incarceration. The pattern that leads to re-incarceration is commonly known as recidivism. As with institutionalization, the potential of re-incarceration for your clients is an important issue to recognize in providing your support services.

3. 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.

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. For prisoners approaching release or ex-prisoners living in the community, institutionalization will be an important issue to recognize in providing your support services. In this way, many long-term prisoners may try to run programs out in the community as they would the prison range (e.g. ordering people about). This type of behaviour, while valued in prison, is seen as inappropriate out in the community.

Recidivism and Re-incarceration

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

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 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.

Canadian Prison Populations

Canadian prisons are very diverse communities – culturally, linguistically, racially, 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 and particularly in the case of women, a history of violence and abuse perpetrated against them. Often it is this history that has brought them into conflict with the law.

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. It is critical that as an HIV/HCV worker, you recognize the diverse intersecting characteristics that create multiple forms of oppression: poverty, racism, sexism, homophobia and transphobia.² Targeted, sensitive and culturally appropriate education and prevention messages must be a high priority for all community-based agencies.

According to a report released in 2010 by CSC, at 4.6 percent, the rate of HIV infection in federal prisons is 15 times greater than that in the community as a whole. As for HCV in federal prisons, the 31 percent rate of infection is 39 times greater than in the population as a whole.³

Specific Prisoner Populations

Prisoners mostly constitute a socially and economically marginalized population in Canadian society. As a group, they have identifiable needs and barriers, particularly with regard to HIV and HCV. 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 be interacting with some or all of these groups. The following briefs are only intended to provide you with an overview of some of the prison sub-populations. While the following information is not comprehensive, it will provide you with an introduction to the needs of some prisoner populations along with guidance for making your prison programs more accessible and relevant to your clients.

Prisoners Who Use Drugs

In the prison system, drug use is an issue that cuts across racial, ethnic, gender, geographical, generational and other boundaries. Those prisoners who do not themselves use drugs will have friends who do. For this reason, drug use is an issue that touches almost every person in the prison environment. The percentage of incarcerated people using illicit drugs (which, in the prison context, includes alcohol) is reported by CSC as being much higher than the percentage in the general population. In 2007, CSC reported that “four out of five prisoners had serious substance abuse histories and problems.”⁴ Even for those prisoners who might not regularly use drugs, the opportunity to get high can be a welcome relief to the overall boredom of being in prison. 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. In many ways, drugs assume an even larger significance in prison than they do in the outside community. There are two reasons for this:

TIP: 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 a prisoner subject to generally increased surveillance by the institution. 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. PASAN is of the opinion that many people who use non-injection drugs specifically start injecting in prison because of correctional policies regarding urinalysis.

1. The issue of securing and using drugs is one that affects a large majority of the prisoner population.
2. 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, visitors, lawyers, clergy, volunteers, community organizations, non-correctional workers come in to do contract work (construction, plumbing, telephone repair, etc.) or to deliver food and other necessities. This large number of individuals coming and going every day provides ample opportunity for drugs to be brought into institutions. For this reason, prisons monitor 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.

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/HCV worker the question you need to address is not “how do we stop drugs getting into prisons?” but rather “how do we prevent the spread of disease through the use of drugs?”

For HIV/HCV 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 healthcare rights for incarcerated people.

Systemic Barriers – Prisoners Who Use Drugs

The biggest barriers encountered by people who use drugs 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 the help and support they may need and want. Prejudice against people who use drugs has also erected general barriers to healthcare services and has limited the healthcare options made available to imprisoned people who use drugs. Prejudice has also severely curtailed the options available to prisoners who use drugs, to prevent HIV and HCV infection. 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 have indicated both disinterest in and resistance to abandoning zero tolerance in favour of harm reduction.

Impact on Community-based HIV/HCV Programs for Prisoners Who Use Drugs

Given the history of failure of the zero-tolerance approach, prisoners who use drugs urgently need access to harm-reduction tools and programs proven effective in the community. Given the prison conditions described above, the persistent lack of harm-reduction options for prisoners has created a very high risk environment for the transmission of HIV, HCV and other blood-borne diseases through injection drug use.⁵ To reduce or prevent the spread of disease through shared injection equipment, prisoners need access to effective harm-reduction options such as needle distribution and methadone programs. 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 who use 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. Despite the recent legalization of medical marijuana in some circumstances, its continuing illegality for recreational use and the illegality of other drugs mean that people who use drugs are also at a very high risk of re-incarceration. Such prisoners may therefore need extra supports in this area.

Drug use is an overarching issue that has an impact at all levels of prison work. In order to be effective in prisons, therefore, workers need to become familiar with drug-use issues,

become comfortable functioning in an environment where drugs are used, and become comfortable in using and advocating a harm-reduction/health-promotion approach to drug use in prison programs and services.

Aboriginal Prisoners

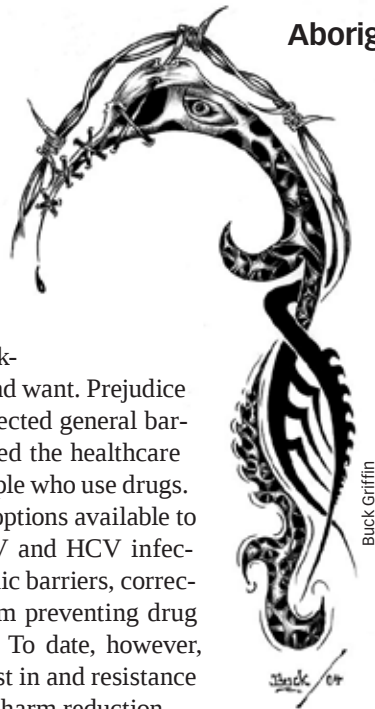
Aboriginal people (First Nations, Inuit, Métis, status and non-status) are the single most over-represented community within Canadian prisons. Aboriginal people continue to be disproportionately represented at all levels of the Canadian criminal justice system. According to CSC, as of the end of March 2009, Aboriginal people comprised 17.3 percent of federally sentenced prisoners, while the Aboriginal population is 2.7 percent of the Canadian adult population.⁶ In 2007 CSC reported that 11.7 percent of Aboriginal prisoners are HIV infected and that 49.1 percent are HCV infected⁷.

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.⁸ Therefore, Aboriginal prisoners are also likely to serve more time than non-Aboriginal prisoners and/or to serve time more often. Consequently, “there are disproportionate numbers of First Nations women in prison; Native women make up 22 percent of the federally sentenced women’s population and the rate of incarceration for First Nations women is 250 times the rate of the general population.

Women prisoners in general and First Nations women in particular, tend to be over-classified as maximum security risks, making their movement within prisons under constant surveillance⁹. In addition, dramatic increases in the rates of HIV infection among Aboriginal communities on the “outside”¹⁰ mean that effective HIV prevention and treatment measures have become absolutely crucial for Aboriginal prisoners.

People from racialized communities and Aboriginal populations are over-represented within the Canadian prison system. Based on an age-adjusted comparison with the Canadian population as a whole, one would expect about 2.5 percent of federal prisoners to be Aboriginal; in fact 17 percent of male and 26 percent of female prisoners are Aboriginal. This number increases in some of the Prairie provinces where Aboriginal populations make up 77 percent of the total prison population.¹¹

In the Correctional Investigators (CI) Annual Report for 2006-2007, the CI reported that while the federal prison



population in Canada actually decreased between 1997 and 2007, the number of Aboriginal federal prisoners increased by almost 26.4 percent. The incarceration rate of Aboriginal prisoners is nine times higher than for non-Aboriginal Canadians.¹²

Systemic Barriers – Aboriginal Prisoners

Despite the efforts of Aboriginal leaders and communities and policies already put in place by Corrections, Aboriginal prisoners’ access to culturally appropriate programming remains problematic in many parts of Canada. The provincial and federal 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 they would 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 those of First Nations 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 in different jurisdictions. Native liaison officers can be very helpful contacts for community organizations wishing to provide HIV and HCV services for Aboriginal prisoners, and they should be on your list of important contacts.

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, sweet grass and other traditional medicines into institutions. Smudging ceremonies are often prohibited or disrupted because traditional medicines that are burned such as tobacco, sweet grass, cedar and/or sage are 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.

Almost 50 percent of Aboriginal federally sentenced women are precluded from accessing the Okimaw Ohci Healing Lodge because they are classified as maximum security prisoners. Many are now confined in the new maximum security units in the regional women’s prisons, while a small number remain confined in the segregated maximum security unit in the men’s Regional Psychiatric Centre in Saskatoon. No maximum security women have ever been able to access the Healing Lodge.¹³

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, HCV and other health programs and messages reflect the diversity of Aboriginal cultures, traditions and experiences.

Impact on Community-based HIV/HCV Programs for Aboriginal Prisoners

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 thus far, their struggle to assert their cultural and healthcare rights continues. 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 should be a priority in the development and delivery of your prison programs and services.

Women Prisoners

Women represent a small fraction of the prisoner population. In the overall prison system, incarcerated women represent approximately 5 percent of the total population.¹⁴ This usually results in programs and health services being developed for and targeted towards men and their specific needs. Since women are becoming increasingly infected with HIV and HCV, there is an increased need for gender-specific education and health services for incarcerated women. According to a 2007 CSC survey, 7.9 percent of women prisoners are HIV infected and 37 percent are HCV infected as compared to 4.5 percent of men infected with HIV and 3.8 percent of men infected with HCV¹⁵. Women are vulnerable to HIV and HCV infection because many are part of social groups that are traditionally marginalized by society not only on the basis of gender, but on the basis of race, class, sexual orientation, disability, substance use and/or occupation as sex trade workers. Consider the following:

1. Most women in prison have histories of poverty, drug use and previous incarceration.
2. Women generally earn lower wages than men and are more likely to be single parents.
3. Women are more often imprisoned for economic offences directly related to poverty – shoplifting, fraud and non-payment of fines, for example.
4. Women are frequently incarcerated for prostitution.
5. Women prisoners are also more likely to be survivors of violence and different forms of abuse.
6. In addition, seroprevalence studies conducted in Canadian prisons have consistently revealed higher HIV and HCV infection rates among women prisoners than male prisoners.¹⁶
7. Women who are classified as maximum security tend to be so designated because they are labelled as having difficulty adapting to the prison (i.e. institutional adjustment) rather than because they pose a risk to public safety.
8. Eighty percent of all federally sentenced women report having been physically and/or sexually abused. This percentage rises to 90 percent for Aboriginal women.¹⁷

Accordingly, although crime rates are dropping, incarceration rates for women admitted to the federal system in Canada are on the rise. Recent statistics indicate that “women account for fewer than 5 percent of all individuals serving sentences of 2 years or more and the vast majority of women prisoners are first time prisoners and in 2001, 82 percent of federally sentenced women were serving their first federal sentence” (Canadian Human Rights Commission, 2003)¹⁸.

TIP: Ensure that your prison 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. Ensure that the HIV/HCV and other health programs and services are designed to reflect the specific needs and experiences of women prisoners.

Systemic Barriers for Women Prisoners

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 that demonstrate that the spending per prisoner is greater for women than men, their assertion of equal access does not match the experiences of many community-based professionals providing services for incarcerated women. 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. This is also 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. This is particularly true for HIV/HCV programs and educational materials, where Corrections – and indeed some community-based programs – have geared their resources towards a white male audience. The smaller proportion of women prisoners compared to men 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 for 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).

Because the custody ratings scale is designed according to white, male, middle-class standards, it results in skewed discriminatory assessments of federally sentenced women, resulting in too many being deemed high security risks. Among the hardships imposed by this is the fact that maximum security prisoners are isolated in segregated living units and, unlike their minimum and medium security counterparts, are not eligible to participate in work release programs, community release programs or other supportive programming designed to enhance their chances of reintegration.¹⁹

There are many more barriers specific to women inherent in prison programming and service delivery itself. Existing prison medical services in particular fail to address the specific needs of incarcerated women, resulting in barriers



Eric Drooker

Gender-specific social stigma – notions about “acceptable” and “unacceptable” behaviour for women – 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.

Impact on Community-based HIV/HCV Programs for Women 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/HCV 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/HCV workers must understand and respect this pain and be prepared to provide additional and appropriate support to women prisoners. Needless to say, all HIV/HCV 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.

80 percent of all federally sentenced women report having been physically and/or sexually abused. This percentage rises to 90 percent for Aboriginal women.²¹

Women prisoners have needs that are unique from male prisoners, which are very much related to gender differences in socio-economic status throughout Canadian society. 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 is similarly linked. People use drugs as a common survival strategy, essential to numbing the pain of years or even decades of violence. 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.

to women prisoners’ access to adequate health care. For example, the history of physical and sexual violence common among incarcerated women demands that prison medical services demonstrate sensitivity to and respectfulness of sexual abuse issues. 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.

The Canadian Association of Elizabeth Fry Societies indicates that crime rates in Canada reached a 25-year low in 2006, yet the numbers of women being imprisoned are increasing and the fastest-growing prison population worldwide is women, particularly racialized, young, poor women and women with mental and cognitive disabilities. The escalating numbers of women in prison is plainly linked to the evisceration of health, education and social services.²⁰

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

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 US 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. Trans prisoners for example, are generally more vulnerable to rape within the institution. In many cases, this risk is exacerbated by placing Trans prisoners in the PC unit (ostensibly to protect them from violence). PC is used to house people deemed to be at risk of physical harm in the general population. The institution may place an individual in PC, or individuals may “check themselves in” to PC if they fear for their own safety. People with “skin beefs” (sex prisoners), child molesters and “rats” (people who have given evidence against another prisoner) are most often designated PC. However, Trans people, openly gay men and openly HIV-positive people are also frequently placed in PC. Many known rapists are also held in PC. As a result, this attempt to protect Trans prisoners from sexual assault frequently increases their vulnerability.

Given this situation, many Trans 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 Trans 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 Trans 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 rape and other sexual assault in their lives, and a great number of prisoners (both female and male) have survived childhood sexual abuse.

HIV/HCV 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.

Separation from children is another issue that disproportionately affects women in prison, as women are more likely to be the sole caregivers for their children. Thus, going to jail can result in women prisoners’ children being placed in the care of the state. 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 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 a prisoner’s healing even further. 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. Women in particular require services that can assist them in obtaining secure and safe housing when they are released from prison. Incarcerated women “often have children who lived in alternative placements with family, friends, or children’s services while the women were in prison. The women need to re-establish themselves with their children, and they require housing that is sufficient for their family²².”

Two thirds of federally sentenced women are mothers, and they are more likely than men to have primary child-care responsibilities.²³ There are about 25,000 children

whose mothers are in either federal prisons or provincial jails in Canada each year — separation from their children and the inability to deal with problems concerning them are major anxieties for women in prison.²⁴

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.

Black, African and Caribbean Prisoners

Within the federal prison system, rates of incarceration for people who identified as Black are higher than in other communities. According to CSC, black prisoners make up 6 percent of those incarcerated in federal correctional facilities and 7 percent of those serving time in the community.²⁵ The Canadian Association of Elizabeth Fry Societies reports that Black women are admitted to provincial custody at a rate of almost seven times that of white women²⁶ and at the Vanier Correctional Centre for Women, admissions of Black women increased 630 percent over 6 years. According to a status report from the Public Health Agency of Canada, “a disproportionate number of Black people are incarcerated in Canada



William Antoine

“Although racism impacts upon people’s lives in a variety of ways, and through many different institutions and structures in society, racism in the justice system continues to be one of the most readily apparent examples of institutional racism. A cursory overview of racism in the justice system clearly reveals that the process of racism is in full operation in every aspect of the justice system in Canada.”³⁰

Racism is directly linked to prisoner health and is outlined in Canada’s Determinants of Health.³¹ From the early 1990s, “anti-racism strategies were recommended to address individual racism and systemic racism (policies, procedures, lack of integration of diverse perspectives, racialized attitudes embedded in routine operations)³².”

Little research (if any) has been conducted on issues around HIV and HCV specific to Black, African and Caribbean populations in prison. However, race and racism has an effect on many of the determinants of health that impact a person’s vulnerability to HIV and HCV: income, education, employment, housing, early childhood development, physical and social environments, access to health services, support networks, gender and a history of sexual abuse. Observations from service providers going into federal prisons indicate that Black prisoners are generally in higher security prisons and therefore have less access to harm-reduction materials.

and people in prison are 7 to 10 times more likely to be infected with HIV than people who are not incarcerated”.²⁷

“In particular, Black women often receive harsher sentences than their white counterparts and, once released, Black women seem reluctant to utilize community services... having returned to their home communities, many avoid disclosing their time away due to the stigma associated with mainstream notions of criminality, which dictate that formerly incarcerated persons are deviant and social outcasts. Many of the offences that women of colour are charged with are a direct result of impoverishment, since poverty often limits women’s choices.”²⁸

Systemic Barriers for Black, African and Caribbean Prisoners

“Anti-Black racism is prejudice, stereotyping and discrimination that is directed at people of African descent and is part of their unique history and experience. In Canada, it is a history that includes almost 200 years of slavery; housing, employment and education segregation; and legally sanctioned discrimination. Anti-Black racism involves systemic discrimination in the immigration and refugee system, the criminal justice system and in employment, education, health and other spheres of society. It is manifested in the current social, economic and political marginalization of Black, African and Caribbean people in society, such as the lack of opportunities, lower socio-economic status, higher unemployment, significant poverty rates and overrepresentation in the criminal justice system.”²⁹

Impact on Community-based HIV/HCV Programs for Black, African and Caribbean Prisoners

As in many other communities, there is intense stigma that exists in Black communities around issues of incarceration, sexuality, gender identity, drug use and most significantly HIV.³⁴ These attitudes are brought into prison and then back out to the community.

Targeted programming needs to be conducted both during incarceration and post-release. A 2006 study (Centre for Disease Control) in the US Georgia State Prison showed that the vast majority of Black men were infected with HIV before incarceration. Although the available data suggests that relatively few infections occur in prison settings, there is evidence that some people with HIV who had received medical

TIP: Many myths and stereotypes fuel HIV and AIDS stigma and discrimination in the Black, African and Caribbean communities. HIV/HCV programming for the prison environment is more likely to be accepted when the development of the education and prevention messages comes from (or is developed in conjunction with) trusted and credible sources within the Black, African and Caribbean communities. Contact Black Coalition for AIDS Prevention (Black CAP), Africans in Partnership Against AIDS (APAA) or African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) for further information.



Helena Dobson

care while incarcerated have difficulty accessing HIV medications upon release—affecting their health and potentially increasing the likelihood that they will transmit HIV.³⁵ Additionally, rates of HIV/HCV and co-infection among Black injecting drug users and prisoners are not well documented, which limits effective planning of prevention, care, treatment and support activities.³⁶

When working with Black, African and Caribbean prisoners, it is important that you avoid a “one-size-fits-all” approach. It is important to remember that there is a lot of diversity in culture, traditions and values among Black, African and Caribbean communities in and outside of prison. It’s essential that HIV/HCV workers take the time to listen and to create the space for Black, African and Caribbean prisoners to identify their own needs. It’s only through this process that you can begin to establish the relationships and support that will most fully meet the needs of Black, African and Caribbean prisoners living with HIV/HCV.

The development of culturally specific programs for the Black, African and Caribbean populations within prisons must be a priority. Ensure that your organizational mandate includes a commitment to providing culturally appropriate, flexible and responsive HIV/HCV services for Black, African and Caribbean prisoners. Organizations should ensure that programming is developed for provincial and federal institutions, with consultation from organizations such as Black CAP, ACCHO and APAA.

It is crucial that non-Black HIV/HCV workers be able to engage respectfully with prisoners from Black, African and Ca-

ribbean communities and that their organizations are made welcoming and accessible to these communities as a whole.

Before beginning to work with the Black, African and Caribbean prisoner populations, all workers should understand how their own beliefs and organizational practices could enable stigma and discrimination in their prison work.

It is essential that all prison workers receive training on cultural competence and anti-racism issues. In addition, organizations (at a broader staff, board and volunteer level) should receive anti-racism/anti-oppression training to ensure effective and appropriate programming.³⁷

It is vital that organizations are committed to understanding the factors that contribute to especially high levels of anti-Black racism, not only in the prison system but also in other settings.

The above briefly provides a snapshot of the salient issues that Black, African and Caribbean prisoners encounter. The above section clearly does not encompass the diversity that is also found within Black, African and Caribbean communities themselves. As such, more research on the cultural dimensions of the Black, African and Caribbean communities is warranted and strongly recommended. This section has attempted to highlight some of the currently salient issues for incarcerated Black, African and Caribbean prisoners.

Gay, Lesbian and Bisexual Prisoners

Though there is virtually no Canadian research on the unique impacts of homophobia on prisoners’ health, it has been consistently observed that levels of homophobia can be very high among both prisoners and prison staff. In PASAN’s experience, it is very challenging to explicitly develop supportive programs or advocate openly for gay and bisexual male prisoners. By contrast, in women’s institutions, PASAN has rarely encountered the same barriers raised by homophobia; in fact, most women prisoners are quite open to discussing same-sex relationships and safer sex options between women.

Due to the lack of literature on gay, lesbian and bisexual prisoners, and unlike other populations listed in this section, this manual does not include an extensive section on developing programs for gay, lesbian and bisexual prisoners. Instead, unique challenges and recommended tips as they relate to institutionalized homophobia are embedded throughout different sections of this manual (Prison-Specific Prevention Strategies, Protective Custody Ranges, Taking a Holistic Approach to Prisoner Health). Institutionalized homophobia should not prevent you from discussing same-sex relationships when appropriate. Gay, lesbian and bisexual prisoners should be recognized as a significant sub-set of prisoners and given particular focus when context allows.

Trans Prisoners

Trans prisoners are among the most often marginalized and disadvantaged in the prison community. Trans prisoners 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.

Trans individuals often face discrimination, harassment or violence. Transphobia is an irrational fear or hatred of Trans people. Transphobia can present itself culturally, institutionally and personally. For example, many Trans individuals face difficulties in obtaining identity documents that accurately reflect their identified gender identity (versus their biological sex). In some cases, this can be because of institutional red tape. In other cases (such as Québec), Trans 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 Trans community. This lack of identity papers reflecting one's gender identity not only leads to psychological stress but also erects barriers to employment, leaving many Trans people with limited options other than working in the underground economy.³⁸ These factors lead many young Trans people to work in the sex trade, placing them at increased risk of coming into conflict with the law.

Many Trans youth also use drugs, which increases their chances of arrest.³⁹ For these reasons, incarceration is quite a common experience among Trans people. The risk of incarceration tends to be greater among male-to-female Trans 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 Trans people live – both in the community and in prisons (see below) – put them at increased risk of HIV infection. Approximately 10 percent of PASAN's HIV-positive clients identify as Trans – the vast majority of these individuals being male-to-female. Yet the proportion of Trans prisoners in the general prison population is much below this 10 percent figure. One could therefore conclude that Trans prisoners are over-represented in terms of HIV infection, even against the prison population's generally increased seroprevalence rates.

Systemic Barriers – Trans prisoners

The legitimacy of Trans people's needs as a group is not accepted in society as a whole, and this of course trickles down to the prison environment. The discrimination, inequality, health and safety issues faced by Trans prisoners are proportionate to the issues faced by Trans people in the community. Existing correctional gender segregation policies determine whether a Trans individual is incarcerated in a male or female institution based exclusively on her or his sex organs. Therefore, male-to-female Trans prisoners (who have not undergone sex reassignment surgery and had their gender change legally registered) are housed in male prisons and

are among the most marginalized and disadvantaged in the prison community.

Male-to-female Trans prisoners are often used as sex objects and as a result are at increased risk of violence within the institution. Many Trans prisoners find it necessary to trade sex for protection. Therefore, their very survival hinges on their willingness to provide sex for their partners, who are often very abusive to them.⁴⁰ 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.

Given the unique and entrenched form of discrimination against Trans prisoners, Trans prisoners face unusual barriers to having their needs recognized and respected in prisons. For example, correctional staff routinely insist on calling Trans 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 Trans prisoners' unique needs. In many cases, Trans 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 Trans prisoners are also routinely held in PC, 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 Trans 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 Trans prisoners are often housed in more restrictive living conditions, with less access to social time and prison programs generally.⁴¹

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

However, Trans prisoners 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 Trans prisoners. While the hormones used by female-to-male transgender people may have a lasting effect, those used by male-to-female Trans people do not. Therefore, losing access to these hormones results in serious physical side effects and in a reversal of body change – 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. This is true in the federal system, whose policies on Trans prisoners are outlined in Commissioner's Directive, which is available through the CSC website. Although GICs have the mandate to evaluate and assess Trans prisoners, the system is problematic, as GICs routinely discriminate against sex workers,

people who use drugs and people with criminal records.⁴² Therefore, GICs do not serve the needs of the street-involved Trans community, who are the most at risk of coming into conflict with the law and spending time in prison.⁴³

Impact of Community-based HIV and HCV Programs for Trans Prisoners

Trans people are among the most marginalized and disadvantaged in the prison community. Given these urgent needs and systemic barriers, organizations wishing to offer prison programming should establish programs and services to meet the specific needs and experiences of Trans people. Consider how to effectively build links with organizations in the community that offer Trans support and health services, and invite them to provide guidance and support in this effort. Ensure that your organization’s HIV/HCV and other health programs and services are designed to reflect the specific needs and experiences of Trans prisoners.

Given the hostility of Trans prisoners’ environment and the barriers they face in accessing health and social services, the HIV/HCV 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.

Community workers in prisons must make an extra effort to reach out to, and provide relevant services for, Trans prisoners. Be proactive in developing relationships with organizations offering Trans support and health services in your region, to advise and assist you in this work.

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2

CHAPTER 2 Getting Started

FOR A COMMUNITY-BASED HEALTH PROFESSIONAL, getting inside a prison to see prisoners should be a relatively straightforward process, however this is only one component of getting started. Getting started in prison programming will first require a commitment from your agency. You will need to ensure that the right resources and infrastructure are in place, and your agency can best do this with an internal capacity scan (see below). When developing your program proposal you will need to thoroughly do your homework so that you understand the needs of specific prison populations, the prison environment and the differences between regions, both federally and provincially. Next, an environmental scan will help your agency make the initial assessments about what's available and what's not, in order to establish your best available options for program delivery.

Getting started also 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. You'll need to determine what type of visit will be most effective for your work, whether to work on your own, in pairs or with peers and, of course, how to advertise your program. Understanding the dynamics of facilitating a prisoner group is important, and this chapter will explain what you need to know to foster participation and to manage the dynamics and nuances of a group. At this point you will have determined your outreach and program format/s and have developed the prison-specific content. Before you get going, there are a few key programmatic guidelines that have proven effective in a prison environment.

Preparing Your Agency

Prior to developing your program you will need to ensure that your agency is ready to undertake this commitment. You need to ensure that the infrastructure and resources are in place. And of course, you will need to do your homework to ensure that you understand the prison environment, the issues and barriers faced by prisoners, the needs of the various prison populations and the health-related issues that exist within the prisons.

1. Your organization as a whole needs to be prepared to meet the increased demand of taking on this work and particularly be prepared to meet the special requirements that come along with working with prisoners.

Chapter Overview:

This chapter will walk you through the necessary program preparations and decisions that you'll need to make in advance of delivering your program as well as offer guidance on how to best deliver your program. It covers everything from ensuring that your agency is prepared to do this work, making contact with the institution and gaining security clearance for facilitating group participation. 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.

2. 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.
3. If you fail to adequately consider and prepare, you will be setting up the imprisoned HIV/HCV-positive prisoners for disappointment and frustration. This can only undermine your work.

Getting started in prison programming involves much more than making initial contact with Corrections staff, the prison and prisoners. It also involves:

1. Making initial assessments about what's available and what's not, in order to establish your best available options for programs and services.
2. Developing your program proposal and/or decisions about individual counselling services.
3. 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.

Finally, it will be important for you, as a worker, to consider the following throughout your time and career in this work:

1. Understand yourself and your motivations for involvement.
2. Be realistic but maintain a strong focus. It is unlikely that you can do it all, so concentrate on what you can change.
3. Recognize when you are in over your head and seek support.

5 Steps of Pre-Work for Entering a Prison

Prior to entering the prison it will be important for you to follow these steps:

STEP 1: Conduct an internal capacity scan. Understanding your agency's mandate and internal capacity to offer a program will be your first step. You will need to determine how you are going deliver your program as well as understand the differences between "piggybacking" and going "solo".

STEP 2: Develop and submit your program proposal in advance to the appropriate Corrections personnel (i.e. federal or provincial) and the prison you intend to visit.

STEP 3: Conduct an environmental scan of the prison you intend to visit. Become familiar with the prison system, structures and protocols.



Peter Collins

STEP 4: Establish contact with the existing prison groups and determine their needs in advance of delivering your program.

STEP 5: Understand what to expect when working within the prison environment and how to support yourself and other workers once you begin the work.

Conduct an Internal Capacity Scan

In order to make your decisions about program and service provision – and therefore to make your proposal – you must first be clear as to your agency's mandate and the capacity of your agency to offer such a program. Conducting an internal capacity scan will help you to assess your capacity as an organization for running a prison program, along with why, when and how it should be run. It will be important to determine how to deliver your program.

"Piggybacking" on Existing Programs

If this is the first time that your agency will do prison work it is recommended that you piggyback on an existing program before going solo. You may also decide to piggyback if your organization cannot commit to a regular program or if the prison has no available space for new programs. Piggybacking means that you act as a guest speaker in an established program with a pre-existing audience.

The Internal Capacity Scan – Checklist

This is an example of a checklist for an internal capacity scan. Use this checklist to make sure you have done due diligence prior to implementing a prison program.

	Question	Status/Notes	Check
1	List the significant events (of your organization) that brought you to the point of deciding to offer a prison program. For example, are there existing gaps in community programming? Have you been contacted to offer a program or have you identified the need on your own?		<input type="checkbox"/>
2	Summarize the factors influencing your decision to offer a prison program. What is motivating you to offer a program?		<input type="checkbox"/>
3	Are all agency staff and the board of directors supportive of a prison program? What concerns or issues have been identified?		<input type="checkbox"/>
4	Does the organization have a clear mandate for a prison program? What is the mandate?		<input type="checkbox"/>
5	What do you want to do with people in prisons? (e.g. What type of support or education will you offer?)		<input type="checkbox"/>
6	Who is in your community (e.g. prisons, populations, services)?		<input type="checkbox"/>
7	What are your boundaries with respect to the services you will provide?		<input type="checkbox"/>
8	Will you need to change or increase your services as a result of offering a prison program? What resources will be required to do this (e.g. telephone system, accepting collect calls, staffing levels)?		<input type="checkbox"/>
9	Is your intent to conduct a prison program on your own or are you going to piggyback with another program or organization?		<input type="checkbox"/>

First of all, determine which group or groups would provide the most appropriate context for your program. 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. You can usually request a list of volunteer programs from the institution, as well as the contact names for the individuals who coordinate these groups.

The positive aspects of the piggyback approach are numerous:

1. It enables your agency to reach prisoners with minimal work and resource commitment.
2. It eliminates your need to negotiate time and room availability with the institution or to advertise your program to get people to attend.
3. 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.
4. Piggybacking 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/HCV 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 anal sex 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.

Initiating Your Own "Solo" Program

Initiating your own program means that you and your agency make a commitment to 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/HCV program as necessary, in which case you will have to advocate for it by educating them on the validity of your program.

TIP: Consider piggybacking with an existing program at least six times before attempting a solo program.

When piggybacking, be aware of potential philosophical conflicts with your host group before they arise, specifically regarding harm-reduction, drug use, anti-racism and anti-homophobia education.

Whether you run your own program or piggyback on someone else's, be sure to 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 prisoners themselves.

Develop and Submit Your Program Proposal

When developing your program proposal, include at a basic level what you intend to do, why it needs to be done, when you'll be doing it and how it will be delivered. Once your proposal is developed, you'll submit it with a letter of intent to the regional or provincial head of health care. This should include the following:

1. State the type of program and why you are offering it.
2. Describe how and when you intend to deliver the program.

3. Request to know who is responsible for or in charge of healthcare programs at the prison.
4. Advise the regional/provincial head of health care that you will be contacting the prison to establish the program.
5. Provide Corrections with a deadline for responding to your inquiry and proposal.

When submitting your proposal to correctional personnel and the institution, ensure that you:

1. Outline the goals of your program.
2. State the mandate of your agency.
3. Clarify 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 your proposal is approved, your program will be assigned a regular time and space within the institution. 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 clients calling your agency for services. Arrange for collect calling before implementing your program – this is the best way for people in prison to reach you.

Conduct an Environmental Scan of the Prison

The goal of the environmental scan is to learn as much as you can about how the prison functions as well as the internal groups and external organizations that are currently offering programs within that prison. You will need to understand the systems, processes and protocols prior to setting foot inside the prison to ensure that your efforts are successful.

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, Aboriginal cultural and support groups, other cultural and/or religious support groups, Narcotics Anonymous/Alcoholics Anonymous, etc. The John Howard Society provides support services to male prisoners and ex-prisoners across Canada. The Elizabeth Fry Society provides similar services for female prisoners and ex-prisoners. Women's prisons also commonly host programs from sexual health organizations and rape crisis centres. Investigate opportunities to establish cooperation with these groups, or to piggyback HIV/HCV education onto one of their pre-existing programs.

Find out what programs are already available in your target institution/s by contacting the institution's volunteer or social program coordinator. Questions you will need answered include:

1. What are the policies and practices in your region regarding HIV/HCV prevention and treatment?
2. Are condoms, dental dams and bleach available?
3. Does the prison provide methadone?
4. Does the health unit utilize the expertise of an outside physician in caring for HIV-positive and HCV-positive prisoners?

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

Determine if 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.

Establish Contact

Send a Letter of Intent to the Prison/Institution

At this point you should have a clear understanding of your mandate and capacity to offer a prison program, you have advised Corrections of your intent, and you understand how the prison operates and the type of programs and organizations that currently work with the prison. Now you are ready to make initial contact with the prison.

This step requires you to send a letter of intent to the prison, which should be addressed to the head of health care or the person that is the key contact for making program decisions (e.g. who do you need to work with to ensure that your program will be implemented). You should send a copy of your letter of intent to the warden/superintendent. Included in this letter of intent will be the following:

1. A brief description of your program and why you are offering it.

The Environmental Scan of the Prison – Checklist

Utilizing this type of checklist will help you ensure due diligence prior to implementing a prison program.

	Key Questions	Status/Notes	Check
1	Who are the main contacts for the prison (e.g. the warden, superintendent, those responsible for the healthcare programs, volunteers, other programs)?		<input type="checkbox"/>
2	What programs are currently offered in the prison by other external organizations? How long have they been operating and how are they structured? What is the mandate of the other organizations? Have you considered the values and beliefs of the other organizations before deciding to partner or piggyback with them?		<input type="checkbox"/>
3	Have you spoken with the other external organizations to learn about their success and approach?		<input type="checkbox"/>
4	What organized, internally run prison groups currently operate? How are they structured, when are they offered and who are the key contacts or chairs of these groups?		<input type="checkbox"/>
5	What are the current prison programs for HIV and HCV prevention, education and support? How are they offered and how accessible are they? Are they combined with other health programs?		<input type="checkbox"/>
6	What type and format of health information would be most useful or beneficial to prisoners?		<input type="checkbox"/>
7	What limits or restrictions are in place for organized groups and programs?		<input type="checkbox"/>

2. A description of how and when you intend to deliver the program.
3. A request for a meeting with the person responsible for or in charge of healthcare programs at the prison, as you should discuss the program with this person prior to implementation.
4. A deadline for responding to your request.

Meet with the Key Prison Official or Staff Person/s

Prepare for your meeting by developing a list of questions that you will need answered, such as:

1. What is the process that my staff will need to follow in order to get inside the prison?
2. How should staff/volunteers apply for security clearance?
3. Will I need security identification?
4. What are the prison boundaries and rules around professional visits?
5. What type of orientation or training is provided to professional visitors?
6. What type of physical search (or searches) should my staff expect?

If you are seeking to establish an ongoing program with regular space allocation and staff security clearances, it is likely that the institution will require a more detailed program proposal.

Contact Existing Prisoner Organizations/Groups

You may be a situation where an individual prisoner or internal group initiated contact with your agency and this is why you have decided to undertake prison work. It is also possible that your agency initiated this work based on your mandate.

Contacting prisoners for the purpose of implementing your program can be accomplished by sending a letter of introduction to all existing organized groups that operate within the prison.

- Address the letter/s to the chair of each existing group.
- Your letter will provide an introduction to your organization, an overview of the type of work you perform and the program that you wish to offer inside the prison.

- Request their support to help develop your program and ask about setting up a meeting or a focus group/s to discuss/determine their needs. Prisoners are your key stakeholders and thus you will want their input about what works best, what is needed and how to best set up the program to ensure that the needs of prisoners are being met.

TIP: Remember, there is such a high turnover of prisoners in provincial institutions and detention centres that specific groups may not exist or operate on a regular basis. In this case, ensure that you are allowed to “speak to or address” the range yourself when you go inside and thus avoid the staff announcing the arrival of the “AIDS program”.

Meeting the elected prisoner representatives face-to-face is crucial for assessing the needs of a given institution and for building trust and credibility between you/your agency and the prisoner population. You will find that these prisoner groups are your best allies within the institution. They often have the ability to assist with organizing programs, focus groups and workshops, and they can help promote the credibility of your agency amongst the prisoner population.

Consulting with prisoners in advance will help you undertake a needs assessment in order to develop an effective program designed around prisoners’ needs. This is a demonstration of your respect for prisoners’ own autonomy and established structures. Making contact directly with prisoners themselves is the key element of the assessment process. You will need to utilize whatever options are possible to consult with prisoners, whether individually or in groups.

Following are examples of the questions you may wish to ask when consulting with prisoners:

1. What is their perception of HIV and HCV in the institution?
2. What is the drug of choice in this institution? Is there a lot of injection drug use?
3. If condoms and bleach are provided by the institution, are they actually accessible?
4. What health information would be of most interest to people here?
5. When and where would be the best place to hold programs?
6. How do people feel about the quality of service from the health unit?
7. Which staff in the institution do prisoners think are supportive of them and would be therefore useful for you to contact?

Federal Prisoners

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

Provincial Prisoners

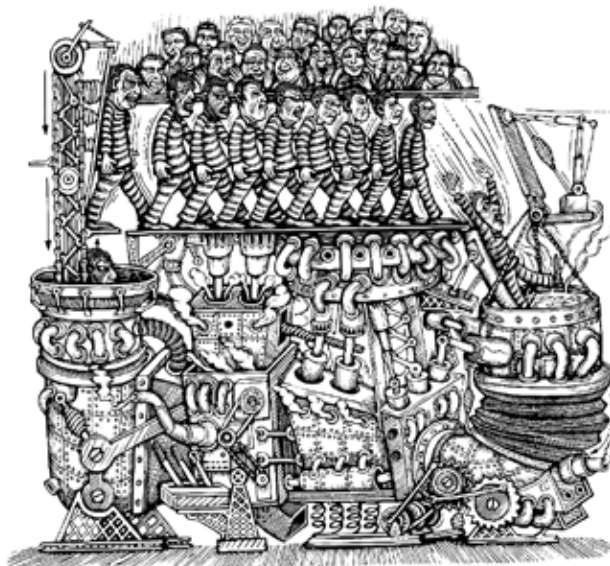
Provincial correctional centres house people serving short sentences (less than two years), so their population is much more transient than that of the federal system. The bulk of prisoners in the provincial system are serving sentences of only a few months.

Many provincial institutions have organized prisoner groups modelled 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 alternative 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 its established program.

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 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 piggybacking, on an existing program.

Understand What to Expect

Making Initial Preparations

At this point, you have made your initial connections with the prison and possibly with prisoner representatives. You have completed your initial environmental scan along with a needs assessment and have identified your most promising program options within the given institutional parameters. You have made the preliminary inquiries regarding visiting options. You have successfully made your program proposal to the institution and/or your community partners and have received their approval, at least 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 orientations or volunteer training sessions.

TIP: Despite the obstacles involved, the constant exchange between the detention/remand centres 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.

1. Arrange for Your Agency to Accept Collect Calls from Prisoners

Most prisons do not allow prisoners to access toll-free phone numbers. Check the situation at your local institution. Ensure that your agency can and will accept *all* collect calls as this will make 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 wishing to access HIV/HCV services, **your agency must accept collect calls.**

If your agency does not accept collect calls, clients 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. 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/HCV services:

1. First, 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.
2. Second, it can often take as long as two weeks for the institution to clear a new phone number, and this delay creates a barrier to crisis counselling (for instance, after receiving a positive HIV 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

Your agency can also refer prisoners directly to CATIE

Have Questions about HIV or hepatitis C Prevention or Treatment?

For free and confidential access to reliable, up-to-date HIV and hepatitis C information in both French and English, call toll-free in Canada at **1-800-263-1638**.

CATIE accepts collect calls from Canadian prisons.

Mail CATIE your questions:

**CATIE
555 Richmond Street West
Suite 505
Toronto, ON
M5V 3B1**

This confidential service provides information on HIV and hepatitis C prevention, treatments, the use of complementary therapies and medical and psychological conditions associated with HIV and hepatitis C. CATIE also provides referrals to HIV and hepatitis C services across the country.

Callers may also request print information packages to address their questions.



CATIE

Canada's source for
HIV and hepatitis C
information

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 interested in calling an HIV/HCV 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.

2. Apply for Security Clearance

One process that will be consistent for all institutions is that you will need to submit to a security check if you want to run a prison program or make professional visits to imprisoned clients. The security check is usually referred to as a CPIC check (Canadian Policy Information Centre check). 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 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. 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 several federal penitentiaries in your area, you may be eligible to apply for regional clearance. You make this application by contacting the appropriate Correctional Service Canada (CSC) Regional Headquarters. If granted, regional clearance will provide you with a CSC ID allowing you access into all the federal prisons in your province. 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.

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. 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. If you are walking past people's individual cells, do not look into a cell unless invited to do so by a prisoner. This shows respect for prisoners' privacy and dignity.

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 (e.g. 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.

You will probably find that the most difficult appeal of a refusal for security clearance will be your first one.

Most prisons are reluctant to be the first to okay 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 if you have had previous conflict with the law, a 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 of 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.

TIP: 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 (e.g., 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 for 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 it 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.

Be aware that the ion-scan can create problems for workers entering the institution, *even if the workers themselves do not use drugs*. 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 24 hours. A series of such positive results may result in your being suspended from visiting the prison. 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 people who use drugs or are street-involved.

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.

People who use drugs 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.

Confidentiality Risks

Confidentiality is a primary concern for prisoners living with HIV/HCV. Therefore, part of your job will be to monitor staff practice to ensure that professionally accepted standards for preserving confidentiality are met. It is fair to expect the standards of confidentiality for prison staff to at least equal those of your own agency. This is an obvious and familiar area of concern for all HIV/HCV workers. When in the prisons, however, 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.

Always remember that the prison is a closed environment and has a staff culture of surveillance. Prison personnel are necessarily curious about any new face they see walking around the prison. 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 HIV/HCV worker in the prison, others may assume that any prisoner you meet with is HIV- or HCV-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 counsellor.” 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, HCV 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 that fits the acronym. Another good “cover-story” is to tell inquisitive guards that you are there to do a housing application. This will usually satisfy their curiosity.

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.

Interacting With Prisoners

If you have never worked with prisoners before, the most shocking thing you will probably find is that they are no dif-

ferent from 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 some 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/HCV 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.

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, you can expect prisoners to look out for you and to help make sure your program runs smoothly.



Prisoners with HIV/AIDS Support Action Network (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 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 productive evening sharing information about HIV, HCV and other subjects with about 50 guys. – PASAN staff

Interacting With Prison Staff

When working in prisons, you interact with prison staff out of necessity. These interactions can be positive, negative or neutral in 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. 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.

The basic guideline for all interactions with staff is to be professional, courteous and smart.

You will, however, also encounter staff who are openly hostile to you and your work. Depending on the individual, this hostility may be due to HIV/HCV-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 beforehand, 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. Note that you may also want to recall the incident at a later date, to advocate the need for staff training in HIV/HCV 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/superintendent. 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 HIV/HCV/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 and are available in the government directory of the phone book.

Program Preparation Guidelines

Making Decisions About Individual Counselling Services and Client Visits

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 qualify to offer professional visits to meet with and provide services to individual clients. The institution will demand security clearance from anyone wishing to provide 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/HCV status, as you will be cleared for the professional visit based upon your employment as an “AIDS worker”.

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. 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 prisoners 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.

There are also **drawbacks to this type of visit:**

1. These visits usually happen through glass (with you on one side, a prisoner on the other), and you and the client will have to talk to each other using telephone handsets that are monitored.
2. 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/HCV 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, prisoners must put in a written request for all visitors, and the prison does an ID check before clearing visitors. 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 its procedure for visiting a friend in custody.

Working 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, it's common that while one worker is speaking at the front of 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.

Informal Outreach Environments

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 (e.g., a needle exchange, an Aboriginal organization, a sexually transmitted infection (STI) 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 and HCV information.

Safety Considerations

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. For those community workers who are new to the prison environment, working with a partner (especially one who is familiar with prison settings) will help you become familiar and more comfortable with the environment sooner. The more comfortable and relaxed you feel, the more effective you will be.

Working With Peers

For an incarcerated audience, providing a speaker who is HIV-positive or living with HCV who has served time in prison is the single best method for giving out accessible information. Establishing a successful peer program involves finding an appropriate peer from a prisoner's perspective and offering adequate office space and resources such as harm-reduction materials and pamphlets. Make it a priority to use prisoner and ex-prisoner “peer educators” as part of your prevention education program. If your agency is interested in utilizing ex-prisoner peers, there are two issues to keep in mind in creating the program: security clearance and emotional support.

Security Clearance

You may face difficulties getting ex-prisoners authorized access to the institution. For more detailed discussion of strategies for obtaining peer clearance, refer to *Common Concerns for Workers New to Prison Environments: Refusal of Security Clearance*, earlier in this chapter.

Emotional Support

For any clients, standing up in front of an audience and sharing their life story can be a stressful experience. If the individuals also have a long history of incarceration, they 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. Peers may not realize how difficult it will be until they are 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 peers 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 peers may not have disclosed their HIV/HCV 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 peers 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 some additional support.

Many HIV/HCV organizations and other community groups have utilized peer educators over the years. If you are thinking about starting a peer program, call around to organizations in your region for direction or referral. You may also call PASAN directly for information on our own program.

Ensure a Broad Knowledge Base

To be successful in the prison environment, you need a base of knowledge that is much broader than that needed for the outside community. It is advisable to approach your work from a total health perspective. In addition to your knowledge about HIV/HCV you should also have a good understanding of the following:

- 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
- tuberculosis (TB)
- tattooing
- sexually transmitted infections
- reproductive health and pregnancy (especially important for women’s prisons)
- psychosocial issues (self-esteem, positive mental health strategies, etc.)
- harm-reduction strategies

If you come into the institution and try to strictly adhere to a traditional HIV/HCV 101 presentation, you will be ineffective and most likely alienate your audience. It is much more likely that prisoners’ first interest will be overall problems in accessing health care, rather than HIV/HCV-specific 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/HCV prevention messages, but rather that you prepare to provide them in a more creative, strategic manner – in the course of the broader conversation and by drawing parallels or connections between HIV/HCV issues and whatever other issue you might be discussing. This is the art of doing HIV/HCV education within the prison setting, and it’s a skill that you can develop with experience.

The more broadly knowledgeable you are on health, the more useful you are for prisoners. By demonstrating a breadth of knowledge and a willingness to discuss multiple health topics, you will dramatically 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 and HCV, this also reduces the stigmatization of your program, and your audiences will be larger and more receptive.

Provide “Cover” When You Advertise Your Program

Give careful thought as to how your program will be advertised. How you choose to promote your program will determine who comes out to participate. In prisons, an “HIV and HCV Awareness” program will attract far fewer participants than a “Health Information” program. Therefore, it’s important to strike a delicate balance between advertising your program as accurately as possible and making it “neutral” enough 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, TB, etc. Unless you are qualified and prepared 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 while also providing an easy and logical link to discussing HIV and HCV. Consider bringing a supply of 8 x 11-inch 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.

TIP: When facilitating a workshop for prisoners, some workers may 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 10-year bit. It’s disrespectful to even make such comparisons.

“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.

Foster Group Participation

Remember that you are the outsider coming into the prison environment. While you have expertise in HIV/HCV-prevention strategies, prisoners in your group will have expertise on the environment in which they are living. Your role is to bring these two bodies of knowledge together through the forum of your program. This can only happen by involving prisoners in the discussion and by creating an atmosphere in which they feel comfortable and motivated to discuss such issues with you.

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.

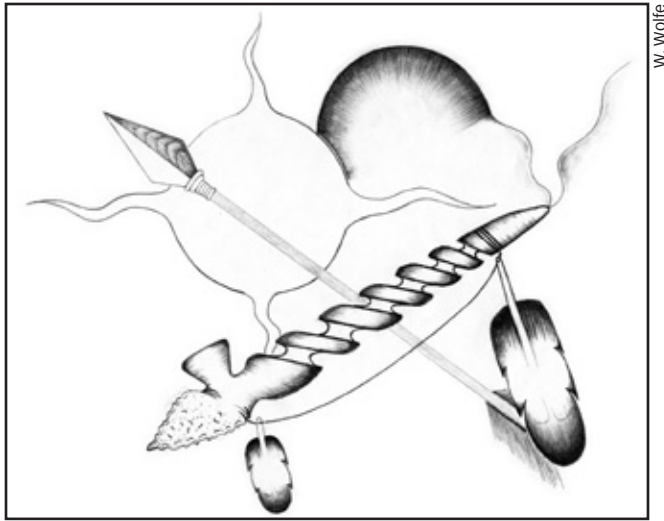
1. In order for your prison workshop to be effective, you will need to create a participatory atmosphere.
2. Don’t expect to do a theatre-style lecture, where you are standing at the front of the room and prisoners are a passive, silent audience.
3. Use facilitation skills to draw out conversations from reluctant participants.
4. Be prepared to constructively manage raucous debates, ensuring that accurate HIV/HCV information does not get lost in the fray.

In a more “open” environment, you may 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 halfway through. Some programs might have two or three people participating, while others might have 20 or 30. Rarely, if ever, can you predict any of this beforehand. 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, or 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 will allow prisoners access to 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. 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.

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. 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.

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 overcrowded prison environment, so it’s not surprising that it will carry over into your program.

In federal institutions your program will likely include prisoners from different ranges/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. 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 this is something you must be alert to.

- 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.
- At 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.

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.

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?”

“How do you get access to bleach at this institution?”

Prison Staff Presence

Over the course of a 90-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 is always preferable to avoid having staff present during your program, as 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. 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: Trust-building is a crucially important aspect of developing prison programs. Therefore, consistency on your part is essential. Fulfill your commitments.

Documentation

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. 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

As an individual worker, you should familiarize yourself with the recommendations made in the several comprehensive documents published on HIV and HCV in prisons over the past 10 years. 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 prevention materials, and the need for new prevention programs. Documentation of such information on a local level is crucial for identifying national trends and needs and for advocating effectively for change.

Evaluate Your Work

Evaluation plays an important part in justifying the value of HIV/HCV programs and prison work to your organization, your funders and the prison administration. Evaluation must form an ongoing part of your HIV and HCV prevention education program. Reviewing the effectiveness of your work will help to ensure that you provide the highest quality programs for prisoners.

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. 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.

Talk to the prison healthcare staff, as they may have a sense of how your program is affecting prisoners. Are they receiving more requests for information on HIV or HCV 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.

Chapter 2 Further Reading

HIV/AIDS and HCV in Prisons — A Select Annotated Bibliography 2nd ed., Health Canada, 2007.

Hard Time: Promoting HIV and HCV Prevention Programming for Prisoners in Canada, PASAN and Canadian HIV/AIDS Legal Network, 2007.

“Viral time bomb”: Health and human rights challenges in addressing hepatitis C in Canada, Canadian HIV/AIDS Legal Network and Centre for Addictions Research of BC, 2008.

Hepatitis C Peer Support Group Manual, CATIE, 2008.

Harm Reduction in Prison: The Moldova Model, Open Society Institute, 2009.

3

CHAPTER 3

Program Development –

Prevention Education, Outreach, Care, Treatment and Support

HIV and HCV in Prisons

IN 2007 THE RATE OF HIV infection in federal prisons, 4.6 percent, was 15 times greater than that in the broader community as a whole. As for HCV in federal prisons, the 31 percent rate of infection was 39 times greater than the population as a whole.¹

HIV and HCV infection rates have reached epidemic proportions in Canadian prisons. It is essential that you as a prison worker recognize and understand basic prevention and treatment issues for prisoners. Not only are HIV and HCV infection rates higher in Canadian prisons in comparison to the general public, but worldwide this has become a common phenomenon. This is often accompanied and exacerbated by high rates of other infectious diseases such as tuberculosis (TB). Despite the high rates of HIV and HCV among prisoners, correctional systems across Canada continue to limit – or even deny – prisoners access to the tools proven to reduce the risk of HIV and HCV transmission.

Both HIV and HCV are transmitted through blood-to-blood contact and therefore share some common routes of transmission. HIV is also spread through contact with infected semen (including pre cum), vaginal fluid, rectal fluid and breast milk. HCV is more transmissible than HIV through shared needles, and HIV is much more transmissible than HCV through sexual contact.

Infection with HIV and or HCV among the prison population might occur prior to or after entry to the institution. Both HIV and HCV infection among prisoners is strongly associated with injection drug use; one CSC study reports that prisoners in federal facilities are 30 times more likely to have ever injected drugs than other Canadians.² While some people initiate injection drug use outside of prison, some others inject for the first time inside as a way of coping with the difficult prison environment. The lack of needles and fear of getting caught increase people's willingness to use non-sterile equipment, increasing the risk of transmission of HIV and HCV in prison.

Tattooing and body piercing in prison also place people at a high risk for HIV and HCV infection because of the lack of access to sterile equipment including needles, tattoo and piercing guns, ink and ink caps.

While sexual activity is considered to be a less significant risk factor for transmission within the prison system compared with some other modes of transmission, it does occur and should not be discounted.

Chapter Overview:

This chapter will help you develop programs to provide (a) accessible HIV/HCV prevention education and outreach and (b) support to clients living with HIV and/or HCV. The first half of the chapter highlights models of, challenges to and strategies for HIV/HCV prevention within the prison environment. The second half of the chapter provides information on the unique care, treatment and support needs of prisoners living with HIV and/or HCV and how outreach workers can respond to them.

When doing HIV/HCV prevention education in prisons, dispelling myths about transmission is an important part of your task. The group living environment of prison tends to heighten fears about transmission. Therefore, you need to spend time talking specifically about how HIV and HCV are not transmitted. This is equally important as discussing factors that affect risk. You should also emphasize that, within the prison, HIV-positive prisoners are at much greater risk of illness from casual contact with HIV-negative prisoners than vice versa. Prisoners know that illnesses such as colds and the flu will spread very easily in the closed living quarters. Be sure to explain how dangerous these sicknesses can be to people with weakened immune systems. A frank discussion of how HIV and HCV are not transmitted is critical for promoting a less hostile atmosphere for prisoners living with HIV and HCV.

Individuals with either HIV or HCV infection may be at risk of becoming co-infected with the other, and it's recommended that people diagnosed with either HIV or HCV get tested for the other. In Canada, people who are co-infected are more likely to be Aboriginal, current or former injection drug users (IDUs), current or former prisoners and/or people who received contaminated blood or blood products in the course of their health care.³ In prison, co-infection with HIV and HCV is more common among women than among men. Co-infection has implications for care and treatment. When HIV is also present, HCV progresses two to three times faster and HCV treatment may be less successful in co-infected peo-

ple. Also, decisions about HIV treatment are more complex due to the drug interactions between antiretroviral therapy (ART) and HCV treatment and the side effects of treatment, specifically liver toxicity. The impacts of HCV on HIV disease progression are less well known.

HIV and HCV information is an area where you and/or your agency may need to seek out specific training. Contact CATIE for more information and assistance, 1-800-263-1638.

Comparing HIV and HCV

There are also differences between how people perceive and are affected by the viruses. For most Canadian prisoners, 25 to 40 percent of whom are infected with HCV, HCV is a more urgent issue. You will find that prisoners are generally very interested and open in talking about HCV. You will most likely find that the stigma attached to HCV is much less than that of HIV. This is primarily because of the high rates of HCV among prisoners, but also because homophobia is not a barrier for HCV discussions in the way it can be for HIV discussions.

It is a useful strategy to begin your presentations by talking about HCV rather than HIV, as your audience will respond much more quickly and openly to this issue. People are much more open in disclosing their HCV risk behaviour, and thus you may find people in your group freely disclosing their HCV status.

Although HIV and HCV are often referred to together in this manual, there are many important differences between the viruses including:

Virus	HCV	HIV
Part of the body targeted	HCV replicates and multiplies mostly in the liver causing liver damage.	HIV targets immune cells (CD4+ cells) for replication causing weakening of the immune system.
Transmission	Through contact with infected blood.	Through contact with infected blood, semen (including pre cum), vaginal fluid, rectal fluid or breast milk.
Virus survival outside the body	HCV can survive for at least four days outside the body. In certain conditions, such as the inside of a syringe, HCV can survive for up to eight weeks.	HIV dies within minutes in open air outside the body. In certain conditions, such as the inside of a syringe, HIV can survive from one to three weeks.
Testing	Antibody test looks for exposure. RNA test looks for infection. The window period for testing is three to six months after exposure to HCV.	Positive antibody test shows infection. The window period for testing is three to six months after exposure to HIV.
Treatment	Lasts six months to a year depending on genotype. The goal of treatment is to clear the virus from the body.	HIV treatment is lifelong. The goal of treatment is to reduce and keep down HIV viral load.

Your audience will probably have as many or more questions about HCV than about HIV, at least at first. As an HIV/HCV educator, you can seize this awareness of and interest in HCV as an important opportunity to reach prisoners with comprehensive prevention information. HCV can be spread in prison through the sharing of sharp instruments, injection equipment (commonly referred to as “rigs,” “fits” or “works”) and other equipment for tattooing, shared needles (for injection drug use), straws (for intranasal drug use), pipes, spoons, cookers and other drug-related equipment and personal hygiene equipment such as razors, toothbrushes, scissors and nail clippers. Prevention messages around some of these risk factors apply to HIV prevention as well and you can begin to work in HIV prevention messages once you’ve established a group discussion about HCV.

HIV/HCV Prevention Education and Outreach in Prisons

You are hopefully at the point where the institution has approved your proposed HIV/HCV prevention program. You’ve been cleared by security. You’ve scheduled your trip to the prison. All that remains is to meet with prisoners and provide them with information. You now face three major tasks in preparation:

1. Deciding on the most appropriate format for your program and outreach strategy.
2. Developing the content of your program.
3. Structuring your approach.

Before getting started, it might also be useful to say a few words about the difference between HIV/HCV “prevention education” and “outreach”. The goal of HIV/HCV prevention education in prisons is to pass on accurate information, to promote safer behaviours and practices, to challenge related phobias and to encourage support for people living with HIV and HCV 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 those who are HIV/HCV-positive) 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. Education remains one of the most important ways to promote and protect the health of prisoners and prevent the transmission of HIV and HCV. It should not be limited to written information but should include ongoing educational sessions and should be delivered by community-based HIV/HCV organizations, health or prisoner organizations. Wherever possible, prison-

ers should be encouraged and assisted in delivering their own peer education, counselling and support programs. Education should not be limited to inmates. There is a great need for ongoing education for both staff and prisoners⁴.

Outreach and Program Format Options

Different institutions house and manage their prisoner populations in different ways, 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 within their ranges all day. Any movement outside 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 to and from various parts of the facility and so they don’t announce a program in the institution. Sometimes 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.

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/HCV programs in such institutions face a dual challenge: that of attracting prisoners’ interest enough to 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 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 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. 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.

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/HCV information. Below are two informal options for reaching prisoners when you don't have the benefit of a private program space.

Format 1 – Walkabouts

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 prisoners' living units from the connecting hallways).

While obviously not an ideal or confidential situation for conducting comprehensive prevention education, walkabouts will provide an opportunity for you to conduct outreach in

TIP: 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 she or he will be interested in HIV/HCV 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 to share with others.

all areas of the prison. This approach can therefore 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. Walkabouts can provide you the opportunity to broadly distribute written HIV/HCV-prevention information, health-promotion information and contact information for your agency.

Despite the advantages, be warned that doing walkabouts can also be a difficult and frustrating process. Moving within the institution from one area to another means that you will be interacting 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.

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, although, in the experience of PASAN this is a rare exception. 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.

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 pick them up. For example, try to avoid materials where “HIV” or “HCV” 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 issues into account. Use plain language, vernacular, illustrations and diagrams. 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 a quick question, or to pick up a pamphlet or business card without drawing attention to her or 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 prisoners and 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: Always remember that by coming onto the range, you are entering 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, counterproductive and ultimately ineffective to demand everyone's attention or to assume that everyone will want to hear what you have to say. Instead find a way to politely let people know who you are and that you are available, if they would like to talk.

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 institution'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 to put their names down for the

"HIV/HCV program". Many interested people may choose not to participate due to the risk of stigmatization. Clients who are HIV-positive, 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.

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 good attendance. On the other hand, if they 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.

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 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.

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. In some institutions, a general call is used in conjunction with a sign-up process. Any interested individuals may decide at that moment to leave what they are doing and come down to the program. Where available, this system is good insofar 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 "HIV/HCV/AIDS program is starting in the chapel in 10 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.

Options for "Open" Environments with Greater Freedom of Movement

Different outreach and program opportunities exist in institutions that 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 institu-

tion 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 without guards escorting them. Obviously, in such environments, arranging for sign-ups and general calls is unnecessary, as prisoners have more autonomy in how they spend their time. However, you may still want to try to arrange to have prisoners put up posters promoting your event. Once again, you may or may not have your own program room. 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.

TIP: Ask the institution if you can bring in cookies or donuts with you to serve during your program. Outside food is always popular and may attract greater numbers. 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/HCV issues, they can say that they’re only there for the food.

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/HCV 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.

Format 1 – General Outreach Sessions

If you are working in an institution where 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.

Format 2 – Addressing Pre-arranged Meetings as a Guest Speaker

All federal prisons and some provincial correctional centres have established prisoner-run groups. These groups offer excellent opportunities for you to get in and meet with prison-

ers. First, they meet on a regular – often weekly – basis, and will have the use of a designated meeting-space within the institution. Second, as prisoners themselves run these groups, their meetings are usually well attended. Consider approaching a pre-existing group that meets regularly in the prison. Offer to make a presentation to group 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 to introduce yourself/your organization and to 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 that you 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. Remember that prisoners cannot receive incoming calls.

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 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. 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.

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 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?

Creating Accessible Prevention Messages

As an HIV/HCV educator your goal is to promote behaviour change. Through your work, you seek to provide people with the knowledge, skills and initiative to adopt practices that will reduce their risk of HIV/HCV infection or transmission. You encourage and educate people to use the tools – condoms, dental dams, needle exchanges, sterile tattoo and piercing equipment, etc. – that are known to reduce the risk of HIV and HCV transmission. However, in the prison environment you will be working with a population that simply does not have access to many of these risk-reduction tools. The question for prison HIV and HCV educators is How do we promote behaviour 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.

TIP: Be Aware of Literacy Issues in Developing Your Printed Materials

Many prisoners have low literacy and educational levels. Others may have learned (or may 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 to this audience. Use plain language. Use the vernacular. Use illustrations and diagrams. Prisoners and/or prisoner groups themselves can be very helpful in developing or advising on appropriate printed materials. If you need help in developing materials at an appropriate literacy level, you can also seek the assistance and advice of a literacy and/or ESL organization in your community.

In this sense, you’ll need to approach prison work with the same philosophy you 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/HCV 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. The first step when preparing effective HIV/HCV prevention messages for prisoners is to learn what tools are available in your specific institution or region, and what tools are not available.

Some of your questions will be easily answered by a phone call to the prison health unit. Other questions will be answered by 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 prisoners. This is because there is frequently a gulf between official policy and everyday reality. In such cases, go with the information provided by prisoners, as they are the people for whom you need to develop practical – not theoretical – prevention strategies.

Prison-Specific Prevention Strategies

Implementing effective HIV and HCV prevention strategies in prison settings is limited due to security issues. As such you will most likely experience difficulty bringing your prevention strategies into the prison. The following list of prevention strategies has been generated by prisoners, primarily within the federal system.

TIP: To be effective with harm-reduction education, 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 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.

Safer Drug Use

The major risk factor for transmission of HIV and HCV within the prison context is the sharing of injection drug equipment. In prison you need to be prepared for and comfortable with answering questions on harm reduction and safer drug use. The reuse of syringes also increases the risks of other infections, abscesses and vein damage related to injection drug use.



Peter Collins

TIP: 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.

The lack of access to sterile syringes is perhaps the most urgent prevention issue in Canadian prisons today.

In an ideal environment, no one would ever have to share a syringe or other equipment (i.e. water, spoons, cookers and

filters). However, prison is far from an ideal environment, and prisoners who inject drugs rarely have the option of using brand new equipment. This means that people who inject drugs in prison are either forced to share equipment or to use their own personal rigs over and over again. 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. Even when offered a “new” syringe in prison, there is no guarantee that it has never been used. You will find many people that inject drugs 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 a prison. While it is essential to be clear about the risks of sharing injecting

equipment, the reality in prisons is that people who inject drugs have to share their 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 equipment.

Needle Distribution

The most effective way to reduce the spread of HIV and HCV through sharing injection drug-use equipment is by using sterile syringes (“clean needles”) and other equipment used to prepare and inject drugs. While there is easy access to drugs of all varieties in Canadian prisons, there is no access to sterile equipment in Canadian prisons. Despite advocacy efforts by prominent community-based organizations and respected medical professionals, no jurisdiction in Canada currently provides sterile syringes for prisoners who inject drugs. This creates a scenario where prisoners across Canada regularly share injection equipment by necessity. It is not uncommon for an institution of 500 prisoners to have only three or four syringes in circulation. This means that all people injecting drugs 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. Given the high levels of injection drug use in prison, HIV/HCV workers need some knowledge about issues related to overdosing, in order to provide supportive education services. Seek out needle-distribution programs and/or drug-user groups in your region for additional information and training in this regard.

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 prevention tools. You may also contact PASAN for more advice on prison-specific harm-reduction strategies.

Bleach

Cleaning syringes with disinfectant such as bleach does not reduce the risk of HIV and HCV infection sufficiently among people who share drug injecting equipment.⁵ Disinfecting injection equipment with bleach is not 100 percent effective in preventing HIV transmission, and there is no conclusive evidence that bleach is effective in preventing the transmission of HCV.⁶ The probability of effective decontamination of needles using bleach is further decreased in prison because cleaning is a time-consuming procedure; some prisoners are reticent to engage in any activity that increases the risk of alerting prison staff to their illicit drug use, given the penal consequences that follow.⁷ Thus, the available evidence indi-

cates that bleach disinfection of syringes is not a substitute for the use of sterile needles.

However, numerous experts, guidelines and reports have recommended that in the absence of access to sterile needles and syringes, prisoners should be provided with access to bleach as a means of reducing transmission of HIV.

1. Bleach must be distributed in a non-stigmatizing manner in multiple discreet places throughout the institution.
2. All new prisoners entering an institution should be provided a “bleach kit”, as this will help protect the identity of prisoners who inject drugs.

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.

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.

If it is necessary to share spoons or cookers, bleach should ideally be used as a cleaning agent.

Methadone Maintenance Therapy

Methadone Maintenance Treatment (MMT) is an effective alternative for opioid users and is offered at both a federal and provincial level. Methadone is a synthetic opiate substitute prescribed by physicians for chronic opiate users. If people are on MMT at the time of their arrest they are usually allowed to continue with the therapy. However, if there is any interruption in the MMT at the time of arrest, it is extremely difficult and sometimes almost logistically impossible to restart or continue the MMT. Interruptions of MMT therapy can also occur during institution transfers.

It will be important for you as a worker to understand the provincial policies and institutional practices for MMT. For many street-involved people who inject drugs (who have perhaps been out of the healthcare system for many years),

MMT programs also offer an important opportunity to develop a relationship with a physician or community health centre, which can lead to an improvement in their overall health.

TIP: Methadone is administered orally, and so MMT reduces the need to use or share injection equipment. MMT therefore offers people who inject drugs another important option for reducing their risk of HIV or HCV transmission. Many health professionals view MMT as an important harm-reduction tool for people who inject drugs. Prisoners that inject drugs 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 MMT programs are implemented and enforced consistently, their efficacy will be greatly reduced.

A prisoner's methadone dose should never be arbitrarily reduced. For example, if a prisoner is being prescribed 120 mg of methadone by his or her physician on the outside, she or he should be prescribed the same amount once she or he enters the prison system. Reducing the methadone dose drastically can have all kinds of negative effects, including forcing prisoners to purchase opiates from the prison underground, thus making them more vulnerable to debt and related violence.⁸

MMT is only initiated for pregnant women entering the provincial prison system. Federally, MMT has been widely available since 2002-2003. British Columbia has found ways of making MMT programs work inside provincial prisons. You may wish to consult with Positive Living BC to learn from their experience.

Non-Injecting Options

Be prepared to suggest options for taking drugs that do not involve injecting and therefore carry a smaller risk of transmitting HIV/HCV. 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.

Alternative methods such as smoking or snorting carry associated risks with their own sets of harms. It is important to provide strategies for harm reduction around any methods you suggest.

Safer Tattooing

Tattooing has always been a very popular prison art form. Tattooing is particularly important to some Aboriginal prisoners,

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 percent 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 HCV 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.

as it is also considered a rite of passage in some Aboriginal cultures. 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

TIP: When doing your HIV/HCV-prevention education session, identify the fact that you will be talking about many different risk behaviours. 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 prisoners know or care about.

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 HCV. 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

TIP: Many of the materials we call for in other areas of HIV/HCV 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.

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.

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

Personal Hygiene Items

Within many institutions, predominantly provincial, personal hygiene items are in short supply and are 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 HCV, and possibly HIV, transmission. If this is the case at your local institution, you should advocate with the warden/superintendent to end this practice. Make sure to notify the Medical Officer of Health in your public health region about this situation and request their intervention with the prison.

Safer Sex

Ideally, condoms, lubricant, dental dams and female condoms would be easily and discreetly available to all prisoners both federally and provincially. Federally, the Commissioners Directive 821 states that condoms, lubricant and dental dams must be located in three discrete locations within the prison and within Private Family Visit areas (see below).⁹ Unfortunately, this is often not the case.

While accessing these materials is often problematic for prisoners, their availability at least provides 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.

Provincially, the current system of distribution for safer sex materials is unacceptable, inconsistent and increases the risk of HIV/HCV transmission through unsafe sex practices. Pris-

oners may be fearful of the repercussions of asking staff for condoms because they know that they will be watched more carefully, their cell mate might be moved or they may be accused of bringing in drugs. Receiving an institutional offence provincially could mean harsher conditions, reduced privileges, reduced likelihood of parole, fewer opportunities, etc.

TIP: During your safer sex discussion, alternate between using “he” and “she” throughout.

Condoms, Dental Dams and Lubricants

The traditional tools to help reduce the spread are not universally available in Canadian prisons: condoms, dental dams and water-based lubricants. Given that homophobia within prisons is equally as or more prevalent than within general society, methods of distribution create enormous barriers for prisoners wanting to practice safer sex, even in prisons that technically do provide condoms.

While the federal prison system makes condoms available, as do some of the provincial systems, access to condoms is not consistent across the country. Even in those jurisdictions or prisons where condoms are allowed, flawed or short-sighted methods of distribution often mean that access to these effective safer sex tools is limited at best. In many prisons, prisoners cannot access condoms discreetly or anonymously.

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.

Condom Requests

It is common for prisoners to have to request condoms from staff members (usually healthcare staff, but in some cases guards), or pick them up in high-visibility areas. It is also common for prisons 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. 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 Women's Prisons

In women's institutions, HIV/HCV 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. When providing 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.

You will also find that HIV/HCV education workshops in women's institutions will often lead to questions and discussion about broader sexual and reproductive health. When doing HIV/HCV 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.

in theory, the argument falls apart under scrutiny. There are a number of items readily available to prisoners (from sandwich baggies to cling wrap to latex gloves) which can fulfill an identical function. Such items are not prohibited. Therefore, this is not a valid argument for limiting access to condoms.

Consensual Sex Prohibited

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. Trans prisoners experience particular barriers in this regard. In general, staff "assume" that Trans prisoners will be involved in sexual relationships within the prison. Trans 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 Trans prisoners. For more on the risks specific to Trans prisoners, see Specific Prisoner Populations, Trans Prisoners, Chapter 1.

In Men's Prisons

Levels of homophobia in male institutions can be very high among both prisoners and staff. While this obviously does

In male institutions, sexually active prisoners are a very diverse group that includes:

- gay and bisexual men
- Trans people
- heterosexual men who engage in same-sex relationships only when incarcerated
- heterosexual men who engage in relationships with Trans 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.

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 blow jobs, but nobody's giving them." This atmosphere, combined with the complex makeup of the sexually active prisoner population, makes providing 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 being 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 to gay prisoners.

Private Family Visits (PFVs)

While it is necessary to discuss safer sex within 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 24 to 48 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.

Safer Cutting/Slashing

Another potential risk behaviour commonly found in prisons is “cutting” or “slashing”. This is a practice whereby individuals deliberately cut or slash 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/or 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 prisoners at risk for HIV or HCV transmission.

TIP: Slashing is another issue around which you as a 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.

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 mea-

sure, encourage people who slash to cut parallel to veins and arteries. Slashing across veins and arteries is a very dangerous and potentially life-threatening practice due to the risk of severe vein damage and loss of blood.

Finally, the unclean prison environment also poses increased risk of cuts becoming infected. To minimize the risk of other infections, encourage people who slash to wash their cuts carefully, to use polysporin antibiotic 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. Washing the area with soap and water prior to cutting can further reduce the risk of infections.

Theoretical Risk Situations

When conducting 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. When doing prison work, two theoretical risk situations often come into the conversation.

1. The first is that of a 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- and/or HCV-positive, this situation does present a theoretical risk of transmission. This is because blood-to-blood contact is occurring.
2. Another concerns 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 and/or HCV infected, this presents a theoretical risk situation because blood-to-blood contact is occurring.

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.

Taking a Holistic Approach to Prisoner Health

HIV and HCV are only two of many complex – and often related – healthcare challenges facing prisoners. In addition:

- Many prisoners struggle to address other healthcare issues that are related to HIV and HCV, such as mental health and drug dependency.
- Opportunistic infections (OIs) associated with HIV, such as TB, are common.

- Overcrowding, poor prison conditions and inadequate medical services exacerbate poor health in prisons and complicate the provision of care by prison health staff.

Efforts to reduce the transmission of HIV and HCV in prisons, and to care for those living with HIV and HCV, must be holistic in approach and be integrated with broader measures to tackle inadequacies in general prison conditions and health care.

Sexually Transmitted Infections (STIs)

Individuals infected with either HIV or an STI are at risk of being co-infected due to common routes of transmission (sexual contact). Furthermore, the presence of an STI, such as a syphilis, may increase the risk of transmitting or acquiring HIV through sexual contact. Therefore, those with an STI are at greater risk of becoming infected with HIV. There are also many STIs that are asymptomatic (e.g. they do not show symptoms) and therefore may never be properly diagnosed. For all these reasons, a diagnosis of a STI or HIV should be accompanied by counselling about HIV/STI prevention and testing.

Tuberculosis

Many prison systems also have high rates of TB. For people living with HIV, TB is the single most common opportunistic infection accelerating the progress to AIDS. HIV infection greatly increases the risk of an individual's developing active TB, and TB has been shown to increase the replication of HIV, thus accelerating the progression to AIDS. Prisoners with HIV have a greater risk of developing active TB compared to the general population. Prisoners with HIV are also more likely to have active TB outside the lungs.¹⁰ Responding to the management of TB and multi-drug resistant (MDR) TB in prison settings requires a comprehensive strategy that should be inclusive of all people living, working and visiting prison settings and therefore must engage active multi-sectoral participation to ensure an effective public health response.¹¹

Giving Advice About Testing

Routine screening for HIV, HCV and other possible infections or diseases is not mandatory in prisons. Voluntary testing is offered to all inmates at admission, and testing upon prisoner request is available throughout a prisoner's sentence. Testing may lead to diagnosis and possible treatment of any disease and ultimately reduce the potential of further transmission in the prison population. And with treatment, other support and education services could be provided that may result in other positive social and health outcomes. The testing done in most institutions is known as "confidential



Peter Collins

testing", which means that the health unit shares all HIV- or HCV-positive test results with the local public health department. The public health department then engages in "contact tracing" or "partner notification".

Those who test positive for any infectious disease should have access to appropriate treatment including referral to specialists in the community, although this access is too often inconsistent or limited. Prison is not a supportive environment for receiving a positive test result. Due to the real and pressing concerns about confidentiality within the prison system – as well as being ostracized – 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.

Testing in the prison setting raises the issue of confidentiality in relation to medical information. The consequences of unauthorized disclosure in the prison setting can be extreme, particularly in the case of HIV disclosure, for which consequences can include verbal abuse, stigma, discrimination in medical and other decision-making, threats of and actual physical violence and in some cases even death. Prison staff members who breach the duty of confidentiality owed to prisoners are in breach of prisoners' right to privacy.¹²

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 symptoms that are potentially related to HIV or HCV, immediate testing is 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 can be the best advice.

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

1. The first is confidential testing, which is the type usually done by general practitioners in the community and in all prison healthcare units. When undergoing confidential testing, by law all HIV-positive tests must be reported to the local public health department. Therefore, “confidential” testing is not truly confidential. This practice is a barrier to many who seek testing but do not want their results to be known to others.
2. 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 taking the test. Anonymous testing only takes place at designated sites across Canada. Access to anonymous HIV testing is another issue where correctional services’ policies are generally at odds with accepted community practice.

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.

Testing in provincial and federal institutions in Canada, at the time of publication, is confidential testing rather than anonymous, meaning that the results of prisoners’ HIV tests are made available to both the prison health unit and to the public health department. 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. Anonymous testing, if and when it becomes available, should be conducted by outside community testing facilities, rather than correctional services, in order to promote confidence in the confidentiality of the results.

At the time of publication, anonymous testing for HCV is not available in Canada.

Mental Health

Often, the behaviours resulting from mental health illnesses are construed by prison staff as disobedience, defiance or disrespect. Sometimes these behaviours are even interpreted as criminal acts within the institution. When this happens, a prisoner may be charged with a disciplinary offence and/or possibly end up in an altercation with security staff. It is important to note that prisoners with mental health illness may also offend other prisoners, which can result in fights, beatings, stabbings and even death. Prisoners with mental health illness may also be the targets of predatory prisoners. This may manifest in implied and direct threats as well as violence to target another prisoner’s meal, clothes, canteen, sex, etc.¹³

There continues to be a critical shortage of mental health services for prisoners. Mental health issues faced by federally sentenced women are considerable and tend to be different from those of their male counterparts. Many women are survivors of childhood and adult abuse, and the post-traumatic effects of that abuse often affects their mental health. Many federally sentenced women are diagnosed with a mental health illness, and women in federal penitentiaries have a higher rate of self-mutilation and attempted suicide than their male counterparts. In many cases women harm themselves primarily as a means of coping with the distress caused by incarceration.¹⁴

For women who have children, the adjustment of returning to the community after being in prison can be extremely difficult and can certainly have an impact on their mental health and well-being. Long periods in prison can result in a dependency on institutional structures and this can have an adverse effect on their children. Issues relating to family/parenting practices, organizing the lives of their children, schooling, social activities for the child/mother are important to recognize as a worker.

Clearly, the residual effects of the post-traumatic stress of imprisonment and the re-traumatization experiences that the nature of prison life may incur can jeopardize the mental health of persons attempting to reintegrate back into the free-world communities from which they came. Indeed, there is evidence that incarcerated parents not only themselves continue to be adversely affected by traumatizing risk factors to which they have been exposed, but also that the experience of imprisonment has done little or nothing to provide them with the tools to safeguard their children from the same potentially destructive experiences.¹⁵

The ability of a prisoner with a mental health illness to secure and maintain employment within the prison environment is fragile given the level of intolerance that exists within the prison system. This can result in prisoners living in imposed

poverty, below the level already experienced by the rest of the prisoner population. In this context, clients with HIV and/or HCV may be more susceptible to predatory “requests” for coerced sex and/or to sell/give up their medicine in exchange for their personal safety, toiletry items or dietary needs.¹⁶

- In 2006, more than one out-of ten male prisoners had a psychiatric diagnosis on admission to the federal prison system. This represented an increase of 71 percent over the previous nine years.¹⁷
- During the same nine-year period, the number of women prisoners who were diagnosed with a psychiatric disorder rose by 61 percent to one out of five women.¹⁸
- In the 2009 the Correctional Service Canada (CSC) ombudsman reported that 10 to 12 percent of prisoners entering the federal prison system have a significant mental health illness or issue.¹⁹
- In Ontario, 39 percent of prisoners have been diagnosed with a mental health illness, have a current medication order in effect, or are receiving ongoing psychiatric evaluation or psychological intervention.²⁰
- It is estimated that one in four prisoners has some degree of mental health illness at admission.²¹

Mental Health and Deprivation

Deprivation is at the root of most prisoners’ experiences in the system. They are not able to access family, foods of their choice, medical care of their choice, sex with partners of their choice. They can’t go to the store, and most can’t access computers. They are deprived of silence, deprived of ownership of their own bodies (because of strip searches and lack of privacy), deprived of accessing harm-reduction materials, deprived of autonomy over their actions, deprived of meaningful work, and the list goes on.²²

- Prisons are harmful because they deprive people of basic human rights and needs. Prisons bring “physical, mental and social harm to prisoners²³” and render them powerless and institutionalized.²⁴
- Deprivation brings pain and hardships to people in prison and can threaten their sense of personal worth, self-esteem and identity.
- Prisoners face the deprivation of healthy physical and emotional contact with partners, children, friends, lovers and other loved ones. This deprivation can create unhealthy communication and dysfunctional relationships.

Deprivation is also linked to the ways in which prisoners negotiate safer sex (people may get more traded goods if they do not use a condom). The deprivation of pain medication can also lead people to hoard medication and sell it for other items.



Tim Felfoldi

HIV and HCV Care, Treatment and Support in Prison

Tackling Stigmatization

Whether a person living with HIV or HCV 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 HIV and HCV-positive clients in prison more vulnerable to health decline than many clients in the outside community. Imprisoned clients are generally forced to live in conditions that increase their vulnerability to medical neglect, opportunistic infections or co-morbidities, needless suffering and untimely death. Imprisoned clients also have fewer opportunities to engage in health-promotion activities such as following a proper diet. Despite its mandate of care, and Charter of Rights obligations to provide that care in theory, in practice correctional systems across Canada limit – or even deny – HIV/HCV-positive prisoners access to a standard of care commensurate with that available in the community. Following is a summary of the current issues that affect the treatment, care and support of those living with HIV/HCV in prisons.

Inside prisons, people living with HIV and HCV are often the most vulnerable and stigmatized segment of the prison population. Fear of discrimination may often deter prisoners from accessing voluntary HIV and HCV testing and prevention education measures, and it discourages prisoners living with HIV and/or HCV from seeking medical services and treatment.²⁵

HIV/HCV education initiatives for prisoners and prison staff should address HIV/HCV-related discrimination. When developing your program, it is important that you are responsive to the unique needs of vulnerable or minority populations within the prison system. Therefore, the needs of incarcerated women; children and young people; migrants; ethnic minorities; indigenous populations; lesbian, gay, bisexual and Trans prisoners; sex workers; and injecting and other drug users should be given particular priority and focus.²⁶

Due to persistent stigmatization in prison, prisoners living with HIV/HCV will rarely come out to your workshops. Those who have HIV/HCV may 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/HCV have about having their confidentiality broken, 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 which people in the group believe that HIV/HCV-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/HCV educational sessions in prisons. Be prepared to facilitate such discussions and to educate people about the importance of confidentiality and of us all taking responsibility for protecting ourselves against HIV and HCV infection.

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 picking it up.

You should also be sure to address the fears and phobias that HIV/HCV-negative prisoners may have about sharing living space with HIV/HCV-positive prisoners. Point out that within the closed living environment of the prison, people living with HIV are very vulnerable to getting sick from other prisoners (colds, flu, effects of inadequate hygiene, sanitary conditions, etc.)

Confidentiality

Confidentiality is a daily concern for prisoners living with HIV/HCV. People living with HIV/HCV routinely face discrimination, ostracism and sometimes even violence, as a result of their HIV/HCV status. This stigmatization results not only in stress and fear, but indeed discourages many people from seeking testing and/or treatment. In prisons, pervasive misinformation creates unnecessary fears about the risk of 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/HCV-positive.

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 clients.

At the staff level, there is a widespread belief – particularly among guards – that a prisoner's HIV/HCV status is a workplace safety issue. Many correctional staff believe that they have the right to know which prisoners are HIV/HCV-positive. 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 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/HCV-positive prisoners. 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 will sometimes go to clever lengths to identify HIV/HCV-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 this prisoner is HIV/HCV-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.

There are also subtle or inadvertent ways in which a client'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. 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 HIV/HCV support worker, assumptions could be made regarding the health of that prisoner. To minimize this particular assumption, it is important that HIV/HCV workers clearly state to prisoners and staff that all people are welcome to access services regardless of HIV/HCV 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 healthcare staff and independent community-based service providers.

TIP: Every breach of confidentiality is serious, and community-based workers should intervene 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 identify and resolve problematic procedures.

In the case of deliberate breaches of confidentiality (by staff), your client may require your support to 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.

Medical Specialists

Having access to knowledgeable doctors who are skilled in treating these infections is critical for the health of those living with HIV and/or HCV (both require different specialists). Given the highly specialized and constantly changing nature of treatment information, few correctional physicians fit into this category. This necessitates the involvement of outside medical professionals to provide the proper standard of care for prisoners living with HIV and/or HCV. Some outside physicians are personally dedicated to providing health care for prisoners and will make an effort to visit institutions to see individual clients on a regular basis. In some regions, the federal correctional system contracts community specialists for this purpose. However, this remains the exception.

If an outside primary care physician is willing to see HIV and/or HCV-positive prisoners, the most common practice is for these prisoners to be transported out of the institution to see the doctor in her or his own office. However, many institutions are reluctant to dedicate the financial and staff resources necessary to escort a prisoner to outside appointments. 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 this prisoner will obviously know where they are all going, and hence may be able to ascertain the nature of the 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 clients. The faces and names of the HIV and HCV specialists soon become known in the institution, and so prisoners consulting those physicians 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 she or he orders. If a prisoner has an established relationship with a 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 prisoners be able to continue to see their community doctor as primary care physician to ensure continuity of care.

TIP: In many jurisdictions, access to appropriate outside physicians is difficult or impossible. 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 people with the opportunity to see a specialist can be complicated.

Drug Therapies

Both HIV and HCV are treated with a combination of therapies that must be administered in a rigorous and consistent manner in order for them to be effective. Failure to follow treatment regimens significantly reduces the drug therapies' effectiveness.

A failure to follow treatment regimens is especially dangerous for persons living with HIV. Improper administration of HIV treatment can lead to the development of drug resistance, completely eliminating present or future effectiveness of that drug therapy for your client. 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 impact on the health and life expectancy of prisoners living with HIV.²⁷ Given the known ramifications on human health, failure in this regard is considered to be medical negligence by many healthcare professionals and HIV/HCV workers in the community.

Several barriers commonly impede a client's proper access to HIV/HCV treatment in prisons. The first barrier occurs when the HIV/HCV-positive client initially enters the prison

system. When a person is arrested and tells the health unit that she or he is on a specific treatment, 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 precaution, such delays can be devastating to the health of the client for the reasons cited above. 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 primary care physician in the community who prescribed the treatment, and get her or him on board.

A number of additional barriers emerge after prisoners are settled in the institution.

- Some prison doctors require a confirmatory test for their files before allowing prisoners access to treatment, 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.
- 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.

Even leaving the prison can create disruptions with the client's treatment. For example, transfers from one institution to another sometimes leave prisoners without a supply of medications. If the new institution does not have the medications in stock, prisoners must wait – and miss doses – while the institutional pharmacy orders them in. Similarly, clients on medication are often released from prison into the community without a supply of their medications and without money to purchase them. Unless clients have previously arranged a doctor's appointment for the day of their release, this again



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creates a situation where they are forced to contend with an unnecessary gap in their treatment that diminishes or eliminates treatment effectiveness.

Diet

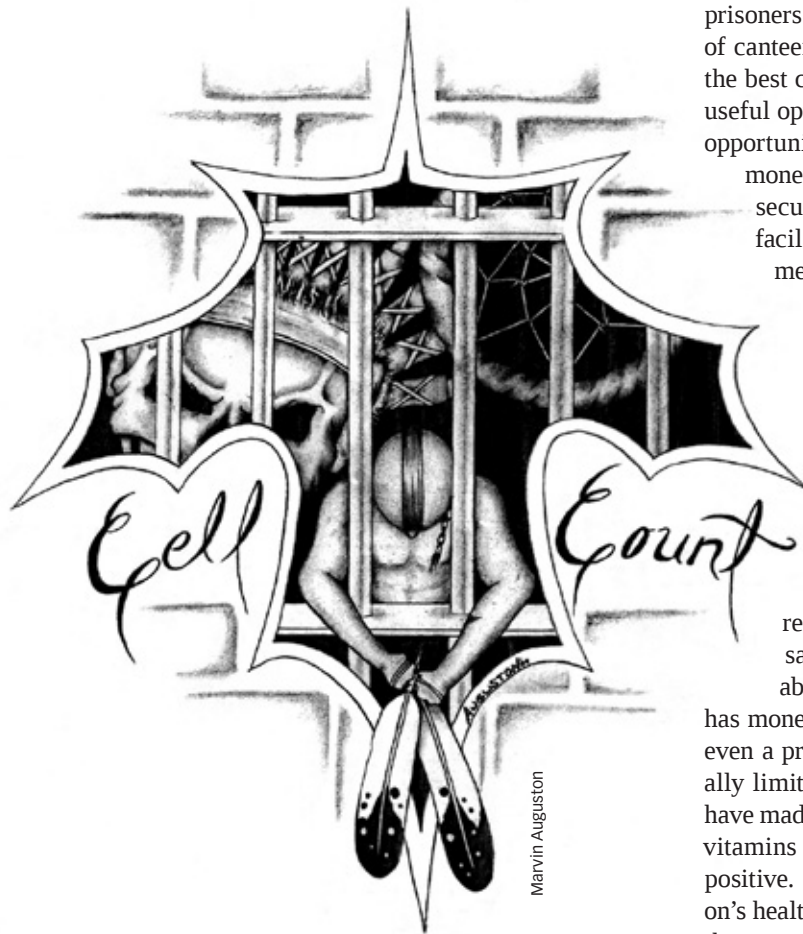
Access to nutritious food is a constant problem for all prisoners. For prisoners living with HIV and/or HCV, the effects of this problem are magnified. We know that eating a well-balanced diet, complete with fresh fruits and vegetables, is an important component of health promotion for people living with HIV and/or HCV. Unfortunately, food choice in prison is very limited, and prison diets do not generally meet most people's criteria for healthy eating.

Prisoners living with HIV and/or HCV generally have no control over their diet. Policies about prisoners' diets are determined at the institutional level, and thus they vary from prison to prison. While some institutions have dietitians 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 mealtimes. If a prisoner needs to take medications at 8 a.m. and 8 p.m. 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 make special meal arrangements for a prisoner living with HIV and/or HCV, this can

TIP: Given the known detrimental effects of interruptions in protease inhibitor combination therapies for people living with HIV, people should never be cut off from these medications without proper medical assessment and informed consent. In addition:

- 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.



jeopardize prisoner 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 prisoner, healthcare unit and 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

TIP: Diet is also an integral part of the proper use of many medications. 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. In some institutions, prisoners can get “special diets” (e.g. 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 your imprisoned clients.

prisoners to purchase snacks from the canteen. The diversity of canteen items available varies from prison to prison, but the best cases provide prisoners living with HIV/HCV with useful options to supplement their diets. However, even this opportunity is limited or negated if prisoners do 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.

Vitamin Supplements

While vitamin supplements could partially offset dietary deficiencies, access to vitamins can also be an ongoing problem for imprisoned clients. 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 multivitamins. Some organizations have made a significant impact on this situation by providing vitamins for their incarcerated clients who are HIV/HCV-positive. Such arrangements can be made through the prison’s healthcare unit, although it may require advocacy to get them to agree. If you are interested in providing vitamins to people with HCV, it is important to consult with a healthcare provider first, since some vitamins can cause liver damage.

Pain-Management Medication

People living with HIV/HCV often experience chronic pain as a part of daily life. Many clients attempt to reduce or manage this pain using a variety of alternative pain-management 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 and/or HCV 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. Many prisoners living with HIV and/or HCV have histories of drug use. This fact, combined with the prison system’s zero-tolerance approach towards drugs, creates situations where prison healthcare 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 and/or HCV. In some cases, prison physicians who are inexperienced in diagnosing HIV/HCV-related pain and/or who harbour negative stereotypes about prisoners or people who use drugs are reluctant to prescribe medication for pain management, or are hesitant to provide it in the dosages necessary.

TIP: One of the most difficult barriers that prisoners face arises when accessing pain management. If prisoners have 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 physicians in the community and request that they contact the institution to advocate on behalf of their patients.

As the community-based worker, you can then intervene with the institution to argue that the recommendations of a 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.

This situation is further complicated by the fact that people who use drugs have often developed high levels of tolerance to the effects of narcotics, which means that a standard dose of a painkiller for non-drug users can easily have no effect on someone who uses drugs. 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, clients 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 individuals’ “drug problem”, reducing or eliminating their access to prescription pain medications usually forces them to 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/HCV among prisoners who inject drugs.

If prisoners are able to access pain-management medication, they are often subjected to increased surveillance by staff. They also risk being denied their prescribed pain medications on the mere suspicion of selling, trading or giving the medicines away. Advocacy is usually required in such situations. Prison administrators and staff often justify denying pain medications by asserting that prisoners receiving narcotic medications are prone to trading or selling them to other prisoners, or that weaker prisoners are vulnerable to having their medications stolen (“muscle”) by stronger prisoners. The prison has no right to deny prisoners living with HIV and/or HCV access to legitimate prescription drugs unless they are able to prove the allegation of improper use against the individual.²⁸ 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 dis-

crimination in the provision of services contrary to human rights legislation.

The above factors have created a scenario in Canadian prisons whereby clients are routinely denied pain-management medication outright, or prescribed it in doses too low to be effective. This leaves many clients 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/HCV transmission risks among imprisoned people who inject drugs.

Palliative Care

Prisoners who enter the later stages of chronic or terminal illnesses – including but not limited to HIV/HCV, need access to palliative care. The prison environment itself – with its security-focused 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 not 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 clients in this way necessarily removes them from their support system within their home institution. This isolates them from the group of people whom they now consider 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 client’s home community outside.

TIP: Prison palliative-care policies and practices vary from jurisdiction to jurisdiction. In a few systems, such as the Québec provincial system, clients are released from prison into a hospice when they experience a severe decline in health, but 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 exist 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.

Prison hospital units are also frequently located in higher security institutions, and so palliative transfers can therefore result in an upgrading of the client’s security classification.



Security upgrades can have the incidental effect of further restricting the client'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).

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

Cognitive Impairment and Dementia

About 60 percent of people living with advanced HIV and 33 percent of people living with HCV experience some form of cognitive impairment during their illness.

HIV- and HCV-related cognitive impairments — including difficulty remembering things, concentrating and thinking clearly — can have a serious impact on how a prisoner functions within the system and completes his or her daily activities. Prisoners experiencing these complications find that prison staff often view their behaviour through a correctional lens, rather than a healthcare lens. For example, when HIV

infects the brain, it can cause a condition known as AIDS Dementia Complex (ADC),²⁹ and this can cause people to act aggressively. Prisoners who are HIV-positive and may be acting aggressively because of ADC are frequently dealt with punitively rather than attended to with an understanding of the nature of the disease. This can also be an issue for prisoners living with HCV because some people experience increased irritability while on HCV treatment.

It is important for you as a worker to understand complications related to HIV and HCV and how these complications can affect the mental health, well-being and behaviours of those who are incarcerated, so that you can help people develop coping strategies.

Anxiety and Depression

Anxiety and depression can also result in behaviours – such as panic attacks, phobias and somatization (experiencing physical symptoms that do not have a physical cause) – that are dealt with in a punitive manner within prisons. Like other mental health illnesses, depression limits daily functioning and can negatively affect a person's physical health. It can interfere with the immune system's ability to fight HIV and can make it more difficult for a person with HCV to actively promote a healthy liver.

HIV and/or HCV can be a cause for depression. Depression may also be brought on by some anti-HIV drugs like efavi-

renz (Sustiva, and also found in the combination pill Atripla) or peginterferon treatment for HCV. Certain conditions related to HIV/HCV infection or treatment, such as anemia (low red blood cell count), severe fatigue and dementia, can cause symptoms that feel very similar to depression.

Again, it is important for you as a worker to understand the complications related to HIV and HCV, how these complications can affect the mental health, well-being and behaviours of those who are incarcerated, so that you can help people develop coping strategies.

Chapter 3 Further Reading

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CHAPTER 4 Client Support

IN GENERAL, IMPRISONED CLIENTS WITH HIV/HCV struggle with the same issues as do those living with HIV/HCV 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, common fears about deteriorating health and death are compounded for prisoners with HIV and HCV – 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). While living in prison can be a dehumanizing and isolating experience for anyone, it can be further intensified for persons living with HIV/HCV. All of these issues affect the types of support services needed by prisoners living with HIV/HCV.

All our client support work is based upon the belief that people living with HIV/HCV 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. People living with HIV/HCV 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. As on the outside, you can provide support to your incarcerated HIV/HCV-positive clients in two main ways:

1. through communication
2. through advocacy work

As trust in your agency grows, you will find more clients 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/HCV services, you will gain greater credibility with the institution, which will in turn make you a more effective support worker. Prisoners may make requests for a number of other support services and it will be up to your agency to establish relevant policies and practices.

Chapter Overview:

This chapter discusses how and when to provide client support through two main ways: communication and advocacy. You'll find practical advice on providing communication whether via telephone or in person, as well as key information on client access, policies and boundaries. 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. There may be times when you are compelled to intervene on behalf of your client/s. This chapter explains what we think are basic guidelines for client and system advocacy, ways to help your clients get their needs met, strategies and examples of advocacy letters to get you started. Last, as an agency gains credibility, prisoners commonly request a number of other support services, some of which are listed in this chapter alongside information about establishing agency policies and practices around these requests.

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 affect the telephone's utility as a support tool. These limitations create challenges for workers hoping to provide counselling or support to prisoners. Before undertaking telephone support, you should be aware of the following.

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.

For more on other considerations for your agency, see the section on Making Initial Preparations: Arrange for Your Agency to Accept Collect Calls from Prisoners and Thinking Ahead About Telephone Policies and Boundaries.

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 12 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. If you or your agency wants to begin providing support services to prisoners, you must accept collect calls.

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 (e.g. 15 or 20 minutes). Therefore, you must learn to quickly assess situations and provide some meaningful support during brief conversations.

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. In federal prisons, this general lack of confidentiality is compounded by a system where prisoners must also submit all phone numbers for security approval. 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 clients' high levels of need – clients in prison can and will call support organizations as often as possible.

Why People Call

Obviously, imprisoned clients 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.

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 Client Support through Advocacy, page 85).

Crisis Calls

These are but a few of the situations in which you may be called upon to provide crisis support to prisoners:

- testing positive
- the onset of HIV-related illnesses

- the onset of end-stage liver disease
- failure to clear HCV on treatment
- drops in T4 counts or increases in HIV viral load
- the death of a friend
- bad news from home

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 clients 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.

“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 10 or 20 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 she or 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.

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 themselves 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 oppor-

tunity 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

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 one of the following with the request: a social worker, the Native liaison person, a case management officer, the chaplain or a nurse. 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.

Listen Actively

Most HIV and HCV 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/HCV 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 that you need this and this done." This can help ensure that you understand the situation clearly and can also help focus the client.

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 with all your 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.

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 that need to be 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.

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 about it next time she or he calls. As well, it is important to hold people accountable for their actions. People in prison are used to extremes, and they need to hear when they have crossed a boundary and you are not okay with it. Don't put up with bad behaviour from prisoners any more than you would from anyone else.

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 problems in addition to HIV/HCV. 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 with the skills to do work with imprisoned clients. 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.

Don't Lose Sight of the Bigger Picture

Life in prison is a day-to-day existence. Prisoners are therefore often exclusively focused 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 clients 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.

Telephone Policies and Boundaries – Thinking Ahead

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 these 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.

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 finan-

cial 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).

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.

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 that 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 and the associated risks.

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 tend 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 okay, 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 (e.g., placing calls to other professionals) or not at all. Remember that once you do something, the likelihood is that every other client in prison will know about it, so come up with a clear boundary and be consistent.

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.

The Issue of Confidentiality

By going into the institution to visit a client as “the HIV/HCV worker”, you are necessarily taking the risk of disclosing your client’s HIV/HCV 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, Chapter 2.)

Consider the Different Types of Visits

As discussed in Chapter 2, you have two options for visiting people in most provincial institutions. One is through the professional visiting process (for which you need special clearance) and 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. 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, Chapter 2.)

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.

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 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 prisoners themselves about where they would be most comfortable meeting you. You can also consult with a social worker or a Native liaison officer about alternative meeting spaces in the prison.

Check Prisoners’ Own Schedules

If you are planning to visit clients, be sure to check with them about their own schedule. The person may have a court ap-

pearance, 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 her or him. Planning ahead will reduce the likelihood of wasted trips.

Follow Through on Your Appointments

Never tell a prisoner you will visit, 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. 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 her or him right away.

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 45-minute support session can therefore easily take an entire afternoon. Plan your schedule accordingly.

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 to clients, as you will be able to give them a consistent schedule of your trips to the prison, so they can prepare for your visits.

Forming Peer Support Groups in Prisons

If you find that you consistently have a number of HIV/HCV-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 clients 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/HCV, 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/HCV 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 (PC) 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.

Client Support Through Advocacy

An Introduction to Advocacy

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 officers – 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.

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. 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 clients 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/HCV services, you will gain greater credibility with the institution, which will in turn make you a more effective advocate. As an HIV/HCV worker in prison, advocating on behalf of your clients will be an integral part of your job description:

1. Your work should be directed to ensuring that adequate standards of care, treatment and support are extended to prisoners living with HIV/HCV.
2. As an HIV/HCV support worker, you not only have the responsibility to act on any denials of HIV- and HCV-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.
3. If you hope to do meaningful HIV/HCV 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.
4. The ultimate goal of your efforts and interventions is to improve conditions for all prisoners living with HIV/HCV.

Basic Strategic Guidelines for Advocacy

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 to you, and which are closed. In addition, demonstrating specific knowledge will significantly increase your credibility when intervening.

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 clients. 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 succes-

sion of limited victories can get you closer to your longer-term goals than will a string of ambitious failures.

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 judgment to assess the quickest and most effective way to reach that goal. Be sure to choose the right tool for the job.

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.

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.

TIP: Despite its convenience and apparent speed, e-mail will not necessarily serve the same purpose as a mailed or faxed letter. Generally, e-mail is still too informal – and is less of a permanent record than a hard copy of a letter appearing on an organization’s stationery.

Remember, too, not everyone checks their e-mail on a daily basis, whereas a faxed letter will be delivered to an individual’s desk by clerical staff. If your fax is urgent, be sure to mark it “URGENT”.

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 that acts thoughtfully yet with strong conviction, you may find that a problem that 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). 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. Other sources of increased advocacy leverage include bringing other allies (individuals, agencies or networks) onside in a cooperative effort; and generating publicity. Usually these latter two options should be saved for situations requiring further escalation.

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.

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.

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?

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 she or 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 to explain what happened. It is important for your client to know that you tried your best and didn't just ignore his or her request for help.

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 (carbon-copied) 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 him or her a thank-you letter 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.

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. 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.

How to Get Your Clients' Needs Met Through Advocacy

Problems requiring advocacy can range from the relatively minor and easily resolvable (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. Effective advocacy is about knowing what buttons to push to resolve your problem, when to push them, and how hard to push. Different approaches work better for different people, for different institutions, for dif-

ferent issues and at different moments in time. Through experience, you will learn to assess which approach offers the best opportunity for a speedy resolution of any given problem. 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, as the following examples illustrate:

1. 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.
2. 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.
3. 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 clients.
4. Sending a letter to court on behalf of a client is a form of advocacy, as it can help inform the judge about HIV/HCV issues.

TIP: Advocacy is nothing more or less than the act of defending or advocating the rights of our clients when they are denied or jeopardized. 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. The better your understanding of the relevant policies, institutional systems and cultures within your region and the personalities involved, the more easily you will recognize the most effective options when faced with an advocacy issue.

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.

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.

1. **Individual Advocacy:** You may be asked to engage in individual advocacy – to resolve a single problem affecting a single individual.

2. **Institutional Advocacy:** You may become involved in institutional advocacy – to address a problem or barrier affecting an entire institution and all prisoners incarcerated within.
3. **Systemic Advocacy:** 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.

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, who and how of your plan.

TIP: 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.

Creating an Advocacy Strategy – 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. 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. To begin to determine the source of the problem, your client is often the best person to consult initially. You may also wish to consult in advance with the staff at PASAN who may be able to guide you in the right direction and provide advice for dealing with a problem.

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 for increasing the likelihood of being able to resolve the issue in a timely fashion. 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:

Is this a new problem for the client?

For example, had she or he been receiving her or 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 prisoner. However, it might also be that a broader change in policy has occurred.

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, however, exceptions to this formula. 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 the official policy of

the system as a whole. Make sure to check this out. You can also consult with healthcare 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. Be alert to any patterns you see emerging over time.

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.

Identify Solutions to the Problem

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 medications. Perhaps her prescriptions have been changed without explanation. Perhaps he is feeling ill and needs to see a nurse or doctor. Perhaps a change of bedding or clothing is needed. Perhaps she needs 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.

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 he been cut off of 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 injects drugs and is concerned about

transmitting HIV/HCV to her or his friends in prison, but cannot access needle exchange because no prisons in Canada offer this program.

All of the above situations 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.

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.

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 she or he is in a federal or provincial institution, a detention centre or a remand centre. The inherent differences between types of institutions will partially condition both applicable policies and your available advocacy options.

Does the institution know prisoners' HIV or HCV status?

Is she or he open about being HIV-positive? Is that knowledge limited only to the prison health unit, or does no one know his or her status? This information is crucial, because having an HIV/HCV worker contact the institution on the client's behalf necessarily discloses HIV/HCV 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 her or his express knowledge and permission.

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 in your records, including, for example:

confirmation that you received verbal authorization; the date, time and call duration; and the exact nature of the request. 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.

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 or 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 your client 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 his or her official title. You may also need to note any institutional reference numbers, including your client's prisoner number.

Identify any potential allies to help you in your advocacy.

Does your client have a primary care physician in the community with whom she or he has an established relationship? Does she or he have a lawyer? Is she or 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.

Identify an Acceptable Solution to the Problem

Assess the Problem

Your assessment of the situation should include at least one acceptable solution to the problem. 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 writing a letter or holding a demonstration to protest correctional policy on institutional climate controls.

Consult With Client

Before taking action or attempting to implement your solution, you should consult your client about the possible solution to the problem, and obtain her or his authorization to proceed. If the client doesn't present you with his or her own

solution or demands up-front, you may have to suggest and explain your assessment of possible and probable solutions or remedies to the problem.

Find an Acceptable Solution

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 or him to agree on an acceptable solution that will meet her or his needs and be possible for you to reasonably negotiate with the prison.

Once you have determined the nature of the problem and the possible remedy, you can decide on your approach and with whom to communicate in order to achieve a resolution.

Targeting Your Intervention – The "Who"

When you decide to address a problem or issue with the institution 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.

Your client will often be the most helpful person to consult when deciding whom to call. Since your client lives in that particular prison, she or he will often know who makes what decisions in the institution, and which staff have been supportive or helped out in the past. In general, the relevant institutional decision-making takes place in two spheres: health care and administration.

Health Care

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, as most institutions will not have a full-time physician on staff. 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.

- The healthcare staff will make decisions regarding access to medications – such as prescriptions, dosage amounts and times – and access to outside specialists.

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 her or him 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)
- media work/press releases
- demonstrations
- participating in coroners’ 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.

- Healthcare staff can also assist your client in obtaining nutritional supplement drinks, changes of bedding and clothing, and in some cases, changes in diet.
 - Healthcare staff may also be helpful in providing access to condoms and bleach in those jurisdictions that make these materials available.
3. **Prison guards** have the most face-to-face contact with 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.

Security and Administration

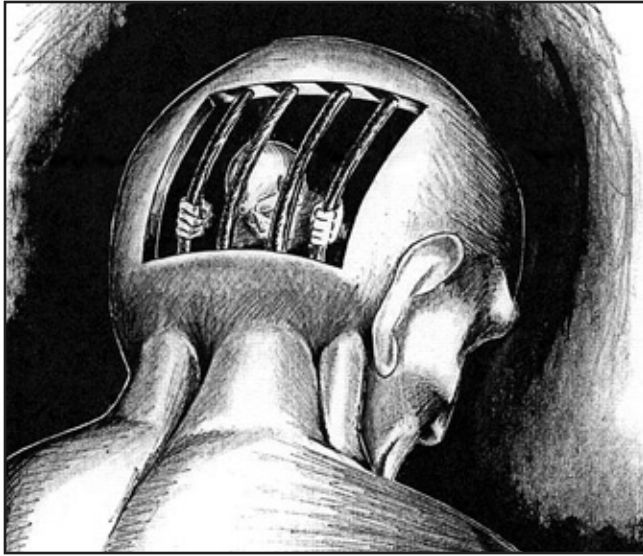
Security and administrative staff make a significant number of decisions that directly affect your clients. Security and administrative personnel decide which range or living unit will house your client; whether she or he is single, double or triple bunked; whether she or he is placed in segregation; and whether she or he is allowed a Private Family Visit (a “trailer visit”).

1. **Wardens** set operating policies for their own institutions, in keeping with established correctional policies set at higher levels.
2. **Deputy wardens/superintendents** are involved in community programming decisions and security clearances for visitors (both professionals and family).

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, above.



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 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 – 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 he or she is in agreement with your ideas.

- Does your client 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 the letter to the warden, a lawyer or other individual/s to try to cause a bit of commotion?

Once you have determined what, who and how – and have received your client’s authorization – it is 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.

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 documenting 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, an articulate 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

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 percent sure that the answer you are giving is true, you should qualify your answer.** This concept is best explained by using an example.

Suppose you are asked, "Did you move into your new apartment on January 1?" Unless you are ABSOLUTELY positive that you did move on January 1, it's wiser to qualify your answer by saying "I moved on or about January 1. 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 2.

4. **Show respect for the proceeding.**

leave the least amount of wiggle room for reluctant recipients. Your letter need not be lengthy – in fact, it shouldn't be long – but, at minimum, it should include all of the components of an effective advocacy letter (see example on page 93).

Copying Correspondence

If you want to be sure of receiving a response, it is wise to send a copy of 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.). You could also copy the correspondence to your client's outside community supports, such as his or her 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.

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 copied, the angrier the recipient is likely to become. This is not a reason to avoid this strategy. On 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.

You also want to avoid overusing this escalation tactic at the outset of your efforts. For example, if you copy 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.

Providing Support through Courtroom Advocacy

When working with people living with HIV/HCV 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.

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, she or he will have to spend all of this time in 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 she or he comes to trial), and at sentencing hearings (held after a person has



Peter Collins

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.

Answering Questions in Court:

One common cross-examination tactic the Crown will use to try to throw you off is examining 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 2010? Did you know Mr. Smith was convicted of aggravated assault in 2008? Do you think Mr. Smith should be allowed to go free simply because he has HIV/HCV?"

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 HCV. 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?" you answer: "I'm sorry, I don't understand what that has to do with his HIV/HCV status?"

When the Crown asks "Did you know Mr. Smith was convicted of aggravated assault?" 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 HIV/HCV?" 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 judgment, 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/HCV. 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 His/Her 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, he or she will soon drop it.

been convicted, when the judge is determining the sentence). Such hearings present opportunities for HIV/HCV 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/ HCV, 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 she or 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 or his assessment of the client's risk of reoffending.

If you are providing a letter of support, please refer to the earlier section of this chapter on writing effective letters. When providing either written or verbal evidence to the court, always remember that your reputation, and that of your agency, are 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/HCV – 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, as well as advice on being an effective witness.

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 the Crown's advantage. The more effective he or she is at getting you upset – and possibly flustered – the less effective you are in presenting your client's case. Do not ever insult Crowns, 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, however, that we live in an ideal world.

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/HCV. 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/HCV).

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 questioning.

The Judge

The judge will make the decision in your client's case, and it is the judge's 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 emo-

tions, and maintain your focus on your number-one priority – impressing the judge. Remember that the judge can ask you questions at any time during your testimony. If the judge asks you a question, be sure you address your answer directly to her or him.

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 entire day at the court. 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 or his case might not come up at all, and instead be rescheduled for the next day. Be prepared to wait.

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/HCV workers engage in client advocacy.

Mandate of the Parole Board

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 reoffend if released, and/or violate the provisions of her or his parole. To determine this, the parole board looks primarily at the person's prior criminal record. The longer the criminal record, the less likely the board will be to grant parole. The board also tends to be particularly harsh in its decision if the individual has previously violated parole or bail conditions or has failed to appear at court hearings.

TIP: Prisoners have the right to waive their parole hearing and many choose to exercise this option if they feel they will be denied parole.

Parole applications are heard by parole boards, which are panels appointed by the federal or provincial governments.

Parole Hearings

Parole hearings occur automatically after prisoners have served a set proportion of their sentence (which varies by jurisdiction). The parole hearing takes place inside the prison. When a prisoner comes up for 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. 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/HCV. As with submissions to court, think of your letter as a chance to educate the parole board about HIV/HCV issues. Take the opportunity to detail the supports that 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 counseling, support groups, volunteering with your agency, etc.) is something concrete that can help reduce his or her risk of reoffending.

In rare circumstances, you may be invited to attend a parole hearing. While prisoners are allowed to have a lawyer and/or supporter attend on their 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, 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. The limitations of appealing for compassionate consideration from parole boards of this mindset are obvious. Still, it is critical that community-based HIV/HCV workers intervene in this process to help provide a counter to discriminatory attitudes.

TIP: 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 or 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?"

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, Corrections will recommend that an individual be "gated". This means that the person will have his or her statutory release revoked prior to being released,

and will therefore serve his or her 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 prisoners can be gated, however, they are entitled to a detention review hearing, where the parole board will consider the request of Correctional Service Canada (CSC) to withhold statutory release.

As with other parole hearings, you can make written submissions to the board on behalf of your client.

Compassionate Release Hearings

A final type of parole hearing is the compassionate release hearing. These hearings are often termed compassionate, but rather than being designed to consider cases on medical grounds, they are conducted as standard parole hearings where prisoners' parole eligibility date has been moved forward due to their failing health. These are actually regular parole hearings and are heard by regular members of the parole board. In the federal prison system, such hearings are officially called "parole by exception".

This is important to understand for two reasons.

1. First, the board members considering the application have no training in medical issues, either generally, or on HIV/HCV specifically.
2. Second, the parole board's primary concern remains public safety, security and prisoners' 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, heartbreaking situations, where terminally ill people are denied release based solely upon their past criminal records. No one should die from HIV/HCV 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 upon earlier in this chapter. It is important to fight the good fight in these situations, but be prepared: these hearings are very stressful and emotional. More often than not, compassionate release applications are refused.

Other Support Services, Policies and Boundaries

Prisoners 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.

Example of an Advocacy Letter

Organization's letterhead

Date

Name of Specific Individual
Name of Correctional Centre
Address

DELIVERED VIA FAX

Dear Name of specific individual:

Re: Mr. John Doe (your client)

1 I am writing on behalf of PASAN (insert your agency/organization's name followed by a description/its mandate) to request your assistance with Mr. John Doe, who is currently incarcerated at your institution. PASAN is a non-governmental AIDS service organization funded primarily by the Ministry of Health and Long Term Care working to provide support, education and advocacy to prisoners and ex-prisoners within Ontario around issues related to HIV, AIDS and HCV.

3 Mr. Doe has been a client of ours since 1994, 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 and HCV, 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 and HCV. 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.

6 If you have any questions, please don't hesitate to contact me at 123-456-7890. I will telephone you this afternoon to discuss the situation.

Thank you very much for your attention in this matter. Your cooperation and assistance are greatly appreciated.

Yours truly,

8 Your name, position and agency

cc. Name of Specific Individual,
Ombudsman

Components of 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 who is being copied – indicate the other players who will receive a copy of this correspondence, if applicable.

Example of a Letter to the Court Regarding Inadequate Health Care

Organization's letterhead

Date

Name of Specific Individual
Name of Correctional Centre
Address

DELIVERED VIA FAX

To the Court (Name of specific individual)

Re: Ms. Jane Doe (your client)

Ms. Jane Doe is a new client/member of the Positive Living BC whom I met upon her recent incarceration in the pre-trial centre (state name of centre). Positive Living BC (insert your agency/organization's name followed by a description/its mandate) is a non-governmental AIDS service organization funded to provide support, education and advocacy to prisoners and ex-prisoners within BC around issues related to HIV and HCV. Due to the serious nature of Ms. Doe's medical condition and her worsening symptoms, we are urgently requesting that she be released on bail or face her charges immediately in order that she can receive immediate medical attention.

Ms. Doe was diagnosed with HIV disease in May of 2008 while in a Vancouver hospital. She was acutely ill at the time of diagnosis and has been suffering progressively worsening peripheral neuropathy since then, to the point where she is unable to walk more than a few steps at a time and is confined to her cell. Unfortunately, this is common in the early stages of a person's HIV infection. It is critical that Ms. Doe receive immediate medical attention for this extremely debilitating symptom of HIV infection. In the pre-trial centre Ms. Doe's neuropathy is not being treated effectively other than a tripling of the medication, which is having no positive effect on the symptoms.

Peripheral neuropathy describes damage to the peripheral nervous system, the vast communications network that transmits information from the brain and spinal cord (the central nervous system) to every other part of the body. Because every peripheral nerve has a highly specialized function in a specific part of the body, a wide array of symptoms can occur when nerves are damaged, such as temporary numbness, tingling and pricking sensations (paresthesia), sensitivity to touch, muscle weakness, burning pain (especially at night), muscle wasting, paralysis, organ or gland dysfunction and the inability to digest food easily or maintain safe levels of blood pressure. In the most extreme cases, breathing may become difficult or organ failure may occur.

Prisoners in Canada are entitled to the same quality of health care while incarcerated as when living in the community, however Ms. Doe is not receiving this level of care and her medical condition appears to worsen each day. The charges Ms. Doe is facing are three years old, and no new offenses have resulted in the ensuing time. I strongly urge the court to undertake whatever is necessary to have our client/member Ms. Jane Doe released on bail or face her charges immediately so that she can receive the necessary and specialized health care that she would otherwise have received in the community. It is our opinion that Ms. Doe poses no public safety issue. Ms. Doe is undergoing a medical/health crisis that requires immediate and considerable attention by a physician specializing in HIV.

You may contact me at the above number or on my cellular at 123-456-7890. Upon Ms. Doe's release we will be providing her with extensive-case management support.

Yours truly,

Your name, position and agency

Example Letter to the Parole Board

Organization's letterhead

Date

Name of Specific Individual
Name of Correctional Centre
Address

DELIVERED VIA FAX

To the Parole Board,

Re: Mr. John Doe (your client)

I am writing in support of my client, Mr. John Doe, and his application for parole. I have been working with Mr. Doe as his primary support worker at PASAN (insert name of your own agency followed by a description/its mandate) since June 2010 (insert date). PASAN is a non-governmental AIDS service organization funded primarily by the Ministry of Health and Long Term Care working to provide support, education and advocacy to prisoners and ex-prisoners within Ontario around issues related to HIV and HCV.

I have been meeting with Mr. Doe on a bi-monthly basis in person for support counselling sessions within the Central North Correctional Centre (insert name of the correctional centre). In addition, I provide ongoing phone support with Mr. Doe on a weekly basis. During our interactions, he is consistently respectful, responsible and thoughtful. Mr. Doe has expressed good self-awareness along with a clear understanding of the impact of his actions on others. While he was incarcerated, I witnessed Mr. Doe's personal growth as a result of introspection and participation in programs, counselling and several other opportunities made available to him within the institution.

Mr. Doe has formed a support network in the community, which includes a number of established organizations and individuals who will assist him stabilizing in the outside community. Mr. Doe maintains healthy relationships with his family and has initiated contact with the AIDS Committee of (insert), both of whom will be reliable sources of psycho-social and practical support. Mr. Doe has concrete ideas of where he would like his life to go, including established career and education goals. Mr. Doe is seriously considering registering at (name of school) to further his education. I believe that Mr. Doe has much to offer and to contribute to the larger community in a positive and productive manner.

As Mr. Doe's worker, I am able to provide him with a number of supports and referrals. This support includes assistance with housing, connecting to an HIV primary care physician, ID replacement and ongoing support counselling in addition to other supports. In addition to the support PASAN will provide, we work with a number of community agencies that are part of the support network for people living with HIV/HCV throughout (insert province/city). These agencies provide supports such as therapeutic counselling, alternative therapeutic treatments and supportive housing for people living with HIV/HCV.

If you have any questions, please contact me at the office at this number, 123-456-7890.

Yours truly,

Your name, position and agency

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.

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.

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 service, 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. Once you do this, your agency will be expected to offer this to all your incarcerated clients, making space and cost a substantial problem.

Handling Money

Since your clients are 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.

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 (partic-

ularly 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.

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.

Chapter 4 Further Reading

Guidelines for Advocacy, The Canadian Association of Elizabeth Fry Societies, 2000.

HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response, United Nations Office on Drugs and Crime, World Health Organization and the Joint United Nations Programme on HIV/AIDS, 2006.

CELL COUNT, PASAN. This quarterly publication is written and edited primarily by prisoners and ex-prisoners themselves and is the only newsletter in Canada providing an uncensored forum for prisoners.

Under the Skin: A People's Case for Prison Needle and Syringe Programs, Canadian HIV/AIDS AIDS Legal Network, 2010.

Clean Switch: The Case for Prison Needle and Syringe Programs in Canada, Canadian HIV/AIDS Legal Network, 2009.

5

CHAPTER 5 Release Support – Before, During and After

What to Expect

When you get the good news that your client is being released, you may think that her or his 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 will experience psychological upheaval and social dislocation. Most likely, your client will need your support more than ever.

While the client's old environment was completely structured and controlled, her or his new one will be overwhelming and unpredictable. Where the prison environment was slow moving and excruciatingly boring, the outside world can seem too fast and over-stimulating. In prison, people are told when to get up, when to eat, when to take medications and when to go to sleep. They were housed, food was prepared and medicines were provided. Newly released people must now find a place to live, cook for themselves, remember their own medications and keep appointments. If clients will be returning to a city, they must re-adjust to large crowds, public transit, technology that they have never seen, etc.

There are likely to be significant changes and new responsibilities that may confront and confuse your client. As a worker, your goal is to assist your clients with the necessary preparations for such challenges – including the mental and emotional challenges they may face as a result of their new environments and responsibilities. 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, individuals' needs change after their release, and they no longer feel it necessary to access specific HIV or HCV 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.

It is important to understand that the social life of recently released people is a complete change from the prison environment. They will be separated from the support of an established circle of friends left behind in prison. The social codes people grew accustomed to on the inside will not always apply on the outside. The individual who

Chapter Overview:

This chapter describes the various services and supports you can provide to your clients as they approach their release date, to help make those first few days a bit less stressful and their transition less overwhelming. We'll also review things that your agency can do to become more accessible to the unique needs of people who have been incarcerated. And we'll look at how you can facilitate their reintegration and continued use of your services.

Post Incarceration Syndrome (PICS)¹

Post Incarceration Syndrome (PICS) is a serious illness that can have significant consequences and challenges for prisoners who have dealt with prolonged incarceration. At the time of publication, this syndrome was not adequately recognized by Correctional Service Canada (CSC) and, for those prisoners who were dealing with the early symptoms of PICS, their resulting behaviours were often dealt with in a punitive manner by Corrections staff.

PICS is a set of symptoms observed with incarcerated and recently released prisoners that can result from prolonged incarceration. According to the research of Terence Gorski, the severity of symptoms is related to the level of coping skills prior to incarceration, the length of incarceration, the restrictiveness of the incarceration environment, the number and severity of institutional episodes of abuse, the number and duration of episodes of solitary confinement, and the degree of involvement in educational, vocational and rehabilitation programs.

Following is a brief explanation of the five mental disorders that represent PICS as written by Gorski.

1. **Institutionalized Personality Traits:** resulting from the common deprivations of incarceration, a chronic state of learned helplessness in the face of prison authorities, and anti-social defences in dealing with a predatory prisoner milieu.
2. **Post-Traumatic Stress Disorder (PTSD):** from both pre-incarceration trauma and trauma experienced within the institution.
3. **Anti-social Personality Traits (ASPT):** developed as a coping response to institutional abuse and a predatory prisoner milieu.
4. **Social-Sensory Deprivation Syndrome:** caused by prolonged exposure to solitary confinement that radically restricts social contact and sensory stimulation.
5. **Substance Use Disorders:** caused by the use of alcohol and other drugs to manage or escape the PICS symptoms. PICS often coexists with substance use disorders and a variety of affective and personality disorders.

Institutionalized Personality Traits – Institutionalized Personality Traits are caused by living in an oppressive environment that demands: passive compliance to the demands of authority figures, passive acceptance of severely restricted acts of daily living, the repression of personal lifestyle preferences, the elimination of critical thinking and individual decision-making, and internalized acceptance of severe restrictions on the honest self-expression thoughts and feelings.

Post-Traumatic Stress Disorder (PTSD) – Post-Traumatic Stress Disorder (PTSD) is caused by traumatic experiences both before incarceration and institutional abuse during incarceration that includes the six clusters of symptoms: (1) intrusive memories and flashbacks to episodes of severe institutional abuse; (2) intense psychological distress and physiological reactivity when exposed to cues triggering memories of institutional abuse; (3) episodes of dissociation, emotional numbing and restricted affect; (4) chronic problems with mental functioning that include irritability, outbursts of anger, difficulty concentrating, sleep disturbances and an exaggerated startle response; and (5) persistent avoidance of anything that would trigger memories of the traumatic events; (6) hyper-vigilance, generalized paranoia and reduced capacity to trust caused by constant fear of abuse from both correctional staff and other inmates that can be generalized to others after release.

Anti-social Personality Traits – Anti-social Personality Traits are developed both from pre-existing symptoms and symptoms developed during incarceration as an institutional coping skill and psychological defence mechanism. The primary anti-social personality traits involve the tendency to challenge authority, break rules and victimize others. In those observed with PICS, these tendencies are veiled by the passive-aggressive style that is part of the institutionalized personality. Those with PICS tend to be duplicitous, acting in a compliant and passive-aggressive manner with therapists and other perceived authority figures while being capable of direct threatening and aggressive behaviour when alone with peers outside of the perceived control of those in authority. This is a direct result of the internalized coping behaviour required to survive in a harshly punitive correctional institution that has two sets of survival rules: passive aggression with the guards, and actively aggressive behaviour with predatory inmates.

Social-Sensory Deprivation Syndrome – The Social-Sensory Deprivation Syndrome is caused by the effects of prolonged solitary confinement that imposes both social isolation and sensory deprivation. These symptoms include severe chronic headaches, developmental regression, impaired impulse control, dissociation, inability to concentrate, repressed rage, inability to control primitive drives and instincts, inability to plan beyond the moment, inability to anticipate logical consequences of behaviour, out of control obsessive thinking and borderline personality traits.

Reactive Substance Use Disorders – Prisoners who experience PICS may also suffer from the symptoms of substance use disorders. Many were addicted prior to incarceration, did not receive treatment during their imprisonment, and continued their addiction by securing drugs while in prison. Others developed their addiction in prison in an effort to cope with the PICS symptoms and the conditions causing them. Others relapse to substance abuse or develop substance use disorders as a result of using alcohol or other drugs in an effort to cope with PICS symptoms upon release from prison.

1. Gorski, Terence. "Post Incarceration Syndrome and Relapse." The Addiction Web Site of Terence T. Gorski, 2002. Nov 2010 <http://www.tgorski.com/criminal_justice/cjs_pics_&_relapse.htm>.

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/HCV, mental health or other serious health issues piled on top of all these adjustments, things can easily spin out of control for a person recently released.

TIP: When someone is released from prison, the first 24 to 48 hours is often stressful and overwhelming. It can take weeks, months or even years for people to resettle themselves comfortably on the outside. Some people never do and they may be re-institutionalized, being unable to function outside of the prison environment - they go through what is called a revolving door, in and out of prison. With your client’s written consent, try to involve other organizations in building a pre-release plan. While some of the elements of the plan?? specifically relate to health, many others do not, and may be taken on by other community-based groups. Do not try to do it all on your own.

Pre-Release Planning

Pre-release planning is one of the most important ways that community workers can help smooth a client’s transition from prison to the community. 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 the planning ahead for the client’s release often falls primarily or solely upon community workers.

For those prisons that 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/HCV. In these cases, community-based support workers have an important contribution to make. Most provincial prisoners do not receive any help in pre-release planning. Although there are discharge planners and social workers at some provincial prisons, there are clearly not enough individuals who are able to help the large numbers of prisoners being released into the community. This means that many prisoners are released from provincial prisons without proper clothing (they leave with what they came in with and it doesn’t matter if they were wearing summer clothes and now it’s winter). There is no legal obligation on behalf of the Ministry to provide appropriate clothing for the season. “There are significant challenges involved with making it back to one’s home community without the additional worry and health concerns connected to travelling without a winter coat for example in February.”²⁹

Your goal should be to establish support structures for your clients prior to their release, such as housing, financial and medical support. By establishing these supports, you can sig-

nificantly increase your clients’ security and stability with their daily living.

Elements of a Pre-Release Plan

If you have clients who are 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 (e.g. 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 that person and offer to assist. Be sure to find out first whether the client has disclosed her or 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.

Correctional staff charged with pre-release planning can be quite open to working with community-based groups and will likely be grateful for your involvement – and particularly for your HIV/HCV expertise. Whether it is just you and the client working together, or you are working in conjunction with prison staff, the necessary elements of a pre-release plan are the same:

1. **housing**
2. **clothing**
3. **financial assistance**
4. **identification**
5. **medications**
6. **access to a doctor**
7. **a buddy**

Housing

Housing is a primary issue for people when they get out. A person needs, first, a stable and safe place to live. Many prisoners may have been homeless or under-housed prior to their arrest. Some may have been renting an apartment or house that 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 friends who use drugs, 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.

Trans 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.

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 refuse to take in people with a criminal record (especially those with a record of violence). Some housing providers are rejecting applications from ex-prisoners due to the perceived risk of increased workplace violence for the housing workers. The Ontario Occupational Health and Safety Act was amended to include language for the prevention of violence in the workplace. PASAN's experience is that since this amendment was introduced in 2010 there has been an increase in the rejection of housing applications. It is possible that some housing providers are associating ex-cons with the potential for violence.

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.

TIP: Consider offering release kits:

- non-perishable foods and snacks

- seasonal-appropriate clothing and footwear
- access to basic housing needs such as linens, soap, kitchen supplies
- safer sex materials (including condoms, lubricant, female condoms and dental dams)
- harm-reduction materials and supplies (including safer crack kits, syringes, vitamin C, alcohol swabs, tourniquet, filters and information on syringe programs in their area of release)
- transit tokens
- transportation assistance from the prison upon release
- financial assistance
- information on HIV, AIDS and HCV
- a list of phone numbers for community health centres and support organizations



Peter Collins

Clothing

Some jurisdictions will release people with only the clothes they were wearing when arrested. If they were arrested in August – wearing shorts, sandals 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 or him clothes to wear when she or 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. Appropriate clothing is critical not only for weather and seasonal conditions. Unfortunately people are sometimes judged by their clothing – think about the perception formed in court by a judge when a client is poorly dressed or is wearing old, outdated or dirty clothing. Those who do not have adequate housing or are homeless may not have access to laundry facilities. Consider how to best support your client's clothing needs – access to clean and appropriate clothing is important for daily living.

Financial Assistance

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 are unable to access support from social assistance before Monday. Even when people are released mid-week, it can often take 24 to 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 social assistance appointment for the person on the morning or afternoon they are released. If you are fortunate enough to know a helpful social assistance 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/HCV, 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.

Identification (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, social insurance numbers (SIN cards) and health cards. This obviously poses enormous problems for clients 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. Birth certificates and SIN cards are the first step. Find out the process for replacing them in your province, obtain the necessary 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 pick up new ID at your office at a later time. There is usually a fee associated with replacing birth certificates and SIN cards. If your agency provides financial assistance to clients, this is a useful grant to make.

TIP: 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. Find out whether your client has any ID. If he or she tells you the police have it, assume it's gone. If the client needs new ID, he or she 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.

Medications

If your client is on any medications, it is important that being released does not cause an interruption in any therapies. Contact the prison healthcare unit to ensure that the person will be released with an appropriate supply of medication. More and more prison health units are now doing this as a matter of routine for HIV-positive prisoners.

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 she or he is released in order to get a prescription. Your client will also need to obtain a drug card from social assistance in order to have his or her medication dispensed.

A Doctor

Once you've arranged for the client to be released with a small supply of medications, it's important that he or she sees a doctor before that supply runs out. If your client already has a doctor in the community, call ahead and make an appointment for as soon as possible after the release. If the client does not have a doctor, set up an appointment with a local 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 or pharmacy, as this will increase the continuity of care (particularly if the person will be seeing a new doctor). Some physicians are very reluctant or will 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 clients need 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. For clients on methadone, find out if there was a methadone provider prior to incarceration; if there wasn't, talk to the social worker/release planner/parole officer in the institution to make sure that is set up before release.

TIP: Identify physicians and/or community health centres in your region that are willing to see patients without health cards or whose 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 will accept your client without a health card, at least as an interim measure.

A Buddy

Having a buddy to act as a guide or helper during the first few days, weeks or months 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

Example of a Pre-Release/Release Form
 For use by the HIV/HCV worker (Prompting Questions)

Client Name:		Today's Date:
Name of Staff Person Completing this Form:		
Date of Release (Provincial):		Date of Stat Release/Parole date (Federal):
Current Status in Canada:		
Do you have the following ID? (If yes, where is it presently located?)		
Birth Certificate	<input type="checkbox"/> Yes	<input type="checkbox"/> No
S.I.N. Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No
License	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Passport	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Housing:		
What city/town will you be living in?		
Will you need support finding housing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever applied for supportive housing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently on any waiting lists?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever lived in supportive housing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Financial Support:		
Have you ever received O.D.S.P (F.B.A)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever received O.W. (Welfare)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever received CPP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical:		
Did you have a doctor prior to being in prison? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list the doctor's name, telephone number and address.		
What medications are you taking? If possible get the list from health care.		

Example of a Pre-Release/Release Form

For use by the HIV/HCV worker (Prompting Questions) continued

What personal supports do you currently have in place?

Are you working with any other agencies? Yes No

If yes, list which agencies and the name(s) of the worker(s):

Will you need/require drug treatment? Yes No

Will you need/require methadone treatment? Yes No

Will you need/require relapse prevention programs? Yes No

Is there anyone you would like to include in your release plan? Yes No

If yes, name whom would you like included. We need you to sign a release of information form.

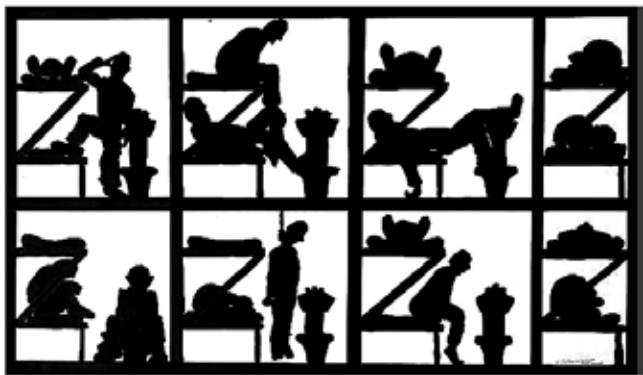
What additional information do you need us to know or what comments you would like to make?

Example of a Pre-Release Checklist

For your client

- Do I know where I am going to live?
- Do I know how to get subsidized housing?
- Do I have a list of local agencies/organizations that can help me? Do I know where they are located and do I have their phone numbers?
- Do I have appropriate identification? Social insurance number, birth certificate, health card, etc.?
- Do I know where to get financial help?
- Do I have a "buddy" or reliable friends that will be able to help me?
- Do I need to get information about government programs (e.g. disability pension, welfare, etc.)?
- Do I know when I will have medical coverage and how to apply for it?
- Do I have a doctor outside? If not, do I know how and where to get a doctor?
- Will I need medications when I am released? If so, how will I pay for them?
- How will I get the emotional, spiritual support needed once I am out?
- Do I know how and where to get professional help (e.g. counselling, therapy, rehabilitation, work skills, job search, etc.) when I get out?
- Do I know what type of social support I need? Do I know how and where to get this type of support?
- Do I have what I need to practice safer sex? Do I know where to go to obtain free supplies?
- Do I know how to access the food bank?
- Do I know how to access the needle distribution program?

Write a list of other items and supports that you may need:



Peter Collins

Taking Medications

Remembering to take medications on time can be a daily struggle. This is often even 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 clients ahead of time. Discuss strategies to help clients remember to take their medications, and talk about ways that you and/or your agency can help.

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 he or she has any friends or family members he or she would trust to fill this role.

Common Adjustments for Ex-Prisoners and Their Support Agencies

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 in staying of prison for the medium and longer term.

Below are some common difficulties affecting ex-prisoners, and some suggestions for you and your agency to better support your clients who will be accessing your services.

Keeping Appointments

You may find that ex-prisoners have real difficulties in keeping set appointments with you. When recently released clients miss their appointments, 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.

If your clients are having trouble in this regard, talk to them about strategies that might make it easier to remember their appointments. If your agency has set days or times for drop-in, you might suggest that clients try to come during those times, to allow them more flexibility on arrival time.

TIP: Women ex-prisoners may have specific support needs when they are released from prison, such as dealing with abusive partners, negotiating safer sex practices, obtaining custody or access to their children from government children agencies or family members. It is useful to develop contacts with groups providing support specific to women. This will assist you in making appropriate referrals for women ex-prisoners.

Making 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.

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 most 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

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. By volunteering, ex-prisoners 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. Volunteering can provide a boost to their self-esteem and can also provide another outlet for them to access regular peer support from other clients. 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.

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 and HCV prevention education prison programs, an ex-prisoner group could also provide a pool of potential recruits.

Going Back to Jail

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. 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 individual and the best efforts of support workers. It is essential that we recognize this struggle within its proper social context and continue to maintain supportive, non-judgmental relationships with our clients, whether inside or out.

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 burnout. 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, 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 timing 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".

For the individuals who have 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 they stayed out for as long as they did. We should not underestimate or diminish the courage and determination it took them to accomplish that much. If this is recognized and supported as a major step in these people's lives, it can be significant in helping them to stay out longer the next time.

Chapter 5 Further Reading

CELL COUNT, PASAN. This quarterly publication is written and edited primarily by prisoners and ex-prisoners themselves and is the only newsletter in Canada providing an uncensored forum for prisoners.

2. "First Report to the Board: The Superjails in Ontario." John Howard Society of Ontario, 2006. Prepared for the Standing Committee on Prison Conditions in Ontario.

Conclusion

PRISONERS LIVE UNDER CONDITIONS THAT are strictly controlled by the institution. Because HIV- and HCV- positive prisoners have enhanced needs, any existing systemic barriers to care and services can potentially threaten their health. HIV- and HCV - positive prisoners live in an environment that is generally stressful, potentially hostile and isolating. Prisoners who are HIV-positive are often feared and ostracized by prisoners and staff members alike due to the high levels of AIDS-phobia. The challenges of HIV in the prison environment require a strategic and coordinated approach from community-based agencies. Stigma, which is such a significant barrier to personal acceptance for people living with HIV, is magnified dramatically in the prison environment. Without access to proper supports and services, the physical as well as mental health of prisoners living with HIV will deteriorate. Although similar situations of isolation exist for prisoners living with HCV, the barriers are more likely to be compounded by misinformation than by high levels of stigma. With rates of HCV skyrocketing in the prison environment, it is this misinformation that is the real issue for concern amongst healthcare providers and educators.

There is an urgent need for more focused and culturally appropriate prison programs that reach marginalized populations – those most affected by and at risk for HIV and HCV. Active intervention, health promotion, education, prevention, comprehensive assessment options, provision of harm-reduction resources, supported treatment and coordination of services needs are recommended as priorities for agencies who offer programs to prisoners, including ex-prisoners and to clients post-release.

We hope that this book has given you some guidance for providing concrete education programming, support services, care and treatment, and advice on negotiating and advocating on behalf of your imprisoned clients. For further assistance or to obtain training support for your organization, contact Prisoners with HIV/AIDS Support Action Network (PASAN).

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