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HARM REDUCTION

FOR SPECIAL POPULATIONS IN CANADA

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Harm reduction policies and programs for persons involved in the criminal justice system

Gerald Thomas, Ph.D., May 2005

This document is intended to provide current, objective and empirically-based information to inform the implementation of policies and programs for promoting the reduction of harms associated with substance abuse in Canada.

This is one in a series of documents on harm reduction for special populations in Canada. The series comprises the following titles:

1. *Harm Reduction Policies and Programs for Persons Involved in the Criminal Justice System*
2. *Harm Reduction Policies and Programs for Youth*
3. *Harm Reduction Policies and Programs for Persons of Aboriginal Descent*
4. *Harm Reduction Policies and Programs for Persons with Concurrent Disorders*

Reducing Harms

Harm reduction is a health-centred approach that seeks to reduce the health and social harms associated with alcohol and drug use, without necessarily requiring that users abstain. Harm reduction is a non-judgmental response that meets users "where they are" with regard to their substance use rather than imposing a moralistic judgment on their behaviours. As such, the approach includes a broad continuum of responses, from those that promote safer substance use, to those that promote abstinence.

The following are features of harm reduction:

- Pragmatism: Harm reduction accepts that some use of psychoactive substances is inevitable, and that some level of substance use is expected in a society.
- Humane Values: The substance user's decision to use alcohol and other drugs is accepted as his or her choice; no moralistic judgment is made, either to condemn or to support use of substances, regardless of level of use or mode of intake. The dignity and rights of the person who uses alcohol and other drugs are respected.
- Focus on Harms: The extent of a person's substance use is of secondary importance to the harms resulting from that use.
- Hierarchy of Goals: Most harm reduction programs have a hierarchy of goals; the most pressing needs are addressed first.[1]

The harms associated with substance use and abuse can include dependence, chronic and acute health problems, accidents, aggression and violence, alcohol and drug-related crime, overdose, public nuisance and contribution to the spread of infectious diseases such as HIV/AIDS and hepatitis C.

In addition, harms that arise from the criminalization of substance abusers include disenfranchisement, exclusion from housing and education, restrictions on travel, and the health and social effects of imprisonment. These "enforcement-related harms" are especially problematic where the punishment is perceived to be disproportionate to the crime, such as in the case of criminal sanctions for the possession of small amounts of cannabis for personal use.

The following are examples of harm reduction policies and programs:

- provision of sterile injection equipment to severely dependent intravenous drug users to reduce the spread of blood-borne diseases
- distribution of controlled quantities of alcoholic beverages to chronic alcoholics in homeless shelters to curtail the ingestion of non-beverage alcohol products
- provision of drug-involved arrestees with information on safer drug use
- amendment of the penalties for cannabis possession to remove criminal sanctions.

The Role of the Criminal Justice System

Although some aspects of harm reduction can be seen as being at odds with the enforcement and prosecution of existing drug laws, the criminal justice system can play an important role in promoting programs and policies that reduce harms for people who abuse substances. It is important to note that drug offence rates reached an all-time high in Canada in 2002, with almost 93,000 charges recorded under the *Controlled Drugs and Substances Act*.[2] Furthermore, approximately three out of four prisoners in Canada are assessed as having issues related to substance abuse. This means that enforcement officers and other elements of the criminal justice system have a significant amount of contact with people who use and misuse substances. Therefore, they are well placed to assist in the implementation of policies and programs designed to reduce harms in this segment of the population.[3]

In addition, research has shown that a large number of prisoners in both federal and provincial correctional facilities in Canada are dependent on alcohol and other drugs (see below). While every effort is made to enforce the legal condition of abstinence within our jails and prisons, the fact is that some federal and provincial prisoners consume alcohol and other drugs while incarcerated. This means that correctional staff and administrators have significant opportunities to implement policies and programs to reduce harms among substance-abusing prisoners in their care.

To provide context, the prevalence of substance use, risky behaviours and infectious diseases in Canadian correctional facilities is described below.

Substance Abuse in Canadian Federal Correctional Facilities

Approximately 70 to 80% of prisoners in the federal correctional system in Canada are assessed as having problems with alcohol and/or drugs.[4] Researchers estimate that 38% to 44% of male inmates are dependent on at least one psychoactive substance (including alcohol).[5] Random urinalysis in federal prisons reveals that an average of 12% of prisoners tested positive for drug and alcohol use in 2000. Cannabis (9.32% of prisoners who were tested) and opiates (1.19% of prisoners who were tested) were the most common substances detected.[6] Furthermore, in the Federal Inmate Survey carried out by Correctional Service Canada (CSC) in 1995, 40% of the 4,285 federal inmates surveyed indicated that they had used drugs or alcohol while incarcerated in their current prison.[7]

Risk Behaviours in Federal Correctional Facilities

Injection Drug Use. Data collected at intake from 7,105 federal inmates between 1995 and 1997 indicate that 18.3% of male federal prisoners self-reported having injected drugs prior to incarceration. More than one-third of these (38.7%) reported having shared injection equipment with other drug users at some point in the past. In the 1995 Federal Inmate Survey (4,285 people were surveyed), 11% of male prisoners reported that they had injected drugs while incarcerated. Of these, 41% stated that their equipment was either not clean or that they didn't know if it was clean at the time of use.[8]

Tattooing and Piercing. In the 1995 Federal Inmate Survey, 45% of male inmates reported having acquired a tattoo while incarcerated, and 17% reported having had a piercing. Approximately 25% of those who received tattoos stated that they were unsure whether the tattooing equipment used was safe and clean.[9]

Unprotected Sex. Six percent of male prisoners in the federal correctional system in Canada reported having sex with other inmates while incarcerated. When asked about their use of condoms, only about 33% reported engaging in protected sex.[10]

Risk Behaviours Among Federal Female Prisoners. High-risk behaviours are also common in federal women's correctional facilities in Canada. In a recent study in which approximately 40% of federal female prisoners in Canada were interviewed, 19% reported that they were involved in injection drug use, 27% said they were involved in tattooing, 16% stated they were involved in body piercing, and 24% reported engaging in unprotected sex. In addition, 9% of women reported engaging in "slashing" or other forms of self-injury.[11]

Infectious Diseases in Canadian Correctional Populations

Prison drug use and the related harms of communicable diseases are now major public health concerns worldwide. This is because almost all prisoners eventually return to the community, and therefore those with communicable diseases can pose significant health risks to the general population. Two diseases are of particular concern in Canadian prison populations: HIV/AIDS and hepatitis C.

The overall rate of HIV infection of inmates in the federal correctional system (1.7%) is over 10 times higher than the rate in the general Canadian population (0.13%).[12] Rates of HIV infection are especially high among federal female inmates; reported rates are over 8% in the Prairie Region. The number of reported cases of HIV/AIDS in the federal correctional system in Canada rose from 14 in January 1989 to 159 in March 1996 to 233 in December 2001. In provincial prisons in Quebec, BC and Ontario, studies have determined that HIV infection rates, which range from 1.0% to 7.7%, are 10 to 60 times higher than in the general Canadian population.

Rates of hepatitis C (HCV) infection among Canadian federal inmates are even higher than those for HIV. The overall prevalence rate (23.6%) is more than 20 times higher than in the general Canadian population (0.8%). Overall rates of HCV infection are much higher for female inmates (41.2%) than male inmates (23.2%). The number of new HCV cases reported by Correctional Service Canada has remained relatively steady since 2000, ranging from 533 to 570 new cases a year.

Examples of Harm Reduction Measures for Persons Involved in the Criminal Justice System

The main argument against promoting harm reduction measures for substance abusers within the criminal justice system is that it would send the "wrong message" and make substance use more socially acceptable. In spite of this challenge, harm reduction policies and programs have found their way into some criminal justice settings in Canada and around the world. The following are examples of criminal justice-based policies and programs designed to reduce harms among substance abusers involved with the criminal justice system.

Implementation of referral policies by enforcement officers for alcohol- and drug-involved arrestees

The Arrest Referral Program, which was implemented in the United Kingdom in 2000, is an excellent example of a criminal justice-based harm reduction program for those who use and misuse substances. Arrest Referral places specially trained substance abuse assessment workers in police stations to counsel and refer substance abusing arrestees who voluntarily request assistance with their substance-related problems. In its first year, the Arrest Referral Program screened approximately 49,000 arrestees and directed almost 25,000 alcohol- and drug-involved individuals to specialized treatment programs throughout the United Kingdom.[13] To improve its response to arrestees who indicate a willingness to address their substance abuse issues, Arrest Referral is now integrating a number of support and counselling services under a comprehensive and sustained "case management" approach.[14]

Creating drug treatment courts to divert non-violent offenders from jail/prison and into substance abuse treatment

Specialized courts for dealing with drug-involved offenders first appeared in the late 1980s in the United States to deal with prison overcrowding and escalating prison costs at the state level. Typically, drug treatment courts combine court-mandated supervision with community-based substance abuse treatment, and offer these services to offenders as an alternative to incarceration.

In 1994, 12 drug treatment courts were operating in the United States. Today there are approximately 1,100, with over 400 more in the planning stages.[15] Drug treatment courts have also been established on a more limited basis in Australia, Ireland, the United Kingdom and several other countries.

Canada currently has two drug treatment courts, one in Toronto (in operation since 1998) and the other in Vancouver (opened in December 2001). They offer court-supervised treatment as an alternative to incarceration for non-violent drug prisoners who voluntarily agree to enter the program.[16] In May 2003, the Government of Canada indicated that it would allocate $23 million over five years to support the Vancouver and Toronto drug treatment courts, and to establish several new courts around the country.[17]

Altering enforcement policies and protocols to reduce harm among drug users

In Vancouver, police procedures were recently changed so that enforcement officers no longer "routinely" respond to overdose ambulance calls. They now attend only if ambulance personnel ask them to.[18] This policy has been shown to reduce the risk of overdose deaths, because drug users are more likely to call for assistance if they know that police are not likely to be at the emergency scene.[19]

Thus, it is important to inform drug users of this sort of policy so they will be more likely to call for assistance in drug overdose emergencies. Although enforcement officers' choice to not attend is one policy change that can improve the likelihood of a timely call for aid, it is just as important that police use discretion in the treatment of substance users at the overdose events they do attend. This will improve their relationship with community members who use drugs.

A second enforcement practice that can promote harm reduction is the use of discretion when policing around harm reduction facilities such as methadone clinics, needle exchanges and safe injection sites. Often these types of harm reduction establishments have strict rules prohibiting the selling of illicit substances on or near the premises. These rules make it easier for enforcement interests to treat these areas as "tolerance zones" with regard to simple possession when drug dealing is less likely to occur.[20]

Giving drug users information on safer drug use practices and drug potency and purity

Given the significant amount of contact that enforcement officers have with those who abuse substances, police are well positioned to provide at-risk substance users with information on safer drug use practices.[21] This information can include everything from pamphlets showing how to sterilize injection equipment, to the location of local harm reduction services, such as needle exchanges. Additionally, due to the frequent testing of seized substances, police often have the most up-to-date and reliable information on the potency and purity of illicit drugs available on the street. When a particularly potent or dangerously impure drug is detected in official testing protocols, police can issue public warnings directed at drug users, thereby reducing the chances of accidental overdoses and poisonings.[22]

Removing the requirement of abstinence as a condition of participation in drug or alcohol treatment programs in prison or while on parole

In traditional approaches to substance abuse treatment, candidates must abstain from drugs and alcohol if they want to participate in a program. One of the most practical applications of harm reduction in the treatment domain, however, is the removal of abstinence as a condition of participation in substance abuse treatment programs. In Correctional Service of Canada (CSC) programs, for example, prisoners are not normally excluded from participating in substance abuse treatment unless their substance use becomes disruptive to the program.[23]

In addition to not requiring abstinence for participation in substance abuse programming, it is also sometimes useful to allow prisoners to set moderated or safer use as their treatment goal. CSC research has shown that prisoners whose treatment goal was to reduce their use of alcohol were reconvicted for new offences at a significantly lower rate than those who attempted to remain abstinent after their release from prison.[24]

Indeed, harm reduction is listed as a "theoretical influence" in CSC's recent efforts to modernize programs for substance-using female prisoners in Canada. It was determined that internalizing strategies to reduce substance use, or reduce the harms associated with substance use, were relevant for some women prisoners as they moved into more empowered and responsible lifestyles.[25]

Disregarding positive results for cannabis use in parolee urinalysis unless the drug use is directly connected to the offender's criminality

A hierarchy of goals and priorities is one of the principles of harm reduction. This translates into a need to differentiate substances according to the health and social harms they generate.

Research has shown that the harms associated with cannabis use are probably less than those associated with alcohol, especially for harms associated with aggression and violence.[26] Due to the relatively low harm potential of cannabis, some correctional jurisdictions have proposed limiting routine testing for cannabis use in urinalysis programs administered to prisoners under supervision in the community. This policy change would be directed at reducing enforcement-related harms, in that ex-prisoners whose cannabis use was not directly associated with their criminality would be allowed to stay in the community rather than having their parole revoked for a technical violation related to illegal substance use.

For example, CSC circulated a report to wardens and other senior prison staff in December 2001 proposing that positive tests for cannabis use among parolees be assessed with discretion unless the use directly raised the risk profile of the offender.[27] This type of policy change could be significant to the operation of parole in Canada, since approximately 80% of prisoners released from federal facilities have parole conditions requiring abstinence from alcohol, illicit drugs or both.[28] To date, though, CSC has not removed cannabis from the list of substances routinely tested for in its community urinalysis program.

Providing bleach to inmates for sterilizing injection equipment

When used properly, bleach has been shown to effectively sterilize used syringes and prevent the spread of HIV among intravenous drug users.[29] Numerous prisons around the world (including facilities in Scotland, Germany, France, Denmark, Finland, Greece, Italy, Australia, Switzerland, Belgium, Luxembourg, and the Netherlands) provide bleach to inmates explicitly to clean injection equipment.[30] Significantly, no prison that has agreed to provide bleach to inmates for the sterilization of injection equipment has ever rescinded that policy.[31]

As of September 2002, all prisons administered by Correctional Service Canada and the provinces of British Columbia and Quebec provided bleach to inmates explicitly as a harm reduction measure. Table 1, below, depicts the availability and accessibility of bleach in Canadian correctional systems as of 2002.

Table 1: The Availability and Accessibility of Bleach in Canadian Prisons, 2002[32]

Jurisdiction	Bleach Available	Bleach Accessible
Alberta	N	0
British Columbia	Y	4
Federal (CSC)[33]	Y	2
Manitoba	N	0
New Brunswick	N	0
Nfld. and Labrador[34]	Y	4
Northwest Territories	N	0
Nova Scotia	N	0
Nunavut	N	0
Ontario	N	0
PEI	N	0
Quebec	Y	2
Saskatchewan	N	0
Yukon	N	0

*Accessibility scored from 0 to 4 based on ease of access and discreetness of dispensing practices.

Providing methadone maintenance therapy to opiate-dependent inmates and parolees

Methadone maintenance treatment (MMT) is the current "gold standard" for treating substance abusers dependent on opiates such as heroin and morphine. Methadone is a synthetic drug that acts as a replacement for opiates in the body and thus can greatly lessen withdrawal symptoms and cravings. At higher doses, methadone also reduces the euphoric effects of opiates, thus further protecting dependent persons against relapse.[35]

In 1993, the World Health Organization issued guidelines for addressing the spread of HIV/AIDS in correctional facilities. The guidelines recommended the provision of methadone maintenance treatment for incarcerated populations.[36] Several prisons (including correctional facilities in Canada, the United States, Germany and Australia) now offer methadone therapy to opiate-dependent prisoners.[37]

As late as 1996, no correctional jurisdiction in Canada provided methadone to incarcerated prisoners.[38] By 2002, however, most correctional jurisdictions in Canada had made methadone treatment available to opiate-dependent prisoners. Table 2 shows which Canadian correctional jurisdictions, as of September 2002, allowed the *continuation* of MMT for prisoners who entered jail or prison while under treatment, as well as those that allowed prisoners to initiate treatment while incarcerated.

Table 2: Availability of MMT in Canadian Prisons, 2002[39]

Jurisdiction	Continuation of MMT	Initiation of MMT
Alberta	Yes[40]	No
British Columbia	Yes	Yes
Federal (CSC)	Yes	Yes
Manitoba	Yes[41]	No
New Brunswick	Yes	No
Nfld. and Labrador	No	No
Northwest Territories	Yes	No
Nova Scotia	Yes	No
Nunavut	No	No
Ontario	Yes	Yes[42]
PEI	No	No
Quebec	Yes	Yes
Saskatchewan	Yes	Yes[43]
Yukon	Yes	Yes

Providing sterile injection equipment (syringes) in jail/prison

Syringe exchange programs have been shown to reduce needle sharing among intravenous drug users, and thus to lower the risk of HIV and HCV transmission.[44] Since 1992, prison-based needle exchange programs have been established in correctional facilities in Switzerland, Germany,[45] Spain, Moldova, Kyrgyzstan and Belarus to address the rising rates of HIV and HCV infection in prison populations.[46]

An international review of operating prison-based needle exchange programs conducted in 2002 found that prison needle exchange programs:

- do not endanger staff or prisoners
- do not increase drug consumption or injection
- reduce risky injection practices and disease transmission
- have successfully employed various methods of needle distribution to meet the needs of staff and prisoners in a range of prisons.[47]

The topic of piloting prison-based needle exchange programs in Canada was first raised in a report prepared by the Prisoners with AIDS Support Action Network in 1992.[48] Since then, several governmental and non-governmental organizations in Canada have reviewed the need for prison-based needle exchanges, and have recommended the implementation of a pilot program to test their feasibility. These organizations include CSC's Expert Committee on AIDS in Prison (1994),[49] Canadian HIV/AIDS Legal Network (1996 and 2003),[50] Task Force on HIV/AIDS and Injection Drug Use (1997),[51] Prisoners with AIDS Support Action Network (1998 and 2003),[52] CSC's Study Group on Needle Exchange Programs (1999),[53] the Canadian Human Rights Commission (2003),[54] the Ontario Medical Association (2004)[55] and the Correctional Investigator (2004).[56] To date, no correctional jurisdiction in Canada provides sterile injection equipment to inmates.

Conclusion

A variety of significant policies and programs are available for reducing harms related to substance abuse among persons involved in the criminal justice system. Several points can be made to summarize this discussion.

First, several of the policies and programs discussed above have been subjected to evaluation research that attempts to demonstrate their effectiveness for reducing harms among those who use and abuse substances. These include the Arrest Referral Program,[57] drug treatment courts,[58] altering police protocols so that enforcement officers don't routinely attend overdose ambulance calls,[59] provision of bleach in prison,[60] provision of methadone maintenance therapy to incarcerated persons,[61] and provision of sterile injection equipment to inmates.[62] These evaluations are of various degrees of sophistication,[63] however. Every effort should be made to apply methodologies that result in meaningful assessments so that the most effective and efficient policies and programs can be identified from the evidence.

While the remaining policies and programs discussed above have potential for reducing harms among persons involved in the criminal justice system, some have not been widely implemented (for example, routine provision of information on drug purity and quality to drug users). They should, therefore, be subjected to rigorous evaluations to ensure that they are effective for reducing health or social harms. Although systematic evaluation studies are relatively rare in the criminal justice field, such studies are invaluable for identifying best practices and ensuring the most efficient use of resources.

Less obvious from this review is the extent to which enforcement interests around the world are capitalizing on the potential to reduce harms among substance users involved in the justice system. Given the significant amount of contact between people who use and misuse psychoactive substances and the criminal justice systems worldwide, it is likely that the potential to reduce health and social harms in these vulnerable and hard-to-engage populations is only beginning to be realized.

While some of the programs and policies described above are being innovatively applied in a few places in the world, realization of the full potential for reducing harms among substance users will depend on 1) the use of evidence to identify which policies and programs are effective at reducing harms, and 2) the diffusion of best-practice policies and programs to criminal justice systems that are open to implementing them.

The beliefs and culture that dominate in most criminal justice systems around the world will be challenged by the move to implement policies and programs for reducing harms among substance abusers. Nevertheless, the diffusion of policies and programs for reducing harms among substance abusers will continue to be a slow process as long as substance abuse continues to be viewed predominantly as a criminal justice rather than a health issue. The importance of education and training in bringing about the necessary "culture shift" for people working in the criminal justice system cannot be overstated.[64] Support for these shifts must be maintained at the highest levels of management, and they must be sustained over time in order for them to be fully implemented at all levels of operation.[65]

One positive event in this process is the recent addition of a "law enforcement and harm reduction" stream at the annual International Conference on the Reduction of Drug Related Harm.[66] At the 15th annual meeting, in Melbourne, Australia, for example, at least nine panels related to this theme brought together health professionals, enforcement officers and others to discuss matters related to reducing harms for substance-abusing persons involved in the criminal justice system. Such events will be crucial for the further diffusion of evidence-based harm reduction policies and programs around the world.

Endnotes

1. Canadian Centre on Substance Abuse National Policy Working Group. (1996). Harm reduction: Concepts and practices, A policy discussion paper. Ottawa: Author.

2. About two thirds of these offences were for the possession of illicit drugs, with about 50% of the total involving possession of cannabis. See Statistics Canada. (2004). Trends in drug offenses and the role of alcohol and drugs in crime. Juristat, 24(1). Ottawa: Canadian Centre on Justice Statistics. Summary downloaded June 25, 2004, from http://www.statcan.ca/Daily/English/040223/d040223a.htm

3. The potential for law enforcement interests to advance harm reduction in Canada is enhanced by the movement toward community policing, which promotes proactive partnerships between elements of the community and enforcement officers in dealing with issues such as substance misuse.

4. Weekes, J., Moser, A., & Langevin, C. (1999). Assessing substance-abusing offenders for treatment. In J. Latessa (Ed.), Strategic solutions: The international community corrections association examines substance abuse. Lantham, MD: The American Correctional Association.

5. Pernanen, K., et al. (2002). The proportion of crimes associated with alcohol and other drugs in Canada. Ottawa: Canadian Centre on Substance Abuse.

6. MacPherson, P. (2001). Random urinalysis program: Policy, practice and research results. Forum on Corrections Research, 13(3), 54-57. Downloaded June 26, 2004, from http://www.csc-scc.gc.ca/text/pblct/forum/e133/133q_e.pdf

7. Since drug use is considered a serious infraction in prison, these self-reported estimates likely understate the true extent of substance use in Canadian prisons.

8. Correctional Service Canada. (1996). 1995 national inmate survey: Final report. Ottawa: Correctional Service Canada, Research Branch.

9. Ibid.

10. Ibid.

11. DiCenso, A., Dias, G., & Gahagan, J. (2003). Unlocking our futures: A national study on women, prisons, HIV and hepatitis C. Toronto: Prisoners with AIDS Support Action Network.. Downloaded August 24, 2004, from http://www.pasan.org/Publications/Unlocking_Our_Futures.pdf

12. The information on infectious diseases among federal inmates and risk behaviours in Canada reported here is taken mainly from Moloughney, B. (2004). A health care needs assessment of federal inmates. *Canadian Journal of Public Health*, 95(Supplement 1), S1-S63. See note 8.

13. O'Shea, J., Jones, A., & Sondhi, A. (2004). Arrest referral statistical update. UK Home Office: Drug Strategy Directorate. Downloaded October 21, 2004, from http://www.drugs.gov.uk/ReportsandPublications/Communities/1034258640

14. Sondhi, A, O'Shea, J., & Williams, T. (2002). Arrest referral: Emerging findings from the national monitoring and evaluation program. Downloaded on December 13, 2004 from http://www.drugs.gov.uk/ReportsandPublications/Communities/1034346010/ArrestReferral_DPASPaper_eighteen.pdf

15. National Drug Court Institute (2004). Drug court facts. Downloaded November 25, 2004, from http://www.ndci.org/courtfacts.htm

16. Kirkby, C. (2003). Drug courts: Who benefits? In G. Thomas (Ed.), Perspective on Canadian drug policy, Volume I. Kingston, ON: The John Howard Society of Canada. Downloaded on November 25, 2004, from http://www.iprt.ie/files/international/drug_treatment_courts_in_canada_c_kirkby.doc

17. Department of Justice Canada. (2003). The Government of Canada commits to expand drug treatment court program. News release downloaded on November 25, 2004, from http://canada.justice.gc.ca/en/news/nr/2003/doc_30914.html

18. Weibe, D.. Personal communication with author, December 15, 2004. The overdose policy was implemented on an "interim" basis on December 10, 2003, for a period of one year. As of this writing, the policy has not been made a permanent part of police protocols, but there are plans to do so in the coming weeks.

Endnotes

19. Roberts, L., & McVeigh, J. (2004). Lifeguard: Act fast and save a life. An evaluation of a multi-component information campaign targeted at reducing drug related deaths in Cheshire and Merseyside. Liverpool: John Moores University. Downloaded October 21, 2004, from http://www.hit.org.uk/dbimgs/Evaluation%20Report1.pdf

20. For a detailed description of what can occur when police use strict enforcement in proximity to facilities attempting to deliver harm-reduction services to drug users, see Kerr, T., Olsen, M., & Wood, E. (2004). Harm reduction activism: A case study of an unsanctioned user-run safe injection site. *Canadian HIV/AIDS Policy & Law Review*, 9(2):13-19. Downloaded December 14, 2004, from http://www.aidslaw.ca/Maincontent/issues/druglaws/HarmReduc_TKERR_9(2).pdf

21. Australasian Centre for Policing Research. (2000). The role of police in supporting illicit drug-related public health outcomes. Downloaded December 13, 2004, from http://www.acpr.gov.au/pdf/drugs/Illicit%20drug%20related.pdf

22. Ibid.

23. Correctional Service of Canada. (2002). Manual for the high intensity substance abuse program (HISAP). Ottawa: Reintegration Programs Division, Correctional Service of Canada.

24. Roy, M. (2001). The national drug strategy for the Correctional Service of Canada. Forum on corrections research, 13(3):5-6. Downloaded October 27, 2004, from http://www.csc-scc.gc.ca/text/pblct/forum/e133/133b_e.pdf Research first presented in Weekes, J., Moser, A., & Langevin, C. (1997). Assessing substance abusing offenders for treatment. A paper presented at the International Community Corrections Association Research Conference, Cleveland, OH.

25. Hume, L. (2001). Substance abuse programming: A proposed structure. Montague, PEI: Correctional Service Canada, Addictions Research Centre. Downloaded December 13, 2004, from http://www.csc-scc.gc.ca/text/rsrch/reports/r120/r120_e.shtml

26. Senate Special Committee on Illegal Drugs. (2002). Cannabis: Our position for a Canadian public policy, Summary. Downloaded November 25, 2004, from http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/ille-e/rep-e/summary-e.pdf

27. Malarek, V. (2002). Canada: Plan floated to ignore some prison drug use. The Globe and Mail. Saturday, May 11, 2002. Reprint of text downloaded October 28, 2004, from http://www.mapinc.org/drugnews/v02/n904/a03.html?172153

28. Couturier, P. Personal e-mail communication with the author, November 1, 2004.

29. US National Research Council Institute of Medicine. (1995). Preventing HIV transmission: The role of sterile needles and bleach. Washington, DC: National Academy Press. Bleach is much less effective for preventing the spread of HCV because the hepatitis C virus is about 10 times harder to kill than the HIV virus.

30. Wiessing, L. (2001). Injecting drug users in Europe. Lisbon, Portugal: European Monitoring Centre for Drugs and Drug Addiction. Downloaded December 2, 2004, from http://www.drugtext.org/library/articles/peddr008.htm

31. Canadian HIV/AIDS Legal Network (2004). Prevention: Bleach. Info Sheet No. 5, HIV/AIDS in Prison. Downloaded on November 25, 2004 from http://www.aidslaw.ca/Maincontent/issues/prisons/e-info-pa5.htm

32. Lines, R. (2003). Action on HIV/AIDS in prisons: Too little, too late; A report card. Montreal: The Canadian HIV/AIDS Legal Network. Downloaded October 21, 2004, from http://www.aidslaw.ca/Maincontent/issues/prisons/reportcard/toc.htm

33. A total of 156 of the approximately 390 federally incarcerated women in Canada were surveyed for a report published in 2003. Two-thirds reported that access to bleach for sterilizing injection equipment was difficult for reasons relating to availability or accessibility. See note 12.

Endnotes

34. Bleach was readily available to prisoners in Newfoundland and Labrador for cleaning purposes, so it is listed here as "yes" even though it is not distributed as part of a harm reduction "bleach kit."

35. Strain, E., Bigelow, G., Liebson I., & Stitzer, M. (1999). Moderate vs. high-dose methadone in the treatment of opioid dependence: A randomized trial. *Journal of American Medical Association*, 281(11), 1000-1005.

36. World Health Organization (WHO) (1993). WHO guidelines on HIV infection and AIDS in prisons. Geneva: Author.

37. Kerr, T., & Jürgens, R. (2004). Methadone maintenance therapy in prisons: Reviewing the evidence. Canadian HIV/AIDS Legal Network. Downloaded November 26, 2004, from http://www.aidslaw.ca/Maincontent/issues/prisons/MMT_150604.PDF

38. Correctional Service Canada (1994). HIV/AIDS in prison: The final report of the expert committee on AIDS and prisons. Ottawa, Ontario: Correctional Service Canada.

39. See note 34.

40. As of 2002, Alberta allowed prisoners who entered prison on methadone to continue treatment for up to one month; it then required them to be weaned off the drug.

41. As of 2002, MMT was available to Manitoba prisoners only in the Winnipeg area.

42. As of 2002, initiation of MMT in Ontario was available only for female prisoners who were pregnant.

43. As of 2002, the initiation of MMT is available to prisoners in Saskatchewan only by approval of the Assistant Deputy Minister.

44. Normand, J., Vlahov, D., & Moses, L. (Eds.). (1995). Preventing HIV transmission: The role of sterile needles and bleach. Washington, D.C.: National Academy Press.

45. Germany has had prison-based needle exchanges since 1995. In 2001, and again in 2003, a number of these prison needle exchanges were closed down due to political pressure. It is interesting, however, that some of the most vocal proponents of maintaining the programs were the staff of the correctional facilities where needle exchanges had been in operation. See note 46.

46. Lines, R., Jürgens, R., Betteridge, G., Stöver, H., Laticevschi, D., & Nelles, J. (2004). Prison needle exchange: Lessons from a comprehensive review of the international evidence and experience. Montreal: Canadian HIV/AIDS Legal Network. Downloaded December 3, 2004, from http://www.aidslaw.ca/Maincontent/issues/prisons/pnep/PNEP-report.pdf

47. Ibid.

48. Prisoners with AIDS Support Action Network. (1992). HIV/AIDS in prison systems: A comprehensive strategy. Toronto: Author. Downloaded December 14, 2004, from http://www.pasan.org/Publications/HIV-AIDS_in_Prison_Systems_92.pdf

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62. See note 48.

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For further information, please write:
Canadian Centre on Substance Abuse
Suite 300, 75 Albert St., Ottawa, ON K1P 5E7
Tel.: (613) 235-4048; fax (613) 235-8101. Visit our website at www.ccsa.ca

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