THE YOU MATTER PROJECT:

PATHWAYS TO CARE FOR STBBIs. A GUIDELINE AND POLICY RECOMMENDATIONS FOR STBBI TESTING AND LINKAGE TO CARE IN BRITISH COLUMBIA PROVINCIAL CORRECTIONAL SETTINGS

YOU MATTER
Pathways to Care for STBBIs

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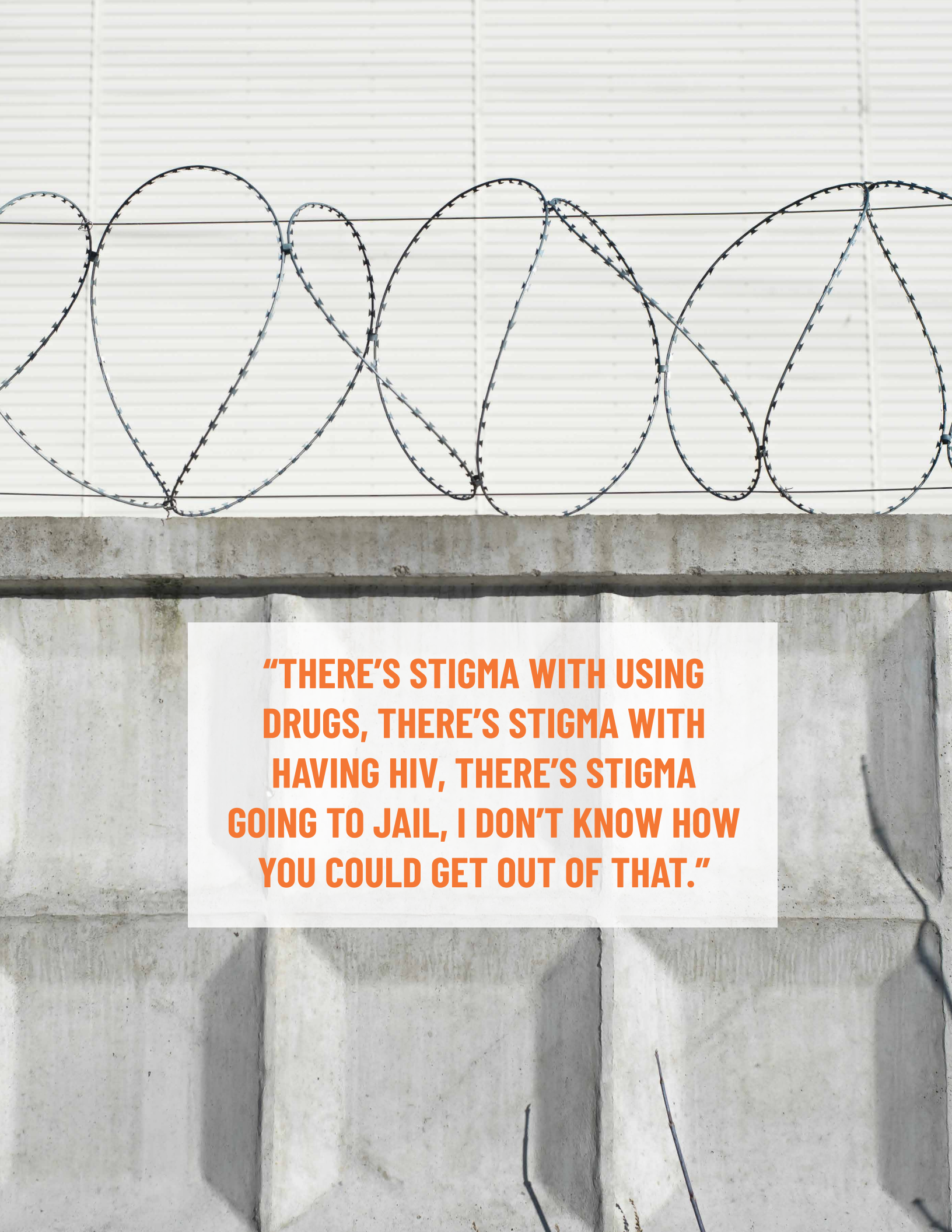

"THERE'S STIGMA WITH USING DRUGS, THERE'S STIGMA WITH HAVING HIV, THERE'S STIGMA GOING TO JAIL, I DON'T KNOW HOW YOU COULD GET OUT OF THAT."

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Abbreviations

BCC	BC Corrections
BCCDC	British Columbia Centre for Disease Control
BCMHSUS	British Columbia Mental Health and Substance Use Services
CHS	Correctional Health Services (British Columbia)
EMR	Electronic medical record (e.g. CareConnect)
HCV	Hepatitis C Virus
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
OAT	Opioid Agonist Therapy
MD/NP	Medical Doctor/ Nurse Practitioner
PAC	Primary Admissions and Care; this is the electronic medical record used by Correctional Health Services in BC Provincial Correctional Centres
PWAI	People Who Are Incarcerated
PWLE	People with Lived Experience of Incarceration
PWLLE	People with Lived/Living Experience of Incarceration (PWAI and PWLLE)
STBBIs	Sexually Transmitted and Blood Borne Infections
PWID	People Who Inject Drugs

1 EXECUTIVE SUMMARY

1.1 Background

People who are incarcerated (PWAI) in Canada are far more affected by sexually transmitted and blood-borne infections (STBBIs) such as hepatitis C virus, HIV, hepatitis B virus and syphilis, compared to the overall population. In correctional centres (provincial or federal) many barriers to care for STBBIs have been identified. Therefore, identifying strategies to address these barriers are crucial to increase access to STBBI testing and linkage to care among PWAI.

1.2 Policy Recommendations and Guidelines Introduction

This document contains policy recommendations and guidelines for the testing and linkage to care for STBBIs in provincial correctional centers in British Columbia (BC), Canada, but may also be adapted for other jurisdictions or correctional settings. These recommendations were developed with input from:

- People with lived/living experience of incarceration
- Health care workers who work at correctional centres
- Corrections staff (e.g., officers, wardens, managers)
- Representatives from various community groups; and
- Researchers (see Appendix B for details on project methods)

The main purpose of the policy recommendations and guidelines is to improve equitable access and uptake of non-stigmatizing STBBI testing and care within BC provincial correctional centres.

1.3 Key Populations & Intersectional Lens

In developing the recommended STBBI policy and guidelines, we queried participants on gender, sexuality, race, ethnicity and geographic location. This was to ensure we could review input by respondent groupings to ensure we could identify group-specific recommendations, particularly with respect to needs or preferences.

1.4 Core Policy Recommendations and Guidelines Summary

This document lists policy recommendations and guidelines including foundational principles that affect the overall care experience, as well as action items specific to STBBI testing and linkage to care. These are summarized below, with more details to be found in section 3.

1.4.1 Address Stigma

To address STBBI-related stigma, a holistic approach is recommended, consisting of: (1) ongoing STBBI education provided to staff and clients, (2) fostering respectful and person-centred language related to STBBIs among staff and clients through modelled behavior and awareness raising, and (3) emphasizing confidentiality.

1.4.2 Increase STBBI Focused Education for Staff and PWAI

Additional ongoing STBBI focused education for both correctional centre staff (inclusive of health care providers, correctional officers and other corrections staff) and PWAI is needed. Printed STBBI education and awareness materials (posters, postcards and pamphlets or booklets) should be available both in the correctional centre health unit as well as living units. Regular educational programs to disseminate information regarding STBBIs should also be provided for both staff and PWAI.

1.4.3 Offer STBBI Testing to Everyone as Soon as Possible

All clients[a] should be advised at the initial intake health assessment that STBBI testing and treatment is available while in custody, then a follow-up appointment with a health care worker (HCW) should be booked within 72 hours of intake to offer STBBI testing , if test was not able to be offered then.

1.4.4 Obtain Consent

All clients should be informed verbally, through brochures and signage posted within the health centre and living units that:

- STBBI testing is routinely offered at the centre for all clients, regardless of risk factors
- They can accept or decline any tests without repercussions
- There will be opportunities to be offered testing at every health care appointment
- Clients should be offered standard or express testing (See Section 3.3.3 for in-depth description of express testing Vs Standard testing)

1.4.5 Arrange Linkage to Community Care before Testing

Clients should sign a release of information form in case they are released before receiving test results and treatment. Their test results could then be sent to their community health care provider (e.g. physician, pharmacy, outreach team, specialist) to start treatment after release.

1.4.6 Review Medical Record for Previous STBBI Results

The Electronic Medical Record (e.g. CareConnect, PharmaNet, etc.) should be reviewed to look for previous positive test results from testing in the community or previous incarceration (e.g. HCV results) as well as dispensation of medication such as for HCV or HIV treatment. This is necessary to avoid repeat testing and expedite linkage to care and treatment.

1.4.7 Provide Client with Test Results

A process must be in place to direct test results to the appropriate health care provider for review within 24 hours of the result being received.

Clients should be provided with test results irrespective of the outcome (whether positive or negative), and this should be done in the most confidential way possible.

1.4.8 Expedite Treatment and Linkage to Care

Linkage to care and STBBI treatment should be initiated as early as possible irrespective of a client's length of stay. HCWs should coordinate STBBI treatment and support referrals in the community. This planning should start as soon as STBBI results are received and written consent is obtained to proceed with referrals.

1.4.9 Documentation

STBBI testing and treatment decision support tools tailored for the corrections environment should be developed and implemented to assist HCWs in providing care.

a Where recommendations are directed to health care providers working in correctional settings, we refer to people who are incarcerated (PWAI) as 'clients'

2 INTRODUCTION

2.1 Sexually Transmitted and Blood Borne Infections (STBBIs) in Corrections

People who are incarcerated (PWAI) in Canada are far more affected by sexually transmitted and blood-borne infections (STBBIs) such as hepatitis C virus, HIV, hepatitis B virus and syphilis compared to the general population. For example, compared to the general population, STBBI infection rates amongst Canada's incarcerated population overall (including both federal and provincial) are:

- 30 times higher for hepatitis C[1]
- 5 times higher for HIV[2]
- 3 times higher for hepatitis B[3], and
- 5 times higher for infectious syphilis[4]

There are many barriers to care in correctional centres, including systemic barriers such as inconsistent availability of STBBI testing or treatment in correctional centres, the widespread belief that engaging in health care is not worthwhile,[5] and expectations of negative experiences when engaging in health care services.[5-9]

Among PWAI who inject drugs (PWID), the proportion living with HIV and/or HCV infection is markedly higher compared to both the overall prevalence among people who are incarcerated and the prevalence in the general population.[10] STBBIs — such as HIV, hepatitis C virus (HCV), and syphilis – synergistically contribute to substance use-related morbidity and mortality, particularly among people who have experienced incarceration.[11,12] Ensuring streamlined pathways to community health services, delivering meaningful education regarding STBBIs, and providing positive health care experiences are crucial factors for increasing PWID/PWAI's engagement in care upon re-entry to community.[13,14]

2.2 Including the Voices of those Impacted in Corrections

This document contains policy recommendations and guidelines for testing and linkage to care for sexually transmitted and blood borne infections (STBBIs) in provincial correctional centres in British Columbia, but may also be adapted for other jurisdictions or

correctional settings. These recommendations were developed with input from:

- People with lived/living experience of incarceration
- Health care workers (HCWs) who work at correctional centres
- Corrections staff (e.g., officers, wardens, managers)
- Representatives from various community groups; and
- Researchers (see Appendix B for details on project methods)

"THIS IS THE FIRST TIME IN MY 30 FCKING... YEARS GOING TO JAIL WHERE I'VE BEEN ASKED TO GIVE INPUT"**

(PWLE Workshop participant)

The main purpose of the recommended policy and guidelines are to improve equitable access and uptake of non-stigmatizing STBBI testing and care within BC provincial correctional centres.

Although STBBI screening is available by request in correctional centres, STBBI testing is not consistently offered in many centres, resulting in poor linkage to care for STBBIs among people who are incarcerated (PWAI).

Development of foundational policies and guidelines for routine STBBI testing in corrections is necessary to create accountability frameworks, streamline care pathways, reduce the occurrence of unintended harms, and increase the likelihood that PWAI will have positive experiences when engaging in health care.

2.3 Document Overview

This recommended policy and guideline document is divided into 6 sections:

1. Executive summary: Brief summary of recommendations
2. Introduction
3. In depth STBBI policy recommendations and guidelines
4. Considerations for key populations
5. Recommendations for putting policy recommendations into action
6. Appendixes with rationale and evidence and additional resources

2.4 Scope

The purpose of this project was to determine how available clinical guidance related to STBBI testing and treatment could be implemented in correctional settings in a culturally safe, trauma-informed and person-centred way. Therefore, these policy recommendations and guidelines focus on how and *when* testing and linkage to care for STBBIs should be offered to PWAI.

Clinical recommendations about treatment or diagnostic testing are out of the scope of these policy and guideline recommendations. These already exist and should be followed accordingly.

2.5 Core Values

Core to the development of these STBBI policy recommendations and guidelines was valuing and centering input from people who would be impacted by the recommendations. This includes people with lived/living experience of incarceration (PWLE), Correctional Health Services (CHS) staff (e.g., nurses, allied health professionals), and BC Corrections staff (e.g., correctional officers, programs officers). These key stakeholders have unique expertise to help make the guidelines practical, impactful and respectful. PWLE are experts in their own care and experiences, CHS are experts in implementing STBBI testing protocols, and BC Corrections staff are experts in navigating existing policies in correctional centres (see Appendix A for stakeholder engagement details).

Based on input from people who would be impacted by these STBBI policies and guidelines, these are the key practices and concepts that informed the recommendations:

- Trauma and violence-informed care
- Cultural safety and humility
- Harm reduction
- Person-centred care
- Addressing STBBI and substance use-related stigma
- Addressing health care inequities
- Addressing the social determinants of health
- Importance of linkage to care to mitigate morbidity and mortality for STBBIs and other health issues
- Evidence, expert and fact-based

"Core to the development of these STBBI policy recommendations and guidelines was valuing and centering input from people that would be impacted by them..."

2.6 How to use this Document

Sections 3 and 4 contain the core recommendations. Most recommendations apply to health care workers (HCWs) who work in prisons, but some recommendations also pertain to corrections staff (COs; e.g., corrections officers, wardens). Recommendations relevant to COs are indicated by the icon to the right.

2.7 Glossary

BC Corrections

In British Columbia (BC), BC Corrections is responsible for managing provincial correctional centres. There are 10 provincial correctional centres in BC. Approximately 39% of PWAI are sentenced, and 1% are detained by Canada Border Services Agency.

Clients

Where recommendations are directed to health care providers working in correctional settings, we refer to PWAI as 'clients.'

Cultural Safety and Humility

Cultural safety is an outcome based on respectful engagement with people from diverse cultural backgrounds (including Indigenous Peoples, immigrants, culturally distinct communities). This respectful engagement recognizes and strives to address power imbalances inherent in the health care system, which are exacerbated when delivering health care within the correctional system, particularly for Indigenous people. It results in "an environment free of racism and discrimination, where people feel safe when receiving health care."[16]

Equity in Health Care Access

Ensuring that the same standard of health care access is available in provincial correctional centres as what is available in the community.

Evidence-based Policy

Decisions or policies that are based on, or informed by, empirical evidence. In the case these recommendations and guidelines, they are based on a combination of findings from the survey results conducted in this work, existing literature, and expert/collaborator input.

Federal Centres

In Canada, people who are sentenced to a period of custody of 2 years or more serve this in a Federal Institution. Correctional Services Canada is responsible for managing Federal Institutions.

General Practitioners

Correctional centres all have access to a Medical Doctor (MD) or Nurse Practitioner (NP) trained in family medicine or general practice; these individuals provide primary health care to people who are incarcerated in that centre.

Harm Reduction

Harm reduction is a public health approach that aims to reduce harms and consequences associated with substance use. Encompassed in harm reduction principles is treating all individuals with respect, and supporting people where they are at.[17]

Health Care Access

Health care access is the ability to obtain health care services such as prevention, diagnosis, treatment, and management of diseases, illness, disorders, and other health-impacting conditions.

Health Care Workers

Broad term to include licensed professionals who work at CHS (e.g. physicians, nurse practitioners, registered nurses, licensed practical nurses, social workers).

Health Equity

Health equity means ensuring that every person has the fair opportunity to achieve their best possible health. To achieve health equity, unnecessary and avoidable differences that are unfair or unjust must be addressed.

Linkage to Care

In the context of STBBIs, linkage to care refers to a client being referred to an STBBI treatment provider and then the client attending an appointment with that provider.

Person-centred Care

Understanding and respecting each person as a unique human being, which means refraining from reducing a person to just their symptoms, disease, or incarceration status.[18] This calls for a holistic approach to care for people who are incarcerated and respect for their health concerns. Additionally, person-centred care is not limited to just the patient, but also includes families and caregivers (e.g. inclusive of people incarcerated, corrections staff, and health care providers).

Provincial Correctional Centres

These centres house people who are serving custodial sentences of less than 2 years (people serving longer sentences are housed in Federal Institutions), on remand (awaiting trial or sentencing) or who are on immigration hold/detention.

Remand

People being held in custody awaiting trial or sentencing are referred to as 'on remand' or 'unsentenced'. Remand is characterized by very short periods of time spent in custody (e.g. average length of stay on remain is 35 days in BC, with an average of 60% of people in custody on remand at any one time).

Social Determinants of Health

The social determinants of health are the non-medical and non-genetic factors that influence a wide range of health, functioning, and quality of life outcomes and risks. These are the economic, social and environmental conditions in which people are born, live, play, grow, work, and age. They are also the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

STI Certified Nurse

Registered nurses who complete BCCNM (British Columbia College of Nurses and Midwives) certification in Reproductive Health: Sexually Transmitted Infections, who may diagnose and treat some sexually transmitted syndromes and infections in clients 14 years of age and older as set out within STI Decision Support Tools (DST).

Stigma

Stigma is a dynamic process of devaluation, discrediting and disgracing directed to individuals with certain characteristics. Stigma is usually related to a set of negative and often unfair or incorrect beliefs that a society or group of people have about something.

Trauma and Violence-informed Care

Trauma and violence-informed care principles include understanding trauma and violence and its impact on people's lives and behaviours, creating safe environments for care provision, fostering opportunities for choice, collaboration and connection, and using strengths-based and capacity-building approaches to support clients.[15]

3 STBBI POLICY RECOMMENDATIONS AND GUIDELINES

The recommendations below are hyperlinked to detailed information in subsequent sections, including literature that highlights existing recommendations and data from the project that supports the recommendations. Click on these links for more details. Other relevant resources that helped in developing these recommended policy and guidelines can be found in the Appendices.

Some recommendations are relevant only to health care workers (HCWs), so we have only flagged those that may be relevant to BC Corrections staff, including Corrections Officers and Wardens with the orange "COs" icon.

3.1 Reducing Stigma Recommendations COs

Eliminating shame, prejudice and discrimination related to STBBIs and/or STBBI associated risk behaviours (e.g. injection drug use, sex work) is central to this work. This means promoting staff use of language that removes judgement from STBBI conversations. Broadly, recommendations for addressing STBBI-related stigma in correctional settings include:

1. Implementing cultural safety (CS) and trauma-informed care (TIC) in all client interactions, including ongoing education for staff capacity to implement CS and TIC,
2. Fostering non-stigmatizing STBBI client provider interactions through person first language and person-centred care,
3. Ensuring privacy and confidentiality,
4. Education for staff and clients (see dedicated chapter on education), and
5. Creating affirming environment where client preferences are respected.

The survey results and open-ended responses from stakeholder consultations and engagements indicated that STBBI-related stigma in BC correctional centres can be a significant barrier to accessing testing and care, and points to a critical need to address and mitigate barriers created by stigma. However, reducing stigma in correctional settings is a complex task and requires addressing multiple factors, including privacy/confidentiality, education and options for PWAI concerning

who they can go to for STBBI information (see Section 10.1 for project data pertaining to stigma).

Table 3.1 Stakeholder Quotes – Stigma

PHASE 1	
PWAI	"I've heard of someone with HIV on the unit – the priority was to get him off the unit as soon as possible." "People are so scared of people with diseases." "There's stigma with using drugs, there's stigma with having HIV, there's stigma going to jail, I don't know how you could get out of that." "When people judge you, you start to shy away from them."
COs	"Less stigma around it being negative to have to get tested, I think the inmates may need to feel a little more support [around testing]."

3.1.1 On-going STBBI Education for Staff and Clients

COs

Provide ongoing education for clients and staff on STBBIs, including how to test for STBBIs and what treatment involves. Education that emphasizes that STBBIs are a medical condition with simple and effective treatments available can help to overcome some of the incorrect or negative beliefs that contribute to STBBI stigma.

3.1.2 Foster Respectful and Person-centred Language related to STBBIs

COs

Foster respectful and person-centred language related to STBBIs among staff and clients through modelled behaviour (e.g. leaders adopt first), and awareness raising (e.g. distribution of posters, pamphlets and events on Days of Awareness).

3.1.3 Ensure Privacy/Confidentiality for STBBI Testing and Care

COs

Ensuring privacy and confidentiality of medical information, including STBBI testing and care in correctional centres, is challenging given the emphasis on security and surveillance of PWAI. The presence of corrections officers (COs) near testing areas or the public nature of telephones – which can also be monitored by staff – reinforces a lack of rights to medical privacy.[19] Institutional processes, including how medications are dispensed in correctional centres (e.g., daily HIV medications), further compromises privacy and exposes PWAI to discrimination from others.[20] The consequences of unauthorized or forced disclosure of STBBI status can have significant and harmful consequences for PWAI.[19-21] As such, policies that enhance medical privacy and confidentiality within correctional centres are essential to promoting safe access to STBBI testing and care. Recommendations to enhance privacy and confidentiality for STBBI testing and care include:

1. Ensure private areas for offering STBBI testing, discussing results and treatment,
2. Avoiding STBBI discussions when not in a private health care room (e.g. not on the unit where officers or other clients could overhear),
3. Officers should stand outside of appointment area at maximal distance whenever possible,
4. Conversations with clients should be at low volume,
5. Clients should be informed verbally and through written materials (posters/brochures) on how confidentiality of their medical information is maintained, including who has access to their medical charts, what information CHS is required to report and what is not required to report,
6. Use educational pamphlets with general titles (e.g., not "HIV" in large print),
7. Provide education to COs and HCWs on the importance of privacy/confidentiality for increasing

STBBI testing/treatment which can lower the prevalence of STBBIs in correctional centres,

8. CO/HCW protocols around privacy (e.g., test requisitions, test results) should be made known to PWAI, and
9. HCWs should provide clear and on-going information to PWAI regarding the confidentiality of their medical information (e.g. explain to them who has access to their medical charts, what information you are required to report and what you are not required to report) in order to address the misconception among PWAI that STBBI test results may be seen by COs or other PWAI.

Table 3.2 Stakeholder Quotes — Ensuring Privacy/Confidentiality for STBBI Testing and Care

PHASE 1	
PWAI	"You put your request into the box, it's locked, but who has access to it?" "Guards can see what is written on the health care requests – it is taped shut but they can easily open it." "What happens if correctional staff finds out, your results can be outed in community [When CO and PWAI live in the same community]." "Bullying happens and people do find out other residents health information. Confidentiality is huge." "Difficult to get your meds privately – all the guys [who] are in line for meds are watching."
HCW	"Medical office space is a bit on the small side, so it can be difficult to ensure corrections staff are far enough away to prevent them from hearing confidential conversations."
PHASE 2	
COs	"HCWs could ensure that the client is in a secure/private area with healthcare provider." "For safety reasons, I don't think you can ask for officers to not be there." "We do close their door and [an] officer is kept visual in case the client ends up being violent." "The results are not discussed. The information could be on a document and given to PWAI."
To make it less likely that other PWAI would overhear discussions between health care staff and PWAI, COs offered the following suggestions:	
	"Move to a location that's not near the waiting area." "Other inmates should be in locked holding tanks and not in screening rooms with inmates being seen." "Have conversation in far office, there should be sufficient ambient noise to distort conversation being heard." "We keep health care at our centre pretty private. One client at a time, or if there is more than one, another officer is present to watch the other client.

3.2 Supporting Education Recommendations

COs

In order to support STBBI education within prisons, additional HIV/HCV education is recommended for Corrections staff, health care staff and PWAI. These educational programs could disseminate information regarding STBBI education and address stigma within correctional centres by addressing STBBI-related misinformation, especially regarding HIV/HCV (see Section 10.2 project data pertaining to education).

3.2.1 STBBI Education Among People Who are Incarcerated

1. Educational posters should be posted in high traffic common areas (e.g. programs room, gym, yard) regarding confidentiality, STBBI transmission, testing and treatment.
2. STBBI information should be available in multiple formats, including in-person 'guest speaker' presentations/workshops, peer-led or delivered workshops, and posters/pamphlets with pictures.
3. Information on STBBI community resources, including peer advocacy resources, should be available in health care rooms and on living units.

3.2.2 Educational STBBI Brochure or Postcard

A brochure about STBBIs should be given at intake (and made available at the health unit and on living units) that includes:

- Which STBBIs are tested for in corrections,
- Symptoms of STBBIs,
- Health implications of untreated STBBIs,
- STBBI transmission/risk factors and dispelling myths about STBBIs,
- How testing is offered in corrections (express vs standard),
- How the tests are done (i.e., urine/blood/finger prick sample),
- Process for getting test results (positive and negative),
- Length of time it should take to get test results back,
- How STBBIs are treated,
- What other follow up is done with some STBBIs (i.e., contact tracing/ongoing care for Hep B&C and HIV),
- How test results are kept confidential in corrections,
- Confidentiality policy, and how to request for results to be shared with your community care providers, and
- The front page of brochures should be generic (no large titles with HIV or STBBIs), to prevent readers from being singled out for reading it. Language of written materials should be clear and simple.

Table 3.3 Stakeholder Quotes — Education

EDUCATION FOR PWAI	"Posters on the unit, [the] hallway for waiting for health care, [and the] med line would be really helpful, [because] we're always standing around waiting, would read it out of boredom." "Informed of correctional centre testing policies, how to request services/care, what services are available, basic STBBI facts in correctional centres, [and] peer support availability."
EDUCATION FOR HCW	"Educational sessions and online modules which will make providers comfortable to initiate treatment." "Huddles in their own centres. Besides the online learning." "Telemedicine could be used for education."

3.2.3 STBBI Education for HCWs and Corrections Staff

COs

All BC corrections staff should receive STBBI education when hired and repeat this training annually. To facilitate retention of knowledge, posters about STBBI risks/transmission/testing should be hung in high traffic areas like staff washrooms or eating areas. Topics should include:

1. STBBI basics (transmission, prevention, testing, and treatment)
2. Stigma and misconceptions about STBBIs
3. Confidentiality of medical information
4. Cultural safety
5. Confidentiality of medical information.

HCWs should receive education when hired and repeat this training annually and training should include:

1. STBBI basics (transmission, prevention, testing, and treatment)
2. Stigma and misconceptions about STBBIs
3. Trauma informed care
4. Cultural safety
5. Confidentiality of medical information
6. CHS STBBI decision support tools.

HCWs should also receive ongoing support and education to help provide test results in a non-stigmatizing and trauma informed way (e.g., create a non-judging and safe environment for care provision; maximize opportunities for choice; collaborate and connect with the client as a person; use a strengths-based and capacity building approach to support clients) [7]. They should also be encouraged to routinely bring up questions and concerns about STBBI testing in their team meetings and have access to an STI certified nurse or nurse educator to address STBBI questions as needed.

3.3 STBBI Testing and Linkage to Care Recommendations

3.3.1 Establish One Overall STBBI Testing and Linkage to Care Policy across all BC Correctional Centres

In order to reduce inefficiencies, improve quality of care, increase consistency and enhance trust with clients, one consistent overall STBBI testing and linkage to care policy should be established and implemented across all BC provincial correctional centres (see Section 10.3 for project data pertaining to Testing and Linkage to Care)

3.3.2 Offer STBBI Testing to All Clients as Soon as Possible

All clients should be offered testing:

1. **During a health assessment appointment** with an HCW within 72 hours of intake that includes, but is not limited to, offering STBBI testing, and
2. **Anytime during incarceration**:
   a) When clients ask for STBBI testing; and
   b) During private health care appointments.

Clients with short sentences/on remand should still have access to STBBI testing and linkage to care as per the above standard.

The health concerns that are top priority to the client should be addressed before STBBI conversations occur in order to build trust and promote person-centered care. Electronic Medical Records used in correctional health care clinics should have a flag to remind HCWs that STBBI testing has not yet been done.

Table 3.4 Stakeholder Quotes — Offering STBBI Testing to Everyone as Soon as Possible

PHASE 1	
PWAI	"Not everyone [is] in a state of mind to remember what they [are] asked at intake, which is why they ask you again later."
COs	"Many of the new intakes come in with illegal substances in their system. This combined with the possibly long hours waiting in a tank to be processed as a new intake before they can be transferred to the induction unit can make them less responsive to offers for STBBI testing. By offering them testing 1-2 weeks after intake, it allows them to settle into their unit and be in the right frame of mind to make such decisions." "Intake is great, but some guys come in rough and aren't capable of making any decision. A few weeks in and most guys have come around enough to do this. Adding a static offering that is well advertised would allow an inmate to make this decision at any time."
PHASE 2	
HCW	"Intake is very challenging, nurse time is limited and many intakes are in a bad space." "Sometimes the first doctor's appointment doesn't happen early enough, or doctors might have more pressing/life threatening issues to deal with during 1st visit." "...everyone gets an appointment with a nurse within 72 hours of intake to discuss STBBIs and be offered testing. [PWAI should] be notified when [their] appointment is... [and] what will be discussed during that appointment." "The majority of clients are not receptive at intake." "The state of individual when they enter the centre is an issue. [It's] not very private at intake – [there are] lots of officers."
PWLE	"Not in very good shape at intake – I just want my blanket and my bed. Maybe the first health care appointment when [I] get levelled." "Everyone should see a doctor when they go in and ask at every appointment." "Both options are good – at intake and later." "First doctor visit after intake, test for STBBIs."

"FIRST DOCTOR VISIT AFTER INTAKE, TEST FOR STBBIS."

3.3.3 Obtain Consent

Provide a discretely titled STBBI information brochure or information card (e.g. "Correctional Health") to all clients at initial intake. Brochures/cards should also be available in common areas (e.g. living units) and in the health care rooms.

Verbally and through brochures/signage posted within the health centre and living units, inform all clients that:

a. STBBI testing is routinely offered at the centre for all clients, regardless of risk factors
b. Clients can decline testing without any repercussions
c. Clients are able to accept some STBBI tests and decline others (e.g. decline HIV testing)
d. If clients decline testing or are unable to consent, there will be opportunities to be offered testing at another health care appointment

3.3.3.1 Standard vs. Express Testing

Offer clients a choice between standard testing, where a pre-test discussion occurs, or express testing if they have no STBBI symptoms and are happy to proceed with testing without out any pre-test discussion.

Standard Option

Standard testing gives clients the opportunity to ask questions or discuss symptoms with a HCW before consenting to testing.

1. A symptom questionnaire[b] (verbal or written) should be completed with the client. HCWs can refer to resources through the BCCDC to respond to questions. If questions are outside of the HCW's expertise, the client should be referred to another HCW with STBBI expertise.
2. Principles of confidentiality should be maintained during the discussion.

Express Option

With express testing, clients may choose to not have a discussion about STBBIs with a HCW prior to obtaining STBBI testing.

1. A form should be provided to the client with a brief symptom questionnaire[2] that they may fill in or simply state a verbal response to, which is reviewed by the HCW.

b If a client identifies STBBI symptoms on the questionnaire, then an appointment with corrections MD/NP should be expedited.

Table 3.5 Stakeholder Quotes – Obtaining Consent

PHASE 1	
PWAI	"I didn't even know I had been tested and the doctor I saw later just assumed I knew that I had [tested positive for] hepatitis C. I was totally caught off guard." A PWAI shared that some residents might be afraid to decline testing "...because you are often penalized for saying no/questioning authority."
PHASE 2	
HCW	"No consent is not an option" "Consent is essential, and we must follow community standards. A correctional centre is not an emergency department (ED) so we can't follow what they do in ED."
PWLE	"Most people care to be asked before they get tested." "[HCWs] could just ask you – do you want to get tested – yes or no?" "... being asked is good."

3.3.4 Arrange Linkage to Community Care at Time of Testing

Obtain Consent for Release of Information

For both standard and express testing, the client should sign a release of information form in the case that the client is released before receiving test results and treatment. The form should request:

1. Client contact info (e.g. phone, address, emergency contact) if possible,
2. Community health care provider (e.g. physician, pharmacy, outreach team, specialist) where the test results can be sent, and
3. Consent for automatic referral for expedited treatment if the client tests positive for an STBBI.

Clients should be asked if they have been recently treated for HCV or another STBBI to determine if further follow up is required. The HCW should call the community treatment provider if the client indicated that they are partially through or recently completed a treatment course, or were soon to start (with written consent from client).

Begin Planning for Connecting to Care After Release as Early as Possible

To facilitate client's linkage to care after release, before the transition occurs, arrangements are needed for peer support, STBBI-related medications, preparing for client release, and documentation (see Table 3-6). On the day of transition, plans are needed for STBBI medications and appointments with community agencies and clinics (see Table 3-7). The recommendations in Tables 3-6 and 3-7 are primarily from discussions with CHS Staff about their workflow processes.

"NO CONSENT IS NOT AN OPTION."

Table 3.6 Planning for Connecting to Care After Release: **Before Transition** to Community	
Peer support	• When planning for transition to the community, assess for interest in peer support programs to assist with appointments, transportation, housing, supports, etc. and make these referrals as soon as possible.
STBBI-Related Medications	• For active STBBI prescriptions, arrange for a transfer of prescription to pharmacy/clinic of client's choice. Call ahead to the pharmacy/clinic to assure that the medication is available there. Assure the pharmacy has a copy of a current prescription and Pharmacare paperwork (if applicable). Assure that the PWAI has 2-4 weeks of medication upon release. • If client is on remand, arrange for medications to be sent with client for court in the case of sudden release.
Preparing clients for release	The client should meet with a CHS nurse or addictions counsellor to discuss: • Collecting demographic information post release (address, phone number, email and emergency contact) • Making a referral to a community STI/HCV/HIV clinic • With client's written consent, share health info with this clinic and other care providers like primary care or OAT providers • Arrange initial consultation with STI/HCV/HIV clinic remotely while still incarcerated • Instructions for self-administering the STBBI medications once in community • Pharmacare coverage (if applicable) to assure that medication funding will not cease partially through treatment • STBBI transmission/ prevention of re-infection • Location of harm reduction supplies in returning community • Overdose education • Need for OAT, if not already receiving • Eligible vaccinations • Completion of contact tracing/case report forms • Recommended follow-up testing if required after treatment (e.g., waiting 12 weeks after HCV treatment) • If diagnosed with cirrhosis, discuss need for 6-month ultrasounds.
Documentation	Compose a discharge letter to be given to the client and fax it to STI/HIV/HCV clinic, pharmacy and other community health care provider with client's consent. Letter should include: • Name of STBBI medication • Name and contact info of correctional centre physician who prescribed the medication • Start date of treatment and anticipated completion date • Name of STBBI clinic in the commzunity that will be involved in care (if applicable) • List blood tests required after treatment and date these tests are due (if applicable) • Cirrhosis follow up, if applicable • Re-infection information and recommendations for regular screening for re-infection.

Table 3.7 Planning for Connecting to Care the **Day of Transition** to Community	
STBBI Medications	• Provide all remaining HCV medication to the client (should have at least a two-week supply to give time for community pharmacy to coordinate) • Provide copy of above discharge letter • Provide requisitions for blood tests required after treatment with consent of correctional centre physician (copy client's regular care provider in the community, OAT provider, and STI/HCV/HIV clinic) • Provide harm reduction supplies and naloxone kit if at risk • Provide with brochures about STBBIs • Provide phone number for CHS nurses in case of questions regarding medication transfer.
Appointments with community agencies/clinics	• Appointments with external agencies should be done remotely/virtually in a private location whenever possible. • If appointments are only available off site, the purpose of the appointment should be kept confidential from Corrections officers.

Table 3.8 Stakeholder Quotes – Arranging Linkage to Community Care at time of Testing	
PHASE 1	
HCW	"Treating clients with short sentences is difficult. [It's] hard to hook people up with resources and follow up after release." "Short stay of clients increases the possibility of loss to follow-up post release." "People with small sentences don't see one (HCW) at all."

3.3.5 Review Medical Record for Previous STBBI Results

For both standard and express consent, the provincial Electronic Medical Record (EMR, CareConnect, PharmaNet, etc.) should be reviewed to look for previous STBBI treatment or positive test results from testing in the community or previous incarceration (e.g. HCV RNA). This should be done before booking a laboratory test. If there is a positive result for an STBBI, the client should be given the next available appointment with the corrections MD/NP or other qualified HCW on site to expedite linkage to care and treatment.

Table 3.9 Stakeholder Quotes – Reviewing Medical Record for Previous STBBI Results	
PHASE 2	
HCW	"Physicians want to know if their patients test negative after treatment." "Before nursing assessment – ask about HCV treatment." "Somebody to go back and review patient history so that repeat testing is not done." "If they are on treatment, a phone call should be made immediately to destination provider." "Treatment provider in community can notify primary care provider at [a] correctional centre if there are other services that need to be done after getting notification of positive results of a client." "Makes sense for correctional centres to continue their relationship established with their own treatment providers. Maybe educate corrections MDs to feel comfortable enough to start treatment."

3.3.6 Setting up Laboratory Appointments

Clients should not have to see an MD/NP to arrange STBBI testing. Pre-signed, standing order laboratory test forms should be arranged by a designated MD/NP for each site in advance.

Once consent is obtained through the standard or express option, the client is given an appointment for the next available lab day to submit a urine and blood sample, as long as their previous laboratory results have been reviewed beforehand.

Table 3.10 Recommended Corrections Intake Screening Tests

Name of test	Requisition	Method of test
Hepatitis C	anti-HCV	Venous blood draw[c]
If previous anti-HCV positive result is available in CareConnect, proceed to HCV RNA and/or genotype	HCV RNA HCV genotype (written in "other tests" section)	Venous blood draw
Hepatitis B	HBsAg, anti-HBc, anti-HBs	Venous blood draw
Syphilis	RPR (written in "other tests" section)	Venous blood draw
Human Immunodeficiency Virus	HIV serology	Venous blood draw
Chlamydia	CT by NAAT	Urine
Gonorrhea	GC by NAAT	Urine
Liver/kidney panel		
Complete Blood Count	Hematology profile	Venous blood draw
Alanine transaminase	ALT	Venous blood draw
Aspartate aminotransferase	AST (written in "other tests" section)	Venous blood draw
Bilirubin	Bilirubin	Venous blood draw
Creatinine/eGFR	Creatinine/eGFR	Venous blood draw
Other tests as required based on MD/NP opinion		

Table 3.11 Stakeholder Quotes — Setting up Laboratory Appointments

PHASE 1 ENGAGEMENTS	
COs	"We are staffed 24/7 with nurses so access to one of these providers would remove barriers to access. An MD is only here certain days of the week, same with lab." "I think any nurse should be able to provide this, but there should be a requirement of taking a STBBI course so that they themselves can be informed to be able to give correct information to clients." "Nurses should be used to full scope, the tendency for CHS is to limit all we can do as nurses, training for full scope for all nurses and use of the knowledge for all nurses." "I don't feel that I still have a solid knowledge of treatments and blood tests required. Things are always rapidly changing."

c See new directions and testing methodologies for other testing methods. Not all methods are available for all sites. When availability of other point of care test modalities change, we suggest reviewing these recommendations.

Table 3.11 Stakeholder Quotes — Setting up Laboratory Appointments

PHASE 2 EXPERT CONSULTATIONS	
HCW	A HCW identified that "...timing of when to ask clients about STBBI testing" is a significant barrier to STBBI testing. "An STI trained nurse [should be] at every site." "Intake nurses would have time to book a nurse clinic appointment for every client at intake though, these nurse clinics would usually be able to see the client within 72 hours."

3.3.7 Provide Clients with All Test Results

A process must be in place to direct test results to the appropriate health care provider for review within 24 hours of the result being received. All results should be provided to clients **no later than 1 week** after results have been received by health care.

3.3.7.1 Returning negative results

1. Results should be shared either in person or in writing, in the most efficient manner for health care providers.
2. To maintain privacy, the result should be provided in a way that precludes other clients or Corrections staff from seeing the results apart from the permission of the client by following principles of confidentiality.
3. Health care providers should not tell clients to assume that they have tested negative if they were not called back in for results (i.e., "no news is good news" is not an appropriate method).
4. Clients should have a confidential way to request to speak with a HCW about the results.
5. Information about harm reduction, how to ask for a retest, and how the test result is kept confidential should be included in the STBBI brochure provided at intake and highlighted to clients when given the negative test result.
6. If negative results are given in person, principles of confidentiality should be maintained, and the HCW should provide time to discuss questions.

Each correctional centre may need to adopt different strategies for delivering negative results depending on the resources each centre has.

Some potential strategies for delivering negative results include:

- All clients are automatically booked a private appointment with an HCW to discuss the negative result in person.
- Clients are given a paper copy of results in a sealed envelope by their case worker/ parole officer. Result is then shredded after it's given.
- A copy of results should be with personal items in a sealed envelope so they are received at release.

- Clients could look up result on a kiosk.[d]
- Result is emailed or texted to client if released before results were available.
- Result is forwarded to client's community OAT pharmacy with written consent.
- Result is forwarded to client's community physician or community outreach team.

3.3.7.2 Returning Positive Results

Clients should be informed of their positive test results in person and by a HCW within one week and principles of confidentiality should be maintained.

1. If the appointment notification is given to a client in writing, the contents of the notification will list the time of the health care appointment, but not the result.
2. When the client receives the result, the initial release of information form (from when testing was offered) should be reviewed and updated with the client.
3. Information about the STBBI treatment options and how the test result is kept confidential should be included in the STBBI brochure provided at intake and reviewed with the client when given the positive test result.
4. If treatment was not provided when the result was given, a separate appointment regarding treatment should occur no later than 2 weeks after results have been received by health care.

Table 3.12 Stakeholder Quotes — Providing Clients with Test Results

PHASE 1	
PWAI	"...the doctor I saw later just assumed I knew that I had [tested positive for] hepatitis C. I was totally caught off guard." "I'd rather be told that I don't have it, then sitting and not knowing." "They say 'no news is good news' around here. But you never know when someone has dropped the ball or lost a result. You never really know if they processed the test." "[We] should get results in a sealed envelope that comes with the rest of your mail, to your own private room, instead of being pulled aside by the nurse which singles you out." "I'd prefer to get my test results in a private meeting."
Barrier to high rates of STBBI testing (Comments)	
HCW	"Short remand time frames [are a barrier to testing]. Many clients are not here long enough to see a lab." "[A barrier to testing is clients are] released prior to lab work being completed."
PHASE 2	
HCW & COS	Some HCW mentioned that they "...want to know if their patients test negative after treatment." COs who disagreed with providing results via kiosks felt that it "..should only be through HCW." Some COs expressed concerns about privacy, explaining that "...this information is easily obtained by other inmates."

d Kiosks, or eServices devices, are deployed to Kamloops Regional Correctional Centre, North Fraser Pretrial Centre, Okanagan Correctional Centre, Surrey Pretrial Services Centre and Vancouver Island Regional Correctional Centre. The other centres (Alouette Correctional Centre for Women, Fraser Regional Correctional Centre, Ford Mountain Correctional Centre, Nanaimo Correctional Centre, and Prince George Regional Correctional Centre) do not have eServices devices but will have them installed in the future. There are currently 122 fully functional devices at the centres, and at the time of this writing, only two devices were down for repair. Kiosks are generally found in common areas or program space, so they are accessible during time outside of cell. Correctional Health Services can leave messages for PWAI via the "CORNET Client Messages" screen, which can then be accessed by PWAI via the eServices kiosk system (personal communication with PSSG, January 18, 2022). At facilities where kiosks are not yet installed, HCWs can explore the use of e-mail or sealed envelope delivery (e.g., medical assistants can print and seal negative results in envelopes, then COs or HCWs (at next appointment) can give to PWAI.

Table 3.12 Stakeholder Quotes — Providing Clients with Test Results	
	Other COs felt the kiosk option was "…not trauma informed." "Their (PWAI) peers may end up seeing their result via paper in their cell. Having a paper copy can make it easier for their peers to see their information. Whereas with a kiosk, they can view it at times where their peers aren't around."

3.3.8 Expedite treatment and linkage to care

1. Treatment, referrals and contact tracing should be provided according to current BCCDC guidelines and decision support tools.
2. The length of sentence or being held on remand should not prevent the initiation of treatment for an STBBI, including HCV infection.
3. People with short sentences should be prioritized for initiating treatment to improve the odds of receiving treatment before release.
4. Eligible immunizations should be administered as per BCCDC recommendations.
5. HCWs should coordinate STBBI treatment and support referrals in the community. This planning should start as soon as STBBI results are received and written consent is obtained to proceed with referrals.
6. In lieu of medical escorts, telehealth consultations should be prioritized for clients who need access to specialized STBBI treatment providers (e.g., for HIV and viral hepatitis).

Table 3.13 Stakeholder Quotes Pertaining to Expediting Treatment and Linkage to Care	
PHASE 1	
PWAI	"They are pretty good at helping us with discharge planning here." "When you leave they ask which pharmacy you're going to (or even multiple ones in the area) to make sure a prescription is there. There are also pharmacies that will drop off your meds to you wherever you are." "Main concern is getting access to health care when I'm released. I no longer have a family doctor."
PHASE 2	
HCW	"Have a system to link patients to care post release for continuity." "Clinic nurse can start sitting and discussing with the client." "Send letter to community, clients may get released anytime – even clients sentenced can suddenly get released; document everything in their release plan in their tracking sheet." "Important to send another letter to the provider about the status of the patient." "Make plans for regular schedule meetings to make implementation progress." "Train nurse practitioner to initiate treatment or do telehealth, as soon as labs [are] done, should be contacted within one week, and not always wait for primary care provider." "Have some support for the discharge planning (see section 1.8) so that nurses feel comfortable and know how to go about it." "[Should have a prompt on discharge sheet that says 'I]f person is on OAT and undergoing Hep C treatment, please do [OAT and treatment] together." "Most of the discharge must be coordinated – need to work hand in glove." "Discharge planning is a shared responsibility; not just up to discharge nurse." "Housing and communication issues are barriers to continuity of care."

3.3.9 Documentation

STBBI testing and treatment checklists or decision support tools tailored for the corrections environment should be developed to assist HCWs in providing care. The EMR should have prompts to:

1. Document when testing was offered and accepted, and to whom.
2. Document the date of laboratory testing completion.
3. Document if testing has been declined.
4. Remind HCWs to re-offer testing to those who have declined.
5. Document what the test results were and when test results have been given.
6. Track the STBBI treatment journey.
7. Track referrals to community care.

4 CONSIDERATIONS FOR KEY POPULATIONS

4.1 Recommendations for Serving Indigenous People

COs

An emphasis on culturally safe care is essential to support STBBI testing and treatment uptake and care for Indigenous people who experience incarceration in BC. Our findings indicate high levels of mistrust among Indigenous people towards correctional centre HCWs and processes. This is consistent with findings from the *In Plain Sight* report that point to mistrust and avoidance of the health care system by Indigenous people in order to avoid discriminatory treatment by health care staff, due to continued stereotyping, profiling and discrimination.[22] Trauma and violence-informed care is also a fundamental component of creating culturally safe spaces for Indigenous people.[16]

Culturally safe care in correctional centres must be prioritized, with an added emphasis by correctional HCWs to develop and maintain trust with Indigenous clients.

4.2 Recommendations for Serving LGBTQ2S+ People

COs

In keeping with best practice guidelines for health care workers, providers should be familiar with approaches to providing culturally competent care to LGBTQ2S+ individuals. This is especially important given the overrepresentation of LGBTQ+ individuals among PWLE.

Privacy and confidentiality are especially important for LGBTQ2S+ individuals. Additional efforts should be made to safeguard information pertaining to sexuality and gender, including matters related to gender transition. As a way of combatting stigma, information about STBBI care and sexual health provided to PWAI should be inclusive of diverse genders and sexual practices.

Approaches to culturally safe STBBI care for LGBTQ2S+ individuals should be aligned with those that promote cultural safety for Indigenous PWAI. Further engagement with LGBTQ2S+ and Indigenous PWLLE is needed to be able to provide more guidance on how to provide STBBI care that is gender affirming and culturally safe.

4.3 Recommendations for Serving Women

COs

In Canada, women who are incarcerated are more likely to be living with an STBBI than men who are incarcerated and the general population. Women often have unique pathways to incarceration compared to men,[23] and experience higher rates of lifetime trauma,[24] including physical and sexual abuse, poverty, unstable housing and stigma. In tandem, women are often confronted with barriers to accessing high quality and appropriate health care both in and out of carceral settings.[25]

To promote trust between women who are incarcerated and HCWs and to improve health outcomes, essential approaches include:

- a supportive, trauma and violence-informed approach to STBBI identification that removes stigma and improves access to health care
- an emphasis on clear and ongoing communication regarding the confidentiality of medical privacy[20]

Women who are incarcerated in Canada also tend to be highly mobile (e.g., have shorter sentences and move back into community relatively quickly), negatively impacting health care access.[26] A coordinated and accountable program of reintegration that facilitates the continuity of health care for STBBIs, as well as safe housing, harm reduction and other supports, is also important in improving the STBBI health of women.[26]

5 OTHER RECOMMENDATIONS AND FUTURE DIRECTIONS

5.1 Implementation Recommendations

To support implementation and adoption of these policy recommendations and guidelines, a protocol for STBBI testing and management of HCV treatment in primary health settings was developed with stakeholders and is located in Appendix B. To complement this protocol, a number of additional elements are recommended;

5.1.1 Working Groups

COs

Each correctional centre should form a STBBI working group that includes:

- A Correctional Health Services (CHS) manager or assistant manager,
- 1-2 CHS nurses,
- A representative from local communicable disease program or public health unit,
- A local infectious disease or HCV specialist,
- A Correctional Health Services MD/NP,
- An STI certified nurse,
- A representative from Corrections staff, and
- A representative from local harm reduction/OAT/HIV/Hep C clinic/outreach clinic.

An STBBI working group is needed because it is unrealistic that centres would be able to achieve optimal STBBI test uptake and linkage to care immediately, therefore a staggered rollout of changes is recommended. The STBBI working group would oversee this rollout, and determine the changes or enhancements needed. The STBBI working group should review STBBI test uptake, test positivity and treatment uptake statistics, at least quarterly, to identify areas to improve on, or strategies that are working well that could be scaled up or implemented in other centres.

Working groups should also review staff and client educational needs and priorities, as well as communication gaps between the CHS team and community treatment providers, local public health units or other relevant community services.

STBBI testing and linkage to care should be added as a standing agenda item on other team meetings, as well as with shift change client handovers/reports.

5.1.2 Correctional Centre Promotion of Guidelines

COs

CHS should conduct training with clients and staff, in addition to information sessions for Corrections staff, to promote the implementation of new policies and guidelines. Ongoing annual refresher training should be provided to staff in the form of a brief online course (for HCW and COs).

Education for clients should be provided at least every 3 months to ensure it is offered often enough that those on short sentences will have opportunity to receive education. STBBI education tailored to Indigenous people should be available as well, which could be offered by facilitating access to programs from Chee Mamuk (Indigenous programming through BCCDC).

5.1.3 Ongoing Monitoring & Evaluation

An annual report on STBBI testing and linkage to care in BC Provincial Corrections should be published and available publicly or to key stakeholders (e.g. Ministry of Health, Ministry of Public Safety and the Solicitor General, Health Authorities, Client Advocacy Groups, etc.). Additionally, a knowledge exchange event with partners and stakeholders (e.g. public health, HCV treatment providers, community organizations, etc.) should be held annually in order to share lessons learned, progress and gaps or solutions.

5.1.4 Future Review of Recommendations

COs

If any changes to contracts or staffing occur, or other related policies or procedures are revised, the implementation of these recommendations should be reviewed and revised. Further revision to recommendations should also be conducted upon review of additional input from clients or other stakeholders.

5.2 Addressing the Social Determinants of Health

COs

While there are limitations to the ability of health care providers in being able to address all of the social determinants of an individual person's health, there are strategies that can be employed to mitigate the impacts of detrimental social and environmental factors. For example, prior to release from custody, facilitating access to birth certificates, ID and assisting with disability or income support payments is extremely important to ensure continuity of care. Additionally, strategies need to be developed to support people being released from custody who are unstably housed, such as referrals to housing programs or other supports. In order for CHS to assist in addressing the social determinants of health among clients, particularly those which impact STBBI care such as unstable housing and poverty, referrals to community transition teams or other community services (e.g., Unlocking the Gates) should be integrated into routine practices for all clients with chronic health conditions, including STBBIs. Expansion of the Indigenous Patient Navigator role and peer roles in provincial correctional centres, which are currently only in certain provincial correctional centres, as well as expansion of the community transition teams, is warranted to assist in increasing connection to care for STBBIs upon release from provincial custody.

5.3 Training and Support for Correctional Health Services Staff

MD/NPs contracted to corrections should be provided opportunity to gain experience in managing STBBIs, for example preceptorship with HCV treatment providers or other specialists.

RNs working in corrections would also benefit from the opportunity to gain additional experience in performing venipuncture in order to obtain venous blood samples. This is within the scope for RNs, however those who have not had experience recently would need a refresher.

Supporting all staff to work to their full scope will further enhance the implementation of these recommendations.

5.4 Recommendations Collaborative Development of Policies and Guidelines

COs

Create a formal mechanism for PWAI and staff to anonymously provide input into STBBI-related procedures, or ensure staff and clients are aware of existing opportunities to provide feedback. Consider creating mechanisms for client and staff input to be incorporated into the development of other new policies and guidelines.

5.5 Testing Alternatives

STBBIs, such as HIV or hepatitis C, can be tested using a blood sample from a vein or from a finger-prick by HCWs or self-testing. Self-testing can be defined as: "...when an individual collects blood or saliva samples, then uses a rapid diagnostic kit to process samples, obtain results and interpret them according to instructions provided with a kit. A kit typically includes information on linkage to care as appropriate."[27] This method can be used as a self-done rapid point of care HIV or Hep C test. Some guidelines recommend the availability of finger-prick testing and self-testing to promote STBBI testing.[27]

While the majority of stakeholders consulted continue to prefer to have a blood sample from a vein collected for testing for infections such as HIV or HCV, a significant proportion indicated that they would prefer a sample to be collected from a finger-prick. As such, methods for STBBI testing that can utilize finger-prick specimens, such as point-of-care tests or Dried Blood Spot sample testing, should be considered for implementation in provincial correctional centres.

Further, phlebotomy training for HCWs working in correctional centres is strongly recommended, as venipuncture is in-scope, particularly for RNs. Relying on external contractors to come in to correctional centres to conduct phlebotomy on fixed days creates a bottle-neck in sample collection. This adds delays to sample collection, which is particularly problematic for PWAI who are on remand or serving very short or intermittent sentences.

5.6 Access to Safer Sex Supplies

COs

Safer sex supplies should be made available and easily accessible to PWAI without having to ask COs in all provincial correctional centres in BC. Condoms, lube, dental dams and medical grade gloves should be prioritized when supplying safer sex tools.

5.7 Drug use + Harm Reduction

COs

Safer drug use and harm reduction tools should be available at the equivalent standard they are available in the community. Consider creating a mechanism for substance use under the observation of health care staff, considering the success of the model for overdose prevention sites that have been implemented in a CSC institution and will be rolled out nationally.[28]

OAT and safer supply (e.g., providing prescribed medications as a safer alternative to the toxic illegal drug supply) should be available in the same way it is in the community, with HCWs who work with PWAI trained on how to initiate OAT.

6 APPENDIX A: ENVIRONMENTAL SCAN

6.1 Environmental Scan: Executive Summary

The purpose of the environmental scan was to assess best practices/methods for (1) conducting education interventions in the context of correctional centres; and for (2) determining best-practice considerations in the development of STBBI testing policy and guidelines.

6.1.1 Education Approaches for Corrections Staff and PWAI

Methods

Three databases (PSYCH INFO, CINHAL, and MEDLINE) were systematically searched for qualitative or quantitative peer-reviewed English-language studies, published in the last 10 years (see Appendix 1 for search terms), reporting on education methods for people who are incarcerated, even if not pertaining to STBBIs. Studies were retrieved for review if papers described and evaluated short-term education sessions (e.g., not long-term career courses) for PWAI.

Results

Of 3287 studies imported for screening, 2594 studies were screened, 436 full-text studies were assessed for eligibility, and 30 studies (17 quantitative, 13 qualitative) met the final inclusion criteria to be reviewed and scored. Of the 30 studies, 18 came from the United States, 5 from Canada, 3 from the United Kingdom, and the remaining 5 varied across the world (Portugal, Iran, France, and Switzerland).

Key findings from peer reviewed literature

For staff, barriers for uptake and implementation of educational efforts within prison settings included a lack of allocated time, space, and resources for educational purposes.[29,30] Limited allocated work hours dedicated to participate in educational training interfered with learning for staff.29 Flexible learning options (including online courses),[29,31,32] as well as in person learning opportunities to facilitate collaborative learning group discussion showed promise.[31,33-35] Online learning may provide the opportunity to start and stop lessons at the staffs' convenience looked to be the most promising as this allows for flexibility in scheduling.

For PWAI, high turnover rates made it difficult to full complete courses.[36,37] In person group classes that facilitated peer-to-peer discussion showed the most success.[38-40] Efforts and attention to the social determinants of health within educational programming should be prioritized for this population.[40]

6.1.2 STBBI Testing in Prisons

Methods

Three databases (PSYCH INFO, CINHAL, and MEDLINE) were systematically searched for qualitative or quantitative peer-reviewed English-language studies, published in the last 10 years, reporting on STBBI testing and uptake in prison settings for PWAI or people who were formerly incarcerated (see Appendix A for a list of search terms). Articles were retrieved for review if they focused on people who are incarcerated (current/past) and included an intervention aimed at increasing/improving STBBI screening uptake/quality in correctional settings (inclusive of HCV, HBV, HIV, syphilis, chlamydia or gonorrhea), which was: (a) described in sufficient detail to be relevant to informing our own intervention, and (b) evaluated effectiveness in some way. We also searched the grey literature for relevant resources (e.g., existing STBBI guidelines for correctional settings, resources specific for PWAI, resources for health care workers).

Results

Of 175 studies imported for screening, 79 full-texts were assessed for eligibility and 29 studies (19 quantitative and 10 qualitative) met the final inclusion criteria to be reviewed and scored. Of the 29 studies, 16 came from the United States, 6 from the United Kingdom, and the remaining 7 varied across the world all from (Ukraine, France, Mexico, Zambia, and Ireland). The majority of studies addressed testing for HIV[41-52] or HCV[43,53-63]; 5 papers included STBBIs other than HIV and HCV, such as hepatitis B, hepatitis E, syphilis, and tuberculosis.[51,64-67]

Key findings from peer reviewed literature

Opt-out testing. Many papers assessed opt-out testing with a common understanding that 'opt-out' testing means people who are incarcerated (PWAI) are notified that screening for one or more STBBIs would be performed unless they declined.[49] Several quantitative (n=5) and qualitative (n=4) papers demonstrated that the implementation of an opt-out policy enhanced the number of people being tested in prison settings.[46,48,49,52-54,58,62,63] Opt-out screening was shown to be cost-effective,[53,62] associated with increased testing autonomy,[47] decreased stigma around access to testing,[49] and was a supported method amongst focus groups.[53]

Relationship. A lack of patient-provider relationship increased challenges around conveying the voluntary nature of opt-out testing[44] - an important finding given that several studies showed misinterpretations of an "opt-out policy" by PWAI.[44,50,60] Two studies in particular[44,50] demonstrated that over half of participants inaccurately reported that HIV testing was mandatory when there was an "opt-out" testing policy in place.

Knowledge. Lack of HIV/HCV knowledge and awareness of testing procedures also added to the inaccurate perception of testing requirements.[50] Fears around being assessed for or on HCV treatment emerged as a theme as a result of misinformation around testing procedures.[53,54]

Power Imbalances. Given that correctional centres, by design, limit the autonomy and rights of PWAI, some studies noted power imbalances and potentially coercive relationships between prison health care staff and PWAI.[43,44] One study demonstrated that even if PWAI are informed that they have the right to refuse testing, feelings of being coerced can still exist.[43]

Confidentiality and Stigma. HIV and HCV related-stigma was also found to be a significant barrier to facilitating testing uptake.[41,43,48,53-56] Many PWAI had concerns regarding confidentiality,[41,42,47,53,54] as well as stigma and discrimination from other PWAI or prison staff associated with a positive diagnosis.[48,53]

Linkage to Care. Poor linkage to care post-release was identified as a significant challenge across studies.[52,54-56,61] Although uptake of treatment within prison was high, prison transfers or release of people who were incarcerated was a persistent barriers to receiving test results and for continuation of treatment.[52,56]

Key Recommendations for Best Practices

Rapid testing. To improve uptake and cooperation surrounding testing for blood borne infections, several studies[42,45-47,55] recommended a less invasive testing option - in place of more conventional venipuncture procedures,[54] specifically, rapid-testing (i.e., lateral flow devices for

point of care testing of oral and finger prick blood samples such as Ora Quick® HCV rapid antibody test or INSTI® HIV rapid antibody test).

Education. A common recommendation to mitigate the above concerns is improved efforts aimed at HIV/HCV education for both prison staff (inclusive of health care providers) and PWAI. Education can address misinformation and ensure that PWAI are fully informed surrounding testing and treatment procedures. This lends to promote autonomy with regards to testing[47] and help facilitate trust between PWAI and prison health care providers.[54] Increased education can also address stigma within the prison system by mitigating false anecdotes regarding HIV/HCV. Appropriate and relevant training must be readily available for prison staff.[61] A focus on lay language and accessible educational material was suggested for PWAI.[60] Overall, increased educational programs to disseminate information regarding STBBI's showed positive results amongst multiple studies.[41,50,53,59,60,63,65] In some cases, peer-to-peer education was also found to be beneficial.[65]

Power Imbalances. To counter power imbalances, it is important to establishing consistent patient-provider interactions and ensure that testing policies are well defined.[44]

Confidentiality. Recommendations for improving confidentiality included: ensuring private areas for testing, disguising educational pamphlets, and allowing PWAI to choose their own times for testing; this can also improve PWAI autonomy.[55,56]

Linkage to Care. The recommendation to improve linkage to care for PWAI transferring to other prisons was to employ a flexible approach for scheduling health care appointments to accommodate lock downs and other occurrences within prison that may interrupt ability to maintain an appointment.[56] Improved engagement with stakeholders and community partners (e.g. community health care providers, local health departments, parole and probation agencies) to coordinate medical and social services following release was recommended to facilitate continuation of care for PWAI who are being released back to the community.[52]

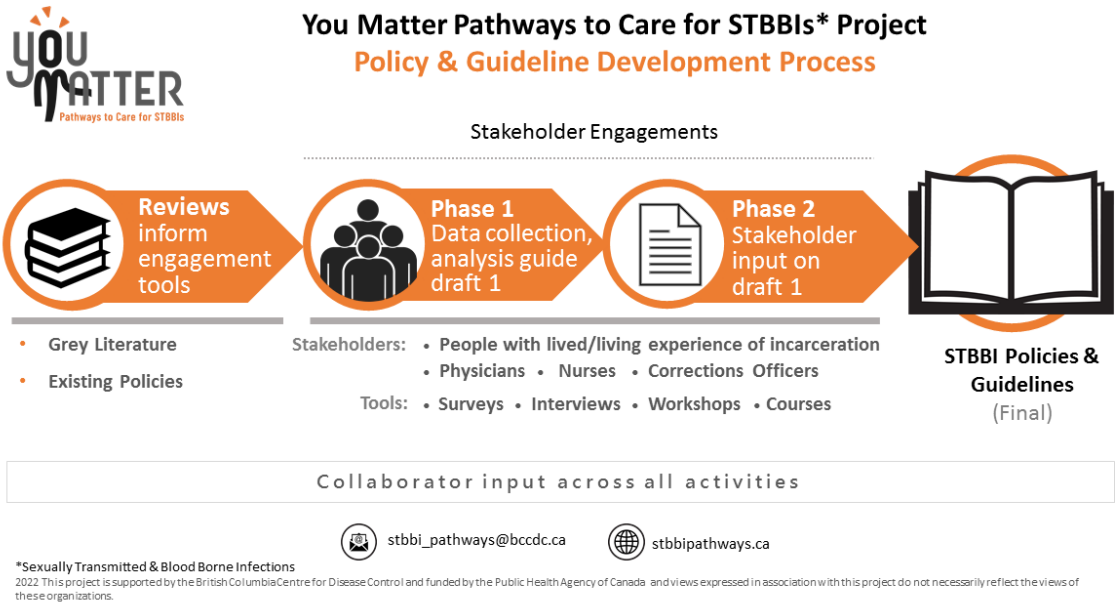
Specific Population. Studies generally lacked considerations for specific populations within prison settings (e.g., people who are racialized, transgender, non-binary, or Two-Spirit people, women). Although no studies focused on a specific populations one study did note that transgender prisoners declined to participate in their study, citing stigmatization as the predominant reason[64] - an important finding pointing to the potential barriers in accessing confidential and safe health care for gender diverse populations within correctional settings.

6.1.3 Summary and Conclusions

The purpose of the environmental scan was to provide a summary of existing best-practices and resources to inform our policy and guideline development with regards to STBBI testing in provincial correctional settings for PWAI. In total, we reviewed 29 peer-reviewed studies and 27 grey literature documents.

Recommendations for best/promising practices include: increased STBBI education for PWAI and prison staff to address stigma and misinformation; improved patient-provider interactions, including addressing power imbalances between staff and PWAI; and efforts to increase privacy and confidentiality measures around testing. Further gaps identified included a need to incorporate culturally-sensitive education, specifically to engage Indigenous populations, and tailored-testing interventions for specific populations in prison settings.

7 APPENDIX B: PROJECT METHODS – STAKEHOLDER ENGAGEMENTS



Studies suggest that routinely offering Sexually Transmitted and Blood-Borne Infection (STBBI) testing results in high uptake of testing in correctional settings.[68-77] However, reported increases in uptake are inconsistent, and there are reports of policy-related unintended harms. In view of this, our project's vision was to create policy and guidelines for STBBI testing and linkage to care for Provincial Correctional Centres in British Columbia (BC).

To optimize the relevance and uptake of the recommended STBBI testing policy and guidelines, we collaborated with key stakeholders and incorporated their perspectives into our recommendations.

First, we contacted key stakeholders prior to the start of our work on this project. First, BC Corrections and Correctional Health Services (CHS) leaders were consulted before the project launch (and at critical points along the project timeline).

Second, we formed a project committee to help guide and support this work. The committee included CHS staff, people with lived experience of incarceration, advocates, researchers, community organizations, physicians and allied health professionals. The committee met monthly to provide input on project direction, set priorities, and discuss progress. Third, we had a telephone meeting with the Okanagan Correctional Centre's Community Connections Group (PWAI n = 7)[e] to get to get their input on our proposed work, honoraria amounts, conducting surveys with PWAI, and STBBI testing.

Concurrently with the above, we conducted an environmental scan to inform engagement activities and the development of survey tools (see Section 6). The two engagement phases of the project were: (1) organizing workshops with key stakeholders to get their initial input about STBBI testing in BC correctional centres; and (2) conducting workshops/meetings with key stakeholders to get their perspective on the core aspects of the first draft of the recommended STBBI testing policy and guidelines. At the end of each engagement phase, we drafted or revised the recommended STBBI testing policy and guidelines.

7.1 Methodological Approach: Phase I

The purpose of the Phase 1 work was to seek input from key collaborators on the experiences and preferences pertaining to STBBI testing in BC Correctional centres.

7.1.1 Recruitment, Data Collection and Participants

Key stakeholders invited for engagement included people who are incarcerated (PWAI) or people with lived experience of incarceration (PWLE), BC Corrections officers (COs) and other staff (e.g., wardens, managers), and health care workers (HCWs) who work in or for BC correctional centres. Initially, we planned in-person workshops to elicit feedback from key stakeholders, but the COVID-19 pandemic restrictions excluded this option; therefore, engagement was conducted via Zoom or Microsoft Teams, with the exception of one in-person workshop with PWLE in Phase 2.

In Phase 1, we conducted engagements through a combination of Zoom, MS Teams, online surveys, paper-based surveys, and online courses containing STBBI policy and guideline input surveys. The Provincial Health Services Authority's LearningHub Online Learning Centre hosted the courses and participants registered for a LearningHub account if they did not already have one.

Phase 1 engagements with key stakeholders had two core components:

1. An educational portion. A brief presentation of basic STBBI facts to ensure everyone had basic information about STBBIs in prisons before providing input. We presented information using one of the following modes: virtual presentation, STBBI factsheets, video, and/or narrated online courses.
2. Survey tools. With the survey tools we asked participants to share their perspectives on different aspects of STBBI testing in correctional centres.

We created survey tools with input from key findings from the environmental scan (e.g., STBBI testing issues identified in the literature), and input from collaborators and other experts. Our community partners, Unlocking the Gates Services Society (UTG) and Circle of Eagles Lodge Society (COELS), also reviewed the survey tools prior to implementation. Each engagement also included pre- and post-workshop quizzes to assess STBBI-related knowledge gains as required by our funder. We have not listed this information in this report.

e The purpose of OCC's Community Connections group is to share community resources with people re-entering community from prisons, particularly housing and employment resources to reduce recidivism. Although the group sees housing and employment as the most important issues for people leaving corrections, that once people have housing, employment and are happy, they also want to improve their health.

7.1.1.1 People Who Are Incarcerated (PWAI)

Recruitment

We engaged with PWAI through five different BC correctional centres located in various parts of the province, including the Lower Mainland, Vancouver Island, the Interior, the North, and the Fraser Valley. Four of these correctional centres (Lower Mainland, Vancouver Island, the Interior, and the North) were centres designated for men, and one (Fraser Valley) was designated for women. Once wardens from each site gave their approval for the project, we connected with programs officers to provide an overview of our project and send printed recruitment posters. Participant recruitment was facilitated by Corrections officers (COs: e.g., programs officers, corrections officers, wardens) who posted or distributed posters inviting PWAI to participate in a series of two workshops.

Data Collection

We created an Instructions and Tools for Engagements booklet (pages 3 to 15 for PWAI engagements) to guide project staff through pre-workshop preparations, including booking workshops and shipping workshop materials and instructions to Corrections officers (COs: e.g., programs officers, corrections officers, wardens). We cannot overstate the fact that BC Corrections leads and COs were crucial to the success of the workshops with PWAI. While we were not permitted to provide honoraria to COs, their willingness to support the project and act as on-site facilitators was integral to the success of this work. Workshop protocols included:

Prior to the workshop

- Send workshop materials to the centre (Project Team members)
- Post or hand out workshop invites (CO)
- Maintain a list of who wanted to participate on the scheduled workshop dates (CO)
- Arrange and/or book rooms with technology needed for virtual workshops (two sessions per group) (CO).

Workshop Session 1: STBBI Basics (90 to 130 minutes)

- Hand out snacks, blank paper and pens/pencils (CO)
- Hand out and collect, as Virtual Presenter requests:
  - Consent forms
  - Pre-workshop survey
  - Post-workshop survey
- Presents STBBI Basics presentation (Virtual presenter)
- Ask participants to sign Session 1 honoraria form (CO).

Workshop Session 2: Project info, discussion about policies, and guideline input survey (90 to 120 minutes)

- Hand out snacks, blank paper and pens/pencils (CO)
- Hand out and collect, as Virtual Presenter requests the PWAI Policy & Guideline Input Survey (CO)
- Present overview of the project and project video, policy and guideline basics, and walks through the guideline input survey (Virtual presenter)
- Collect all completed forms and surveys, put them into postage paid bubble envelopes and mail them back to project team (CO).

After the workshop

- Send cash or transfers funds to Correctional Centre for honoraria (Project team)
- Ensure participating PWAI received their $10/session honoraria (a deposit to their commissary fund) (CO).

Participants

Participant eligibility included anyone incarcerated at a participating correctional centre at the time of the workshop and who were not on any restrictions by the correctional centre. Across the five centres, 64 PWAI participated across the 18 virtual workshops, with each participant invited to attend a series of two workshops.

7.1.1.2 People with Lived Experience of Incarceration (PWLE)

Recruitment

We contracted two community-based organizations that work with people recently released from correctional centres for PWLE recruitment: UTG and the COELS. UTG connects with people during their incarceration, helps with pre-release planning, and supports people following their release from correctional facilities in BC. COELS provides transitional housing to people leaving correctional institutions and focusses on providing cultural supports and programming to meet

the needs of First Nations, Inuit and Métis people who are transitioning back to the community. Each society invited participants with lived experience of incarceration as they encountered them in their work, or with whom they had most recently worked.

Data Collection

UTG and COELS reviewed the PWLE survey and made adaptations accordingly to produce the final PWLE Policy & Guideline Input Survey. Because it was not possible to have two engagements with each PWLE participant, the survey contained all pre- and post-education surveys, a factsheet, background questions, and the policy and guideline input questions. We also provided UTG and COELS with a link to an STBBI basic educational video in case participants preferred viewing a video rather than reading the factsheet. The complete survey was online using the Qualtrics online survey platform.

Tablets with links to the online survey were used to administer surveys to participants. Project staff trained community partners on how to use the tablets on and off-line. An Instructions and Tools for Engagements booklet (pages 16-24 for PWLE engagements) was created to guide project staff through engagements with our community partners.

Tablets and paper-based surveys were mailed to COELS and UTG so they could offer potential participants a choice of: (a) a one-on-one survey interview where the interviewer completes the paper or online tablet survey form for the participant; or (b) where the participant completes their own paper survey or online tablet survey. All PWLE who completed the survey were provided a $25 honorarium to compensate for their time.

Participants

Eligibility to participate included being over the age of 18 years and having previous incarceration in a provincial or federal correctional centre. A total of 122 PWLE participated in the study through UTG and COELS recruitments, with 103 of the 122 participants having been released from a provincial correctional centre within the last two years; 45 with the last 6 months.

7.1.1.3 Health Care Workers (HCWs)

Recruitment

Correctional Health Services managers were concerned about staff burden because of COVID-19 pressures and an existing COVID-19 study in the centres. Therefore, we created an online course for staff to complete when convenient, and recruited via e-mail invites. Our team sent managers a template e-mail that described the purpose of the project and invited staff to complete the course. Managers could then revise the e-mail invite as needed and circulate to all or some of their staff.

Data Collection

The online course for HCWs[f] ran from June 1, 2021 to October 12, 2021 with 64 HCWs completing the STBBI Policy and Guideline Input Survey. The course had the following structure:

1. Background survey
2. Pre-course quiz
3. STBBI factsheets
4. Course module
5. Post-course quiz
6. Course evaluation
7. HCW STBBI policy and guideline input survey.

Items 1, 2, 5 and 7 served as sources of data for the policy and guideline work.

Participants

HCWs were eligible to participate in the course if they provided health care to people incarcerated in provincial correctional centres at the time of the survey. Forty-three HCWs completed the guideline input survey.

7.1.1.4 Corrections Officers and Other Corrections Staff (COs)

Recruitment

Corrections leads asked us to postpone engagements with COs until late summer because of workload issues relating to COVID-19. In August 2021, our team sent managers a template e-mail that described the purpose of the project

f The BCCDC STBBIs in Corrections course is still available at the time of this writing, but without the STBBI policy and guideline input survey as a completion requirement.

and invited COs to complete a brief online course which included an *STBBI Policy and Guideline Input Survey*. Managers could then revise the e-mail invite as needed and circulate to all or some of their staff.

Data collection

The online course for COs[g] ran from August 17, 2021 to September 17, 2021.The course had the following structure:

1. Background survey
2. Pre-course quiz
3. STBBI factsheets
4. Course module (optional)
5. Post-course quiz
6. Course evaluation
7. CO STBBI policy and guideline input survey.

Items 1, 2, 5 and 7 served as sources of data for the policy and guideline work.

Participants

Eligibility required that participants currently work in a BC Correctional centre and 103 COs completed the STBBI Policy and Guideline Input Survey.

7.2 Methodological Approach: Phase II

The main purpose of Phase II was to engage people from each stakeholder group to obtain their feedback on core components of the draft policy recommendations and guidelines created at the end of Phase I.

7.2.1 Recruitment, Data Collection, and Participants

7.2.1.1 People with Lived Experience of Incarceration (PWLE)

Recruitment

UTG staff recruited PWLE for in-person engagements that occurred in December 2021. At this time, COVID-19 pandemic restrictions had not yet escalated which made the event possible. We mailed one-day bus passes to UTG so they could offer them to participants at the time of recruitment, along with directions to the event location. The project rented a room from Simon Fraser University in Surrey, British Columbia for the event, and food and beverages were provided to those in attendance. Participants were compensated $25/hour for their participation at the end of the event and offered a one-day buss pass.

Data Collection

In Phase II, we conducted two in-person PWLE workshops with the main purpose to identify any gaps in the existing guidelines. We reviewed key recommendations and asked participants for any issues or alternatives than what we had presented. Project staff took notes and a graphic recorder depicted some of the discussion points on a large poster.

Participants

People who had ever been incarcerated in a provincial and or federal correctional centre were eligible to join a workshop and a total of 16 PWLE participated.

7.2.1.2 Health Care Workers (HCWs)

Recruitment

We obtained permission from CHS to engage HCWs who work for CHS. In addition, CHS gave us a list of physicians who provide medical services in one of the facilities. We sent a draft e-mail invite to regional managers who could then modify the invite and forward it to all or some of their staff. We also compiled a list of physicians who provided health care at a BC Correctional centre and e-mailed invites directly to them. We sent up to three e-mail reminders to non-responders, and if there was still no response, we made phone calls in efforts to recruit at least one HCW from each of the provincial correctional centres (n=10).

Data Collection

The main purpose of the HCW workshops was to achieve consensus on what HCWs believed was needed to improve STBBI testing across all BC Correctional centers. After determining the need for one basic testing and linkage to care protocol across centres, the group reviewed and recommended changes to a draft STBBI testing protocol diagram for STBBI testing in correctional centres. Because of time limits, the document included overall STBBI testing, and then followed with HCV as an example for managing test results, linkage to care and treatment.

g The BCCDC STBBIs in Corrections course is still available at the time of this writing, but without the STBBI policy and guideline input survey as a completion requirement.

HCW responses were recorded and stored within this document. We used meeting notes and auto-generated meeting transcripts to confirm statements, as needed. Finally, we e-mailed the STBBI Workflow document to the HCWs and requested their input on the document.

Participants

We conducted four Zoom meetings with physicians and nurses with eligibility criteria being that they were HCWS who currently provided health care services to people who are incarcerated in provincial correctional centres, and could attend one or more of the four pre-scheduled workshop times. Six nurses and eight physicians attended at least one workshop. With some HCWs providing care at more than one correctional centre, 8 of the 10 centres were represented by at least one HCW:

- ACCW - Alouette Correctional Centre for Women
- SPSC - Surrey Pre-trial Services Centre
- FRCC - Fraser Regional Correctional Centre
- FMCC - Ford Mountain Correctional Centre
- VIRCC - Vancouver Island Regional Correctional Centre
- PGRCC - Prince George Regional Correctional Centre
- KRCC - Kamloops Regional Correctional Centre
- OCC - Okanagan Correctional Centre

7.2.1.3 Corrections Officers and Other Corrections Staff (COs)

Recruitment

Due to COVID-19 related concerns, we were not able to have workshops with COs in person. Instead, COs who previously completed the online STBBI course we developed for Phase I, were invited to participate in the Phase II survey. E-mails with survey links were sent to COs with an additional two reminder e-mails.

Participants

A total of 16 COs completed the survey, including administration staff, corrections officers, managers, and correctional supervisors.

Data Collection

The purpose of the anonymous online survey (via Qualtrics) was to collect input on what we identified as some topics that required additional clarification.

7.3 Results: Participant Demographics

We used descriptive statistics to assess prominent issues and concerns, and identify solutions. Please see Appendix E (Section 10) of this report for detailed survey results that are relevant to each recommended policy and guideline. This section presents the demographic profiles of PWAI and PLWE participants.

7.3.1 *People with Lived and Living Experience of Incarceration (PWAI and PWLE)*

Phase 1

We merged PWAI and PWLE participant data into one dataset and called this larger group 'People with Lived **or** Living Experience of Incarceration' (PWLLE). Of all PWLLE, 55% (n=96) identified as Indigenous, 35% (n=61) identified as white and 9% (n=16) identified as one of a number of non-Indigenous visible minority groups. Most identified as a 'Man' (see Table 7.1). The highest level of Education for the majority (38%) of participants was 'less than high school education' (see Table 7.2).

Table 7.1 Phase 1 PWLLE Self-identified Gender by Ethnicity								
Question was 'check all that apply' so totals by group can be greater than the number of respondents	Indigenous (n=96)		White (n=61)		Other visible minorities (n=16)		Total (n=173)	
	%	**(n)**	%	**(n)**	%	**(n)**	%	**(n)**
Man	74	(71)	77	(47)	69	(11)	75	(129)
Woman	21	(20)	20	(12)	31	(5)	21	(37)
Non-Binary	0	(0)	3	(2)	0	(0)	1	(2)
Gender Queer	1	(1)	0	(0)	0	(0)	1	(1)
Transgender	2	(2)	0	(0)	0	(0)	1	(2)
Two-Spirit	6	(6)	0	(0)	0	(0)	3	(6)
Prefer to self-describe	1	(1)	0	(0)	0	(0)	1	(1)

Table 7.2 Phase 1 PWLLE Minority v Non-Minority Sexual Orientation by Ethnicity[h]								
	Indigenous (n=87)		White (n=56)		Other visible minorities (n=16)		Total (n=159)	
	%	(n)	%	(n)	%	(n)	%	(n)
Minority	20	(17)	13	(7)	13	(2)	16	(26)
Non-Minority	80	(70)	87	(49)	87	(14)	84	(133)

Table 7.3 Phase 1 PWLLE Highest Level of Education		
(check one)	**%**	**(n)**
Less than high school graduation	38	(68)
High school graduation	34	(61)
Trade certificate, vocational school or apprenticeship training	18	(32)
Non-university certificate or diploma from a community college, CEGEP	2	(3)
University Bachelor's Degree	2	(4)
University graduate degree (e.g. Masters or Doctorate)	1	(1)
Some university or college (but not a certificate or degree)	7	(12)

h Although the experiences of each group is unique, there were insufficient numbers to draw any conclusions by group. Instead, respondents were grouped into sexual orientations that capture minority groupings (e.g., gay, lesbian, bisexual, queer, other self-described) and non-minority groups (straight). We thought this was one way to attempt to capture issues specific to groups who may be more likely to experience stigmatization and marginalization.

Phase 2

A total of 16 (12 men and 4 women) PWLE participated in the in-person Phase 2 workshops.

7.3.2 Health Care Workers (HCWs)

7.4 Project Limitations

- The project was mostly carried out during the COVID-19 pandemic, resulting in a slightly different profile of PWAI during COVID-19 compared to prior to the pandemic.
- Engagements with people in correctional centres were done virtually so we may not have been able to build the same rapport with participants as we would have in person.
- We were unable to do surveys or focus groups at all 10 correctional centres, although the sites we included were very diverse and likely would represent BC's correctional centres fairly well.

8 APPENDIX C: IMPLEMENTATION TOOL KIT AND EDUCATION RESOURCES

Visit stbbipathways.ca for many of documents listed below.

1. Phase 1 Workshop Implementation Tools can be found on our website[i] and include:
   a) Implementation guides
      i) Instructions and Tools for Engagements with people who are incarcerated (PWAI) and people with lived experience of incarceration (PWLE) (PDF)
      ii) Setting up Tablets for the Qualtrics Offline Survey App Setup (PDF)
   b) Documents for PWAI/PWLE engagements
      i) 1. PWAI Guideline input survey
      ii) 2. PWAI Pre-test survey
      iii) 3. PWAI Post-test survey
      iv) 4. PWAI Presentation Example
   c) Documents for HCW engagements
      i) 1. HCW Guideline Input Survey
      ii) 2. HCW Pre-Post survey
      iii) 3. Graphic – EASE Model (Draft)
   d) Documents for CO engagements
      i) 1. CO Guideline Input Survey
      ii) 2. CO Pre-Post Survey
2. Clinic Templates can be found on our website[j] and include (many are specific to British Columbia):
   a) STBBI (HCV) testing and linkage to care workflow
   b) Script for Routine STBBI Test Offer
   c) Standing Order Requisition Sample – Intake STBBI tests
   d) Standing Order Requisition Sample – Intake Liver tests
   e) HIV Discharge Planning Form

i https://stbbipathways.ca/workshop-implementation-tools/
j https://stbbipathways.ca/clinic-templates/

3. A variety of STBBI-related education resources can be found on our website for:
    a) Community and clients (e.g., Videos, You Matter Factsheet, Playing card template)
    b) Health Providers (e.g., Videos, Online course, Factsheet)
    c) Corrections Staff (e.g., Online course, Video, Factsheet)
4. A variety of hepatitis C-related education resources are also located on our website:
    a) Community and Clients (e.g., Hepatitis C The Basics online course, Hepatitis Education Canada booklets, BC Government, have you been tested?)
    b) Health Providers (e.g., BCCDC Hepatitis C course for public health providers, CATIE treatment basics)
5. The BCCDC Hepatitis C treatment guide for Health Care Providers can be found on the BCCDC website[k].

k http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%201%20-%20CDC/BCCDC%20HCV%20Tx%20Guide%20Grey%20FINAL%20April%202021.pdf

9 APPENDIX D: OTHER RESOURCES TO SUPPORT STBBI TESTING

1. Harm reduction course through CATIE: https://www.catie.ca/harmreduction
2. BC STI certified nurse decision support tools: https://www.nnpbc.com/education/decision-support-tools/decision-support-tools-list/
3. Playing cards
4. Other Community and Client items listed in Appendix 8

10 APPENDIX E: DATA AND EVIDENCE USED TO INFORM RECOMMENDATIONS

10.1 Stigma

10.1.1 Literature: Existing Recommendations/ Current Evidence

STBBI-related stigma, especially concerning HIV and HCV, is prominent in correctional centres and can be a significant barrier to facilitating testing uptake.[7,41,43,48,54-56] For PWAI living with HIV or HCV, stigma can also lead to isolation and discrimination[20], physical or verbal abuse [19], and threats of violence[21], and can compromise access to HIV care and treatment.[19,21,78]

10.1.1.1 Stakeholder Input

1. Among PWLE, 43% of respondents (n=72) indicated that fear of being judged or stigmatized would prevent them from being treated or tested for STBBIs while incarcerated.
2. In a focus group discussion with PWAI in March 2021, one participant shared "I've heard of someone with HIV on the unit – the priority was to get him off the unit as soon as possible". A participant from a focus group the following month in April 2021, noted "people are so scared of people with diseases".
3. Correctional staff were asked what could increase the number of people who get tested for STBBIs in corrections, and one respondent replied: "Less stigma around it being negative to have to get tested, I think the inmates may need to feel a little more support [around testing]". A total of 38 out of 61 comments suggested the need for education and changing policies for mandatory testing.

10.1.1.2 Existing or Related BC Corrections Policies/Guidelines/Protocols

Table 10.1 Existing Stigma-Related PHSA Policies

PHSA Policy #C-99-11-20568 Consent to Health Care Policy

All staff must conduct themselves in a civil, respectful, cooperative and non-discriminatory manner during the consent process in accordance with PHSA's Fostering a Culture of Respect policy. Additionally, Indigenous Cultural Safety will be applied for Indigenous patients, ensuring their wishes, values, beliefs and cultural traditions are considered and respected, throughout the consent process.

PHSA Policy # C-99-11-20200 Code of Ethics

We are committed to putting the interests of our patients first. We strive to uphold the following values:

- Treating patients with respect, dignity, courtesy, compassion, kindness, fairness and optimism;
- Providing health and social services to patients and their families with sensitivity and respect, being mindful of individual differences and cultural safety and ethnic diversity;
- Providing appropriate information to patients concerning their health and health-related matters in order to enable them to make informed decisions about their health care;
- Respecting the autonomy of patients and the right of those with capacity to make their own decisions regarding their health care; and Upholding legal and ethical duties to protect patient privacy and confidentiality

PHSA Policy Commitment to a Culture of Patient Safety

Wise Practices, the inclusion of diverse Indigenous knowledge and health practices that contribute to sustainable and equitable conditions, are given equal space and weight with Best Practices, a Western evidence-based approach to care reflecting current medical and therapeutic perspectives on standards or points of view.

Definition of Wise Practice: Effective and culturally appropriate actions, tools, principles or decisions that contribute significantly to the development of sustainable and equitable conditions and practices and, in doing so, produce optimal results for Indigenous Peoples. Definition of Best Practice: A practice that has been shown by research and experience to produce optimal results and that is established or proposed as a standard suitable for widespread adoption.

Table 10.2 Existing Stigma-Related BCMHSUS Policies

BCMHSUS-CHS CCR-105 P.h Patient Complaint Management: Resolution within FPH & PHSA Patient

Care Quality Office Involvement

Every staff member is responsible for the timely acknowledgement, documentation and resolution of a patient care quality complaint. Other complaints and suggestions will also be acknowledged and responded to, as appropriate. We expect that staff and patients/family/visitors will treat each other with mutual respect and dignity while delivering and responding to care quality complaint.

10.1.2 Ensure Privacy/Confidentiality for STBBI Testing and Education

10.1.2.1 Phase 1 Stakeholder Input

1. Although 95% of HCW's indicated there was a confidential and private way to ask for the STBBI test in their respective correctional centre, only 46% of PWLE indicated the same, which highlights a major disconnect between what is perceived and experienced by PWLE when it comes to confidentiality and privacy within correctional centres.
2. Although the majority of stakeholders indicated that PWAI have to submit a health care request in order to access testing, the level of confidentiality and privacy surrounding this method was inconsistent across centres based on responses from HCW's and corrections staff.
3. As noted by one participant during a focus group with PWAI, "You put your request into the box, it's locked, but who has access to it?" Another workshop respondent noted: "Guards can see what is written on the health care requests – it is taped shut but they can easily open it."
4. Of 142 PWLLE, 54% (n=76) indicated that that they were concerned correctional officers would have access to their test results.
5. One HCW responded [paraphrase]: Medical office space is a bit on the small side, so it can be difficult to ensure corrections staff are far enough away to prevent them from hearing confidential conversations.
6. A lack of privacy within the correctional centre also has implications for when PWAI return to their home communities, as noted by one workshop participant: "What happens if correctional staff finds out, your results can be outed in community [CO and PWAI live in the same community]."
7. A total of 73 PWLLE (51.4%) indicated that they were concerned that other people who were incarcerated would know their test results.
8. One workshop participant noted [paraphrase]: Bullying happens and people do find out other residents' health information. Confidentiality is huge.
9. Another participant noted that it was "…difficult to get your meds privately – all the guys are in line for meds are watching," indicating that issues around privacy and confidentiality do not end with testing procedures; accessing treatment and care is also not private.

10.1.2.2 Phase 2 Expert Consultation

<u>*COs*</u>

When asked "*What can be done to make it less likely that corrections staff would overhear discussions between health care staff and PWAI?*", COs suggested the following:

- HCWs could "…ensure that the client is in a secure/private area with health care provider." COs expressed safety concerns about leaving HCWs with PWAI alone in a private area stating that: "For safety reasons, I don't think you can ask for officers to not be there," but closing the door to increase privacy while maintaining sightlines might be possible in some cases, as expressed in this quote: "We do close their door and officer is kept visual in case the client ends up being violent."
- Others also suggested that "The results are not discussed. The information could be on a document and given to PWAI."
- To make it less likely that other PWAI would overhear discussions between health care staff and PWAI, COs offered the following suggestions:
- "Move to a location that's not near the waiting area."
- "Other inmates should be in locked holding tanks and not in screening rooms with inmates being seen."
- "Have conversation in [the] far office, there should be sufficient ambient noise to distort conversation being heard."
- "We keep health care at our centre pretty private. One client at a time or if there more than one. Another officer is present to watch the other client."

10.1.2.3 Existing BC Corrections Policies/Guidelines/Protocols

Table 10.3 Existing Privacy-Related PHSA Policies

PHSA IA_020 Privacy and Confidentiality Policy

The disclosure of Personal Information to persons or parties other than staff must be made only where such disclosure is permitted by FIPPA and authorized by PHSA. PHSA is authorized under FIPPA to disclose Personal Information in the following circumstances:

- Where specifically required or authorized by legislation to release personal information.
- Where required by the terms of a court order, subpoena or warrant.
- Where compelling circumstances exist affecting the health or safety of any individual.
- Where the individual consents in writing to the information being disclosed.
- To a service provider for PHSA where the service provider is obligated by legal agreement to abide by FIPPA, and the conditions under "Sharing Personal Information with Third Parties" are met.
- To protect the public in circumstances where there is a risk of significant harm to the environment or to the health or safety of the public or a group of people. Personal information may also be disclosed for the purpose of a common or integrated program between PHSA and another public body or the Ministry of Health only if a written agreement describing services, personal information sharing, and other specific legal conditions has been signed. Staff must consult the IAP office in the preparation of the required written agreement.

Corrections Act 19 Inmate Communication

- An authorized person may restrict, intercept, monitor or record inmate communication in accordance with this section and the regulations.
- An authorized person may without individualized suspicion intercept or record inmate communication.
- An authorized person may restrict, intercept or monitor inmate communication if one or more of the following apply:
  - the authorized person has reasonable grounds to believe that the inmate is
  - involved in illegal activities,
  - harassing or causing harm to others, or
  - participating in an activity that may jeopardize the safety, security or operation of the correctional centre;
  - a court order restricts or prohibits communication or contact between the inmate and the other person;
  - the other person has indicated to the authorized person that he or she does not wish to communicate with the inmate;
  - if inmate communication has been restricted, an authorized person must as soon as practicable

Corrections Act 19.1 Disclosure

- An authorized person may, (a) in prescribed circumstances or in relation to prescribed classes of inmate communication, disclose in the prescribed manner that a communication is inmate communication, and (b)in prescribed circumstances or in relation to prescribed classes of communication specified under section 33 (2) (u) as privileged, disclose in the prescribed manner that a privileged communication originates from the correctional centre.
- For the purposes of subsection (1) (b), an authorized person may without individualized suspicion intercept a privileged communication.

Table 10.3 Existing Privacy-Related PHSA Policies

Adult Custody Policy 9.1.4 Information Sharing

- Confidentiality of personal information is maintained in accordance with the Freedom of Information and Protection of Privacy Act (FOIPPA). Sections 33.1(1)(b), 33.1.(1)(t) and 33.2(a) of FOIPPA provides approved personnel the authority to review and sever personal medical records in response to access to information requests.
- Information obtained from inmates by health care staff during assessment and treatment is confidential, with the following exceptions: Information entered by health care staff through the CORNET Alerts screen and CORNET Client Log updates intended to safeguard the safety and security of inmates and staff; and relevant information about inmates disclosed to the mental health liaison officer. CORNET Is the Corrections Network data information system used to document movements of persons in custody, etc.

Adult Custody Policy 9.1.5 Health Care Space

- The Corrections Branch provides adequate health care space, equipment supplies and materials to meet the needs of each centre.
- Space is designed to permit the inmate to be examined and treated in private.

Adult Custody Policy 1.7.23. Medical Information

- Medical documentation is confidential.
- Medical documentation that accompanies an inmate on off-site escort to hospital/ medical centres is prepared by health care personnel and forwarded to escort staff in a sealed envelope, as soon as possible.
- Medical information and documents returning with the escort staff are delivered to Correctional Health Services.

Adult Custody Policy 1.7.24. Confidentiality

Escort staff do not discuss an inmate's circumstances with anyone except individuals, such as hospital security staff and police, who have a valid need to know."

Table 10.4 Existing BCMHSUS Policies on Procedure for Health Service Request

BCMHSUS-CHS CCR-219X P.x Health Service Request Procedure

Clients complete a paper or electronic health service request from their living unit. Completed paper Health Service Request (HS 020B) forms are forwarded confidentially and daily to health care professionals. During the intake process, clients are advised by the intake nurse of the process for submitting health service requests in both electronic (if available in that centre) and paper format. The client may make a verbal request to a CHS health care professional. This provision is especially important in consideration of varying client literacy and technology competencies. During segregation and medical observation rounds, the health care professional will proactively ask the client if they have any health service requests. All responses to health service requests are documented in PAC to ensure continuity of care and communication with the interdisciplinary team.

10.2 Education

10.2.1 Literature: Existing Recommendations/ Current Evidence

Misinformation around transmission, treatment, and care of STBBIs can perpetuate STBBI-related stigma as well as lead to gaps in STBBI care and treatment[19,20]. Increased education can help to mitigate stigma within correctional centres by addressing misinformation, especially regarding HIV/HCV. A lack of HIV/HCV knowledge and awareness of testing procedures within correctional centres can also add to the inaccurate perception of testing requirements[50] and can perpetuate testing hesitancy[7,54]. Education can ensure that PWAI are fully informed about testing and treatment procedures, which promotes autonomy with regards to testing[55] and helps facilitate trust between PWAI and correctional centre health care providers[54].

Additional HIV/HCV education for both correctional centre staff (inclusive of health care providers) and PWAI is needed. Increased educational programs to disseminate information regarding STBBIs have been successful across a range of studies within correctional settings[7,41,50,60,63,79]. In some cases, peer-to-peer education was also found to be beneficial[65].

10.2.2 STBBI Education for People Who Are Incarcerated

10.2.2.1 Phase 1 Stakeholder Input

PWAI were asked to select from a list which methods were good ways to distribute STBBI information to PWAI. The most popular responses were:

- Posters on the walls in common areas (62% of PWLE, 71% of HCWs, and 62% of COs).
- A focus group participant noted that: Posters on the unit, hallway for waiting for health care, and med line would be really helpful, [because] we're always standing around waiting, would read it out of boredom [statement paraphrased].
- Brochures given at intake (46% of PWLE, 50% of HCWs, 58% COs).
- Through unit leaders/reps (i.e., peer educators) (31% of PWLE, 36% of HCWs, and 19% of COs).

PWAI and HCWs also provided additional insight around STBBI information and education:

- Out of 163 PWLLE, only 60 (37%) indicated that they would be comfortable talking to a correctional centre health care nurse about STBBIS, highlighting again major issues around trust and confidentiality.
- A total of 137 PWLLE (86%) indicated that they would be comfortable talking to a peer or non-correctional centre health care worker over the phone or virtually about STBBIs.
- Of 42 HCWs, 57% of them chose basic information provided to residents via welcome pack/ intake package to be a good way to distribute information (e.g., informed of correctional centre testing policies, how to request services/care, what services are available, basic STBBI facts in correctional centres, peer support availability).

10.2.2.2 Phase 2 Expert Consultation

During Phase 2, Corrections officers were asked "Where the best place to put STBBI is related educational posters to increase the likelihood they would be read by PWAI". About 83% mentioned that it would be best to place them on the unit, while 67% of them agreed that STBBI-related posters should be placed at the health care unit.

10.2.3 STBBI Education for Corrections Officers

10.2.3.1 Phase 1 Stakeholder Input

Only 13% (n=13) of corrections staff reported that lack of education among corrections staff is a barrier to STBBI testing at their centre, with lack of knowledge around the types of STBBI tests available in the centre being selected by 12 out of 13 staff as a knowledge gap.

10.2.3.2 Phase 2 Expert Consultation

Staff education is essential to help reduce stigma around STBBIs and encourage testing and treatment within correctional centres. During our follow-up survey with COs, most of them selected that they would want to learn more about:

- "Which STBBIs can be tested for in corrections" (CO= 92%),
- "How staff can protect themselves from STBBI infections" (CO= 92%), and

- "Which STBBIs can be treated and/or cured in prison to reduce their spread" (CO=75%).
- They also mentioned that they would prefer the STBBI education to be in a form of:
- "Online course similar to the BCCDC STBBI course for corrections staff" (CO=64%) and/or
- "Ongoing e-learning modules (on additional STBBI-related topics" (CO=45%).

Concerning when STBBI education should be held, Corrections officers preferred during orientation (when hired) (50%) and annually (65%). COs also identified the most needed STBBI related information to be:

- Which types of STBBI tests are available (CO=92%),
- Which STBBIs are transmitted through blood (CO=92%),
- Which STBBIs are transmitted through saliva (CO= 92%),
- Which STBBIs are transmitted through feces CO=92%), and
- What can be done if you are exposed to specific STBBIs (CO=92%).

10.2.3.3 Existing BC Corrections Policies/Guidelines/Protocols

Table 10.5 Existing PHSA Policies on Consent and Education

PHSA POLICY #C-99-11-20568 Consent to Health Care Policy

Patients must be provided with the information they require in order to make informed Health Care and consent decisions.

This information needs to be provided in a language (See PHSA Language Access policy) and at a level that is understandable and meaningful to the Patient. This information includes:

- The condition for which the Health Care is proposed;
- The nature of the proposed Health Care;
- The risks and benefits of the proposed Health Care; and
- An outline of any alternatives to the Health Care, including the alternative of doing nothing and the risks and benefits of each.

Adult Custody Policy 8.1.2. Infection control information and educational program

- Understanding and action are possible primarily through information and education.
- A comprehensive educational program for staff and inmates is developed in all centres.
- Wardens or designates implement the program in conjunction with local health professionals.
- As part of recruit training, the Corrections and Court Services Division (JIBC) provides supplementary information on transmission control and preventive measures.
- Educational programs are developed that discuss communicable diseases generally and individual diseases specifically (e.g. tuberculosis, HIV and hepatitis).
- At a minimum, the Adult Custody Division provides for: Availability of information on transmission control and precautions to minimize transmission of infectious disease for inmates and correctional staff; instruction on use of items for infection control (i.e. condoms, lubricants and bleach); and opportunities to update staff and inmates about current information.

Table 10.6 Existing Education-Related BCMHSUS Policies

BCMHSUS-CHS GUI - 140X: Education Materials

Health Services Managers will ensure the required client educational and teaching resources are available in each Correctional Health Services program. Group manuals will be purchased and made available as required. Client requests for information not readily available will be fulfilled whenever possible.

Resources to be made available include but are not limited to:

- Information regarding community resources for primary health and mental health and substance use treatment is made available to the client upon request by the intake nurses, mental health screener, access and transition nurse or the mental health coordinator.
- Health information about medications, chronic disease, and infection control procedures, naloxone and other specific individual client requirements for education of treatment processes are provided on an as needed basis.
- Mental health and substance use literature on an individual and group basis is provided as needed.

10.2.4 STBBI Education for Health Care Staff

10.2.4.1 Phase 1 stakeholder Input

When asked an open-ended question regarding what health care workers need to provide the best possible STBBI testing and care, 16 of 39 respondents (41%) indicated responses surrounding the need for more training, continued education and resources for HCWs.

Of 163 participants, 60 (37%) PWAI/PWLE indicated that they would be comfortable talking to a correctional centre health care nurse about STBBIs, highlighting major issues around trust in terms of accessing STBBI care in correctional centres

10.2.4.2 Phase 2 Expert Consultation

During the phase 2 engagement with HCW, some of them mentioned:

- Educational sessions and online modules will make providers more comfortable to initiate treatment.
- Huddles in their own centres. Besides the online learning.
- Telemedicine could be used for education.

10.3 STBBI Testing and Linkage to Care Recommendations

10.3.1 Offer STBBI Testing to Everyone as Soon as Possible, Multiple Times as Needed.

10.3.1.1 Literature: Existing Recommendations/ Current Evidence

Current practice supports the testing for STBBIs soon after incarceration, such as within seven days of entry, or if that is not possible, within 2-4 weeks of entry[80]; that HIV testing should be available upon request any time during incarceration[81]; and that everyone in a correctional centre is tested once per year.[27]

10.3.1.2 Phase 1 Stakeholder Input

BC Stakeholder input regarding the timing of testing was consistent with existing recommendations with most suggesting that testing should be offered at the initial health assessment done at intake.[I]

I The data presented here is one sample cut three ways: (1) Non-LGBTQ2S+ and LGBTQ2S+; (2) Men and Women; and (3) Non-Indigenous and Indigenous to view trends in preferences across PWLLE.

Figure 10.1 PWLLE When is the best time to offer STBBI testing?

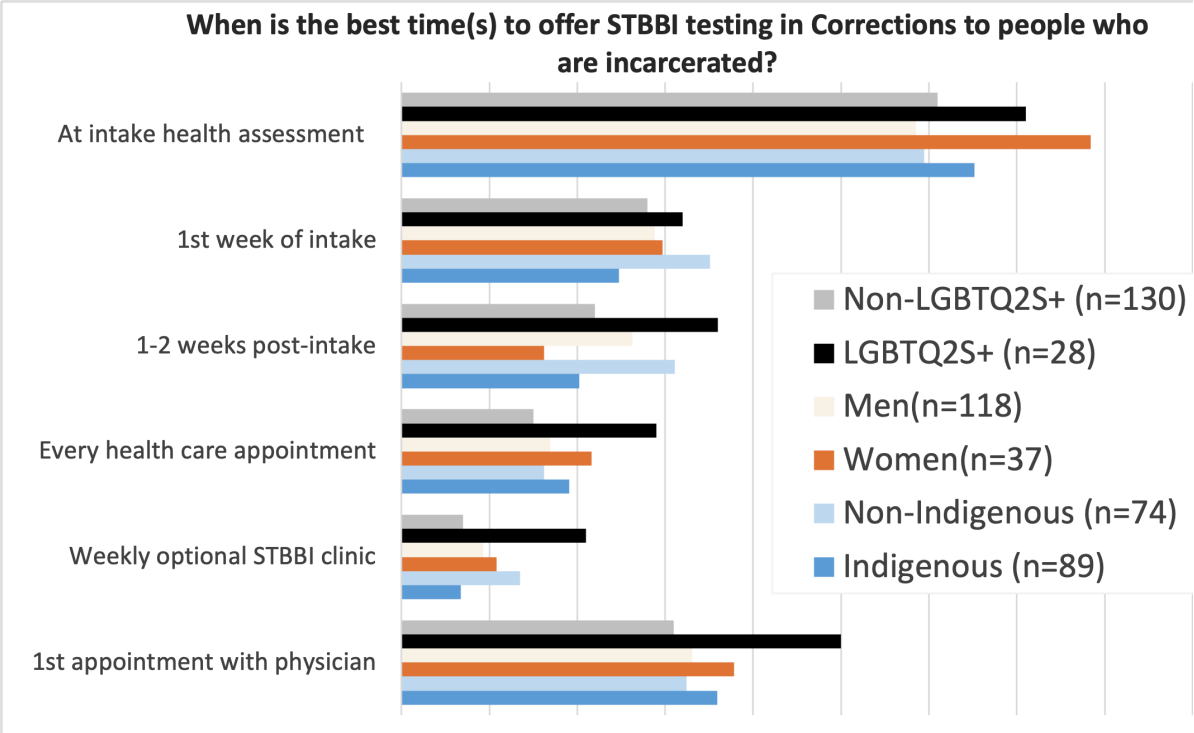
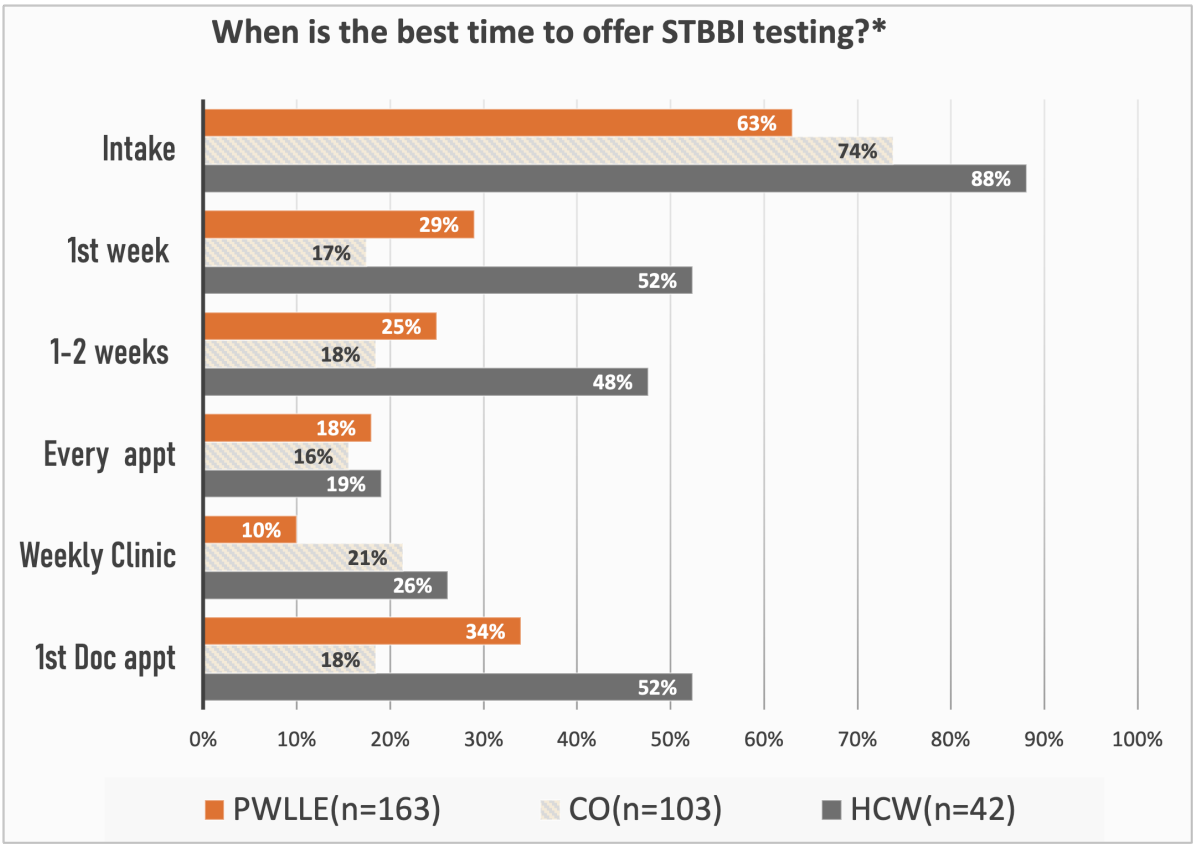


Figure 10.2 PWLLE CO HCW When is the best time to offer STBBI testing?



One item that had consensus across stakeholder groups was the importance of following up with opportunities for testing after the initial intake given concerns around intake into a correctional centre being a time that is often challenging for individuals. Intake can be challenging because PWAI can be feeling physically and mentally stressed which can impair their ability to give consent.

In a focus group discussion with PWAI in April 2021 surrounding the timing of STBBI testing, participants stressed that although intake is an important time to assess health needs, it isn't the best time for everyone. One participant noted that: "…not everyone [is] in a state of mind to remember what they [are] asked at intake, which is why they ask you again later."

Responses from the Corrections staff survey echoed these sentiments. One respondent explained: "Many of the new intakes come in with illegal substances in their system. This combined with the possibly long hours waiting in a tank to be processed as a new intake before they can be transferred to the induction unit can make them less responsive to offers for STBBI testing. By offering [PWAI] testing 1-2 weeks after intake, it allows them to "settle into" their unit and be in the right frame of mind to make such decisions."

Another respondent indicated: "Intake is great, but some guys come in rough and aren't capable of making any decision. A few weeks in and most guys have come around enough to do this. Adding a static offering that is well advertised would allow an inmate to make this decision at any time."

The above highlights the importance of STBBI testing being offered at multiple time periods. Some PWAI may have varied needs at intake making testing at intake difficult, while others with short duration of stays in provincial corrections would require early testing to ensure there is time to diagnose and provide treatment.

10.3.1.3 Phase 2 Expert Consultations

HCWs and PWLE expressed unanimous concerns with testing immediately at intake due to the nature of the physical environment and mental state of the individual upon arrival. Some relevant comments from our phase 2 workshops are highlighted below.

HCW

- "Intake is very challenging: nurse time is limited and many intakes are in a bad space."
- "Sometimes the 1st doctor's appointment doesn't happen early enough, or doctors might have more pressing/life threatening issues to deal with during 1st visit."
- "…everyone gets an appointment with a nurse within 72 hours of intake to discuss STBBIs and be offered testing. You will be notified when your appointment is shortly. This is what will be discussed during that appointment."
- "[The m]ajority of clients are not receptive at intake."
- "[The s]tate of individual when they enter the centre is an issue; Not very private at intake" – lots of officers.

HCWs also said that personnel providing testing must be trained and required tests should be completed to avoid delays in receiving results. HCWs commented that:

- "Timing of when to ask clients about STBBI testing" is a significant barrier to STBBI testing.
- HCWs suggested that there should be: "…an STI trained nurse at every site."
- They also mentioned that: "Intake nurses would have time to book a nurse clinic appointment for every client at intake though, these nurse clinics would usually be able to see the client within 72 hours."

PWLE

- "Not in very good shape at intake – I just want my blanket and my bed; maybe the 1st health care appointment when get levelled."
- "Everyone should see a doctor when they go in and asked at every appointment".
- "Both options are good – at intake at later".
- "1st doctor visit after intake; test for STBBIs".

10.3.1.4 Existing BC Corrections Policies/Guidelines/Protocols

Table 107 Existing BCMHSUS Policies on STBBI Testing

CCR-719X Testing communicable diseases

- All testing is voluntary
- Upon admission – intake nurse offers to facilitate testing for communicable diseases to each client

CCR-719X Testing communicable diseases

- People incarcerated can request testing for communicable diseases anytime (to health centre nurse, MD, NP;
- Pre-and post-test counselling given for HIV/HCV testing; provided at health centre

CCR-710X Initial Health Assessment

- An initial health assessment is conducted in private by an intake nurse within 24 hours.

10.3.2 Obtain Consent

10.3.2.1 Literature: Existing Recommendations/ Current Evidence

Obtaining informed consent for STBBI testing is foundational to a trauma-informed approach to care [82] and is consistent with existing PHSA health care policies (see below). Survivors of trauma often feel unsafe, particularly in situations of power imbalance. All discussions should take place in a context of being welcome in a judgement-free and non-threatening physical space with very clear statements that STBBI testing and discussions are optional.[82]

Existing guidelines suggest pre-test discussions to include information on why testing and counselling is recommended, the benefits to testing, how the results will be given, the types of services offered for treatment, advice on risk reduction, confidentiality, and an opportunity to ask questions to HCW.[80,81]

PWAI are most likely to access services they trust to maintain confidentiality. In Canada, programs facilitated by community nurses, correctional health care nurses, and peer counsellors have strong rapport with PWAI and are effective in providing STBBI counselling, testing, and distributing harm reduction supplies.[83] Because power dynamics can exist between PWAI and staff, there should be clear policies and opportunities to establish consistency in patient-provider interactions.[84]

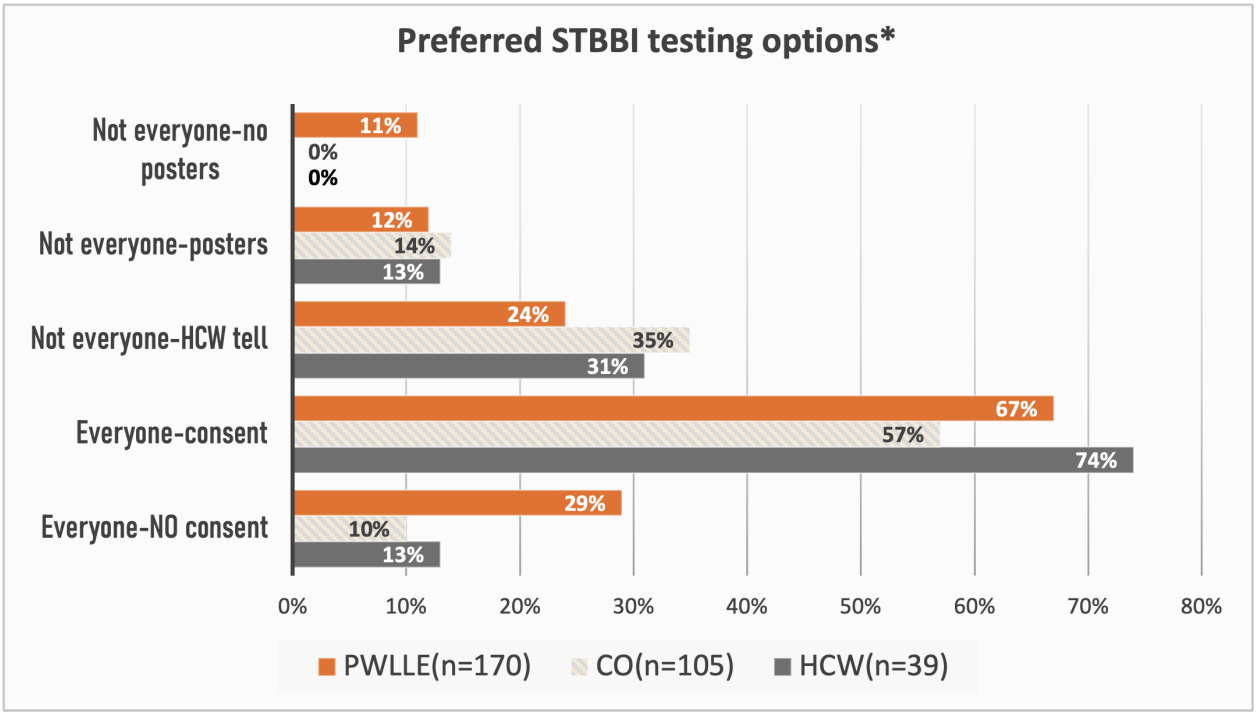
Existing PHSA guidelines on informed consent in health care identify rights and approaches to obtaining consent that are specific to Indigenous people. As specified in the United Nations Declaration on the Rights of Indigenous People (UNDRIP), Indigenous people have the right to **Free and Prior Informed Consent.**[85] Free and Prior Informed Consent means that consent is given freely, without coercion; that information about the health care intervention and consent for it is provided in advance; and that the consent process includes provision of accurate, understandable information.[85]

Policies directing testing requirements, the dissemination of health information, patient consent, and testing methods can increase the feasibility, safety, and rates of STBBI testing among PWAI. Current evidence suggests the use of opt-out testing, where everyone receives a test unless they choose to opt out, to decrease stigma and improve the consent and counselling process.[46]

10.3.2.2 Phase 1 Stakeholder Input

Consent can be challenging. For example, workshop participants expressed that informed consent is not uniformly obtained in correctional health care settings, and is potentially complicated by a lack of information and power imbalances between PWAI and correctional institution staff. One workshop participant shared: "I didn't even know I had been tested and the doctor I saw later just assumed I knew that I had [tested positive for] hepatitis C. I was totally caught off guard." An additional participant illustrated concern about potential impact of power imbalances on testing, within the context of a universal testing policy. The participant shared that some residents

Figure 10.3 PWLLE CO HCW Preferred STBBI testing options



might be afraid to decline testing: "...because you are often penalized for saying no/questioning authority." These issues point to the importance not only what information is being conveyed as a part of obtaining consent, but also how and who is conveying that information.

Stakeholders were presented with five testing options and asked: "Which testing option would help make STBBI testing less stigmatizing, more confidential and easier to get for people who are incarcerated in BC Correctional Centres?" The five options, in order of support from each stakeholder group, are presented in the graph below:

*Question "Policy"- Which testing option would help make STBBI testing less stigmatizing, more confidential and easier to get for people who are incarcerated in BC (Check all that apply). Response options to this question were:

- **Not everyone is tested:** Nobody is told about STBBI testing in-person or through posters. It is up to each person to ask for it.
- **Not everyone is tested:** There are posters in the centre telling people STBBI testing is available. It is up to each person to ask for it.
- **Not everyone is tested:** During a health care appointment, a health care provider tells people that STBBI testing is available in the centre and they can ask for it anytime.
- **Everyone is tested after they give consent:** Before they are tested, a health care provider tells them they can choose to not be tested.
- **Everyone is tested without asking for consent:** People are tested via a blood draw, or given a cup to pee in but they are not told why. Posters around the centre explain that people can choose to not be tested (but no one is told at the time of testing that they can refuse testing).

Based on the data in Figure 10.3, most stakeholders prefer universal testing where everyone is tested after they give consent. A PWAI focus group participant commented that as some people can be embarrassed or insecure to request a test, this method would decrease the associated stigma and shame around STBBIs. Comments from HCWs also support universal testing and suggest additional procedures to streamline testing methods, with one HCW noting that: "Everyone should have informed consent for any testing."

COs also identified universal testing to be best for their workload (i.e., least likely to increase workload) (44%),

followed by appointment-informed testing where not everyone is tested and they are informed at appointments with HCWs (36%).

PWLE were also asked '*What would you want to know about an STBBI* before you would say "yes" to being tested?*' and provided a list of statements to check off. In order of popularity, for PWLE who answered the question (n=149[m]), items being selected by at least one-third of PWLE were as follows:

- How I will get my test results? (47%)
- What are the symptoms of the STBBI(s) I am being tested for? (46%)
- Is there a cure or treatment? (46%)
- What health issues could I have if I don't get treated for it? (44%)
- Who else will be told what my test results are? (42%)
- Who will give me my test results? (40%)
- If I have an STBBI, who else has to know about it (e.g., The BC Centre for Disease Control) ?(38%)
- How can it be passed to others? (36%).

These responses indicate a fairly high desire for STBBI-related information to be provided at time of testing. Only 13% of respondents said there was no information they would need in order to give informed consent to STBBI testing.

10.3.2.3 Phase 2 Expert Consultations

Engagement with stakeholders in Phase 2 further strengthened the importance and requirement of consent. One HCW explained that: "No consent is not an option," and "Consent is essential, and we must follow community standards. A correctional centre is not an emergency department (ED) so we can't follow what they do in [the] ED."

People with lived experience of incarceration also shared similar views during our phase 2 engagement. One participant mentioned that: "Most people care to be asked before they get tested," while others gave examples of how consent could be done, stating that HCWs: "...could just ask you – do you want to get tested – yes or no," or "Yes or no right in front of you – being asked is good."

10.3.2.4 Existing BC Corrections Policies/Guidelines/Protocols

Table 10.8 Adult Custody Policy on Infection Prevention and Control

Adult Custody Policy: 8.1. Infection Control and Prevention

- Staff and inmates in correctional institutions are recognized as being at risk for the transmission of infectious diseases including tuberculosis, hepatitis and HIV. 2. For this reason, all persons are considered potentially infectious.
- Infection control information and educational program 1. Understanding and action are possible primarily through information and education. 2. A comprehensive educational program for staff and inmates is developed in all.

m Excluded: 11 respondents who selected "I don't know" and 15 respondents who selected "Prefer to not answer".

Table 10.9 Existing BCMHSUS Policies on Client Health Assessment

CCR-710X Initial Health Assessment

All on-site and off-site paper medical files will be retrieved and available for review by the health care professionals involved in the clients care while at the centre.

CCR-757X P.x1 Transfer of Clients Between Provincial Corrections Centres

Reviews the client's PAC profile as well as their paper medical file for:

- Frequent Monitoring
- Allergies
- Current Prescriptions
- Next medication administration schedule (assess whether the MAR was saved for the next medication administration time)
- Episode History
- In-house and Offsite Appointments
- Medication Acceptance History
- Alerts, both PAC and CORNET
- Special diets
- Other open tasks

CCR-719X Testing Communicable Diseases

- Clients wishing to be tested for a communicable disease can make their request for testing known to the health centre nurse, physician or nurse practitioner at any time while in custody;
- Pre and post-test counselling is given to clients requesting HIV and hepatitis C testing. Counselling is provided at the health centre.

Table 10.10 Existing PHSA Policies on Consent to Health Care

POLICY #C-99-11-20568 Consent to Health Care Policy

- Every capable adult has the right to give, refuse or withdraw consent to health care, with certain limited exceptions, on any grounds, even if the refusal will result in serious harm or even death.
- Consent must be informed and voluntary (with certain exceptions under the Mental Health Act).
- The patient must have the opportunity to accept or refuse health care without fear, constraint, compulsion or duress.

10.3.3 Arrange Linkage to Community Care at Time of Testing

10.3.3.1 Literature: Existing Recommendations/ Current Evidence

To support continuity of care and treatment and re-integration into community, correctional centres should establish systematic protocols/mechanisms for linking clients with both medical and social service organizations[45] both during custody and at release from custody. Such protocols should be activated as early as possible before clients leave the correctional centre and should include consent to transfer medical records and access to relevant STBBI treatments.[46]

10.3.3.2 Phase 1 Stakeholder Input

Respondents were asked if it was true that PWAI can "…ask the correctional health care staff to send my STBBI* test

results/medical info to a community health care provider of my [their] choice."

Responding "Yes," were 73% of HCWs and 55% of PWLLE, with 25% of HCW and 36% of PWLLE responding "I don't know." This indicates a pressing need to provide education to both HCW and PWLLE around the existence of this service.

10.3.3.3 Phase 2 Expert Consultations

While connecting patients to community care can be difficult, it is critical for patient follow up and continued treatment. Most stakeholders mentioned that clients having short periods of incarceration is a major barrier to STBBI treatment with one explaining that: "Treating clients with short sentences is difficult. Hard to hook people up with resources and follow up after release." Correctional staff also noted that: "Short stay of clients increases the possibility of loss to follow up post release" and also some "…people with small sentences don't see one (HCW) at all."

10.3.3.4 Recommendations for Arranging Linkage to Care at Time of Testing

For both standard and express testing, the client should sign a release of information form, in the case that the client is released before receiving test results and treatment.

The form should request:

- Client contact info (e.g. phone, address, emergency contact) if possible.
- Community health care provider (e.g. physician, pharmacy, outreach team, specialist) where the test results can be sent.

10.3.4 Review Medical Record for Previous STBBI Results

10.3.4.1 Phase 2 Expert Consultations

During consultations with HCWs understanding a patient's medical history was identified as being necessary to determine if they are undergoing treatment or in need of testing and to foster efficient and appropriate use of resources. The process of identifying client history can also open up a communication channel with a community care provider to gain more information about the patient and to provide updates on the patient's results and/or treatment status. HCWs identified several additional reasons as to why understanding a patient's medical history is important:

- Physicians want to know if their patients test negative after treatment.
- Before nursing assessment – ask about HCV treatment.
- Somebody to go back and review patient history so that repeat testing is not done.
- If they are on treatment, a phone call should be made immediately to destination provider.
- Treatment provider in community can notify primary care provider at the correctional centre if there are other services that need to be done after getting notification of positive results of a client.
- Makes sense for correctional centres to continue their relationship established with their own treatment providers. Maybe educate corrections MDs to feel comfortable enough to start treatment.

10.3.4.2 Recommendations for Reviewing Medical Records

For both standard and express consent, the EMR should be reviewed to look for previous positive test results from testing in the community or previous incarceration (e.g. HCV, RNA). This should be done before the health assessment or booking a laboratory test. If there is a positive result for an STBBI, the laboratory test should be cancelled, and the client should be given the next available appointment with the MD/NP or other qualified HCW to expedite linkage to care and treatment.

10.3.5 Set Up Laboratory Appointment

10.3.5.1 Phase 1 Stakeholder Input

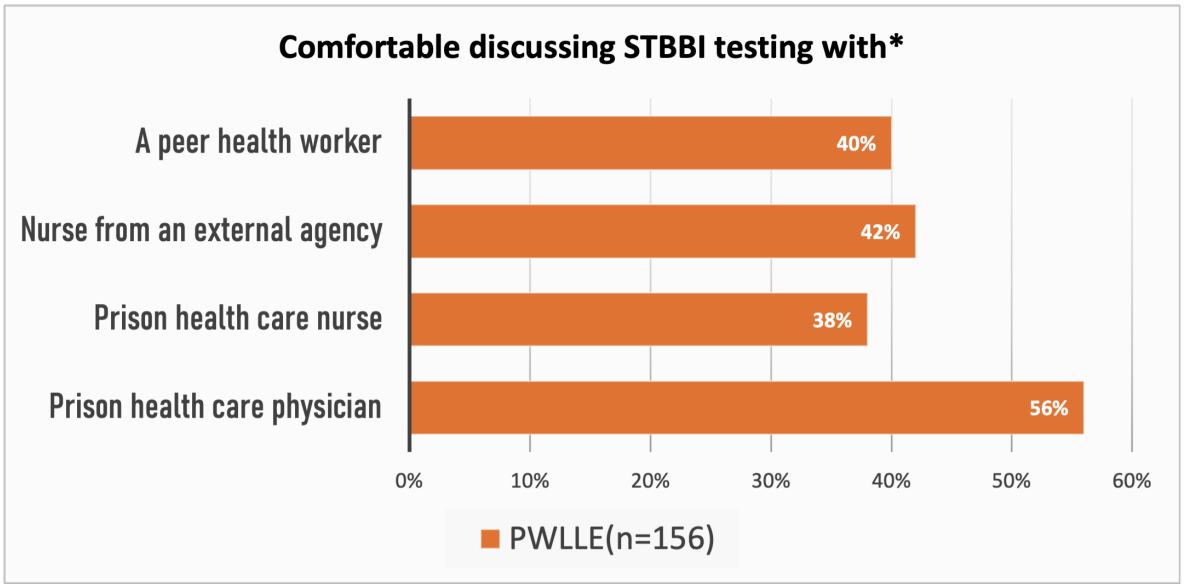
When asked 'Who is the best Candidate to discuss STBBI testing with PWAI?' responses varied by group.

PWLLE

The preferred options for PWLE were different from HCW preferences in terms of who they were most comfortable talking about STBBIs with. More than half of PWLE who answered the question (n=156[n]), selected 'Prison health care physician' (see Fig 10-4).

n Excluded respondents who selected "I don't know," "Prefer to not answer," and "Question not shown (VIRCC)."

Figure 10.4 PWLLE Comfortable discussing STBBI testing with?



*Question "talk-STBBI1" - Who would you be comfortable talking with about STBBI testing? (Check all that apply). There was a 21% difference between PWAI (20%) and PWLE (41%) on this question which may be a result of the relationship developed between the community group (Unlocking the Gates), who conducted the PWLE interviews and the PWLE who were interviewed.

HCWs

As noted, there were some differences between who PWLE considered best suited to discuss STBBI testing, compared with HCWs. HCWs selected the following as the best candidates to discuss STBBI testing and obtain informed consent from PWAI:

- Nurses with STI-certified practice (71%).
- Nurses without STI-certified practice (including LPNs, RPNs, and RNs) (67%).
- General practitioners (52%).

HCWs were asked if they agreed with the statement of being comfortable having STBBI pre-test discussions with clients. 86% either agreed or strongly agreed with the statement. For the 13.9% who disagreed with the statement or didn't know, there may be a need for additional supports and/or training for health care staff. Comments from HCWs on this topic included:

- "We are staffed 24/7 with nurses so access to one of these providers would remove barriers to access. An MD is only here certain days of the week, same with lab."
- "I think any nurse should be able to provide this, but there should be a requirement of taking a STBBI course so that they themselves can be informed to be able to give correct information to clients."
- "Nurses should be used to full scope, the tendency for CHS is to limit all we can do as nurses, training for full scope for all nurses and use of the knowledge for all nurses."
- "I don't feel that I still have a solid knowledge of treatments and blood tests required. Things are always rapidly changing."

10.3.6 Provide Client with Test results

10.3.6.1 Literature: Existing Recommendations/ Current Evidence

Both positive and negative results should be reported to clients using the same protocol[86].

10.3.6.2 Phase 1 Stakeholder Input

PWLLE

For PWLLE, obtaining test results was checked as an important knowledge factor prior to getting tested. PWLLE were asked *'What would you want to know about an STBBI**

before you would say "yes" to being tested?' and provided a list of statements to check off. In order of popularity, for PWLLE who answered the question (n=149[o]), 47% were worried about how they will get their results and 40% wanted to know who will give them their results. These responses indicate a high desire for STBBI results to be provided to clients irrespective of whether the results were positive or negative.

With respect to privacy, responses indicated a potential higher concern among LGBTQ2S+ and Indigenous Peoples for privacy than the total sample. Therefore, the responses for these populations are listed in addition to those for the total sample.

Total Sample

As reported in Section 4.2 on privacy, over 50% of inmates are concerned that corrections staff or other inmates may see their test results. Furthermore, 25% are afraid to even know their test results. During workshops with PWAI, the following comments were made about STBBI diagnosis:

- "…the doctor I saw later just assumed I knew that I had [tested positive for] hepatitis c. I was totally caught off guard."
- "I'd rather be told that I don't have it, then sitting and not knowing."
- "They say 'no news in good news' around here. But you never know when someone has dropped the ball or lost a result. You never really know if they processed the test."
- "[We] should get results in a sealed envelope that comes with the rest of your mail, to your own private room, instead of being pulled aside by the nurse which singles you out."
- "I'd prefer to get my test results in a private meeting."

Indigenous Peoples

Among respondents who were currently incarcerated at the time of the survey, our findings point to several important differences between Indigenous and non-Indigenous participants, especially concerning privacy, confidentiality and lack of trust in correctional HCWs.

Among PWAI, with regards to barriers to HIV testing in correctional centres:

- Indigenous respondents were almost twice as likely compared to non-Indigenous respondents to indicate that they worried that their HIV test results would not be kept confidential from correctional staff (38.2% of Indigenous respondents vs 20% of non-Indigenous respondents).
- Indigenous respondents were also more likely to indicate lack of trust in correctional HCWs as a barrier to HIV testing (29.4% of Indigenous respondents vs 13.3% of non-Indigenous respondents).

With regards to medical privacy:

- Indigenous respondents were more likely to indicate that they were concerned that correctional nurses would see, or have access to, their test results or other health information (26.5% of Indigenous vs. 6.7% of non-Indigenous respondents) [p]
- Respondents who identified as women expressed with regards to concerns around privacy, confidentiality, and lack of trust in correctional HCWs.
- Responses between men and women were relatively similar across the survey, although some significant difference were noted with regards to privacy, confidentiality and lack of trust in correctional HCWs.
- Compared to men, women were more likely to indicate concerns around privacy and confidentiality[q] as barriers to accessing STBBI testing in correctional centres (43.2% of women vs 29.6% of men). Women were also slightly more likely to indicate lack of trust in health provider as a barrier to STBBI testing (18.9% of women vs 12% of men).

LGBTQ2S+

LGBTQ2S+ respondents were more likely to identify privacy[r]-related barriers (48%; 14/29) than were non-

o 11 respondents who selected "I don't know" and 15 respondents who selected "Prefer to not answer"
p Question: Are you concerned that any of the following people might see your test result (or other health information)? (Check all that apply)
q Checked at least one of: 'Officers would know'; 'Worry not confidential'; 'Other PWAI would know'.
r Checked at least one of: 'Officers would know'; 'Worry not confidential'; 'Other PWAI would know'.

LGBTQ2S+ respondents (31%; 43/139[s]). For example, 28% (8/29) of LGBTQ2S+ and 14% (19/139) non-LGBTQ2S+ said that concern about other PWAI knowing that they were getting an STBBI test might stop them from wanting to get tested for STBBIs.

HCW

Providing STBBI test results in ways that protect client privacy, can be challenging for one-third of health care staff (11 of 33) who find that: "In the course of [their] work duties, [they] have time to discuss STBBIs with people incarcerated."

53% of HCWs indicated that too few health care staff on site is a barrier to high rates of STBBI testing at their centre. Additional comments to this survey question included:

- "Short remand time frames [are a barrier to testing]. Many clients are not here long enough to see lab."
- "[A barrier to testing is clients are] released prior to lab work being completed."

10.3.6.3 Phase 2 Expert Consultations

During Phase 2 engagement, stakeholders agreed that clients be provided with test results irrespective of the status (whether positive or negative). Some HCW mentioned that they "…want to know if their patients test negative after treatment."

Corrections officers were also asked if they think that providing STBBI results via kiosks is a feasible solution. About 64% of them thought it was a feasible solution. COs who disagreed felt that providing results "…should only be through HCWs." Some also expressed concerns about privacy, explaining that: "This information is easily obtained by other inmates." Others felt the kiosk option was "…not trauma informed."

COs were also asked about the feasibility of providing negative results via a letter from health care. About 86% of them thought that this option was more feasible. COs who disagreed were concerned that: "Their (PWAI) peers may end up seeing their result via paper in their cell. Having a paper copy can make it easier for their peers to see their information. Whereas a kiosk, they can view it at times where their peers aren't around."

10.3.6.4 Existing BC Corrections Policies/ Guidelines/Protocols

Table 10.11 Existing BCMHSUS Policies on STBBI Testing

BCMHSUS-CHS CCR-719X Testing Communicable Diseases
Pre and post-test counselling is given to clients requesting HIV and hepatitis C testing. Counselling is provided at the health centre.

10.3.7 Expedite Treatment and Linkage to Care

10.3.7.1 Literature: Existing Recommendations/ Current Evidence

While linkage to care for STBBIs varies slightly for each infection, linkage is generally achieved by establishing a follow-up appointment to discuss treatment options with a specialist or other STBBI treatment provider. Promptly providing PWAI who are living with an STBBI information about what their options for linkage to care are, and explaining what these options involve, is essential.

Further, clients must be given opportunity to determine if they would like to have a follow-up STBBI consultation, and then have this facilitated. Health care providers in provincial correctional centres have unique barriers to successfully linking clients to STBBI care, as those on remand can be released suddenly. The median length of stay is just 35 days for those on remand and 65 days for those who are sentenced, and STBBI treatment providers are often located outside the correctional health care system. People serving custodial sentences can also be released or transferred immediately following a court date, further impairing fulsome discharge planning efforts. Therefore, depending on the individual person's circumstances (e.g. their custodial status [on remand or sentenced], sentence length, or length of time until court date), this can impact what options for linkage to care are feasible for them while in custody. However, sentence length should not dictate if care is offered, more just what *type* of care is offered.

Medical transfers out of correctional centres to attend appointments at hospitals or other outpatient clinics have been identified as potentially breaching client

s The sample size for LGBTQ2S+ was small, therefore we are including the number of respondents for this group.

confidentiality and privacy, as Correctional Officers and other residents will become aware that a patient has had a medical transfer. Additionally, those sent out for a medical transfer face shame and judgement by having to move through public areas in the presence of Correctional Officers, and often while handcuffed. Therefore, in-reach from STBBI treatment providers to the correctional centres should be available wherever possible, either through in-person onsite visits, or through telehealth.

10.3.7.2 Phase 1 Stakeholder Input

When asked if they were aware that clients could ask health care staff to send test results and/or medical information to a community health care provider, 55% of PWLLE (n=164) and 73% of staff (n=40) responded **'Yes'**; 41% of PWLLE and 25% of health care staff responded "**I don't know.**"

Some PWAI commended their centre's protocol for linkage to care post-release, citing that:

- "They are pretty good at helping us with discharge planning here."
- "When you leave they ask which pharmacy you're going to (or even multiple ones in the area) to make sure a prescription is there. There are also pharmacies that will drop off your meds to you wherever you are."
- "Main concern is getting access to health care when I'm released. I no longer have a family doctor."

10.3.7.3 Phase 2 Expert Consultations

Linking patients to community care was identified as an important part of the discharge process that must be coordinated and should be prioritized as early as possible. There were concerns about loss to follow up post-release during our Phase 2 engagement with HCWs. HCWs mentioned that: "Housing and communication issues are barriers to continuity of care." In order to curb this, stakeholders made several suggestions/comments:

- "Have a system to link patients to care post release for continuity."
- "Clinic nurse can start sitting and discussing with the client."
- "Send letter to community- clients may get released anytime – even clients sentenced can suddenly get released; document everything in their release plan in their tracking sheet."
- Important to send another letter to the provider about the status of the patient.
- Make plans for regular schedule meetings to make implementation progress.
- Train nurse practitioners to initiate treatment or do telehealth; as soon as labs done, should be contacted within 1 week; and not always wait for primary care provider.
- Have some support for the discharge planning (see section 1.8) so that nurses feel comfortable and know how to go about it.
- Prompt on discharge sheet "…if person is on OAT and undergoing Hep C treatment, please do that together."
- Most of the discharge must be coordinated – need to work hand in glove.
- Discharge planning is a shared responsibility; not just up to discharge nurse
- Housing and communication issues are barriers to continuity of care.

10.3.7.4 Existing BC Corrections Policies/Guidelines/Protocols

Table 10.12 Existing BCMHSUS Policies on Linkage to Care

BCMHSUS-CHS Policy #CCR-648X Medications upon release

- When the release date of a client is known in advance, up to a 14 days' supply of medications may be provided to ensure continuity of medication therapy upon release into the community.
- Clients who are unexpectedly released may advise a pharmacist in the community of the name of the centre where they were treated, and ask the pharmacist to call that centre to receive an ongoing or bridging prescription until they are able to access a prescriber in the community. Bridging prescriptions will generally last between 7 and 14 days, or longer,
- For the provision of controlled drugs and narcotics, CHS does not provide the medication to the client. Rather, a prescription is provided and should be sufficient to accommodate the client until the earliest possible scheduled appointment with a prescriber.
- New orders for controlled drugs and narcotics are faxed to the client's designated pharmacy, and originals mailed in. Accommodation for additional supply is given on an individual basis.
- Clients on the Self-Medication Program may be given all the medications in their possession.
- Clients at risk of non-adherence should be reassessed, and alternate arrangements may need to be made for provision of medications.
- The nurse must document in PAC and the client discharge form the quantity of medications provided upon release and any known follow-up arrangements.
- Depending on the medication, the condition and the anticipated appointment with a doctor.

BCMHSUS-CHS Policy #REC-212 Release of Clinical Information

- Patients/clients are allowed access to their clinical information, subject to a written request, as per FIPPA using the appropriate form
- 39 (4) Medical Fitness of Inmate. Information sharing
- If the health care professional consulted under subsection (3) advises the person in charge that the inmate suffers from an acute or dangerous illness, the person in charge must take reasonable steps to facilitate the inmate's access to treatment, if any, available in the community at the time of release.

Table 10.13 Existing BCMHSUS Policies on Linkage to Care

BCMHSUS-CHS CCR-710X

At the completion of the IHA the nurse will make the appropriate referral(s) to a health care professional to address the client's health care needs.

10.4 General Considerations for Serving Specific Populations

10.4.1 Current Evidence and Existing Recommendations

10.4.1.1 Indigenous

Approximately 4% of BC's residents identify as Indigenous.87,88 In our PWLLE survey, Indigenous participants were significantly overrepresented. In total, self-identified Indigenous people accounted for 54% (n=100) of PWLLE, including 53% of participants currently incarcerated at the time of the survey. This number is significantly higher compared to the current (2021) BC Corrections profile of 35%, however, since we did not survey a random sample of PWLLE the higher proportion reflected in our survey does not necessarily indicate that Indigenous people make up over 50% of individuals in BC custody.89 Nevertheless, even 35% is a staggering over-representation of Indigenous people within BC's correctional centres. In Canada, the over-representation of Indigenous people in the criminal justice system is attributed to the ongoing history of colonial violence perpetuated against Indigenous people, including through historical and ongoing displacement of Indigenous peoples from the land, the residential school system, and long-term effects of intergenerational trauma90. It also calls for changes to the criminal justice system to address systemic racism.

10.4.1.2 Women

In Canada, women who are incarcerated are more likely to be living with an STBBI than men who are incarcerated, and the general population. Women often have unique pathways to incarceration compared to men,[23] and experience higher rates of lifetime trauma,[24] including physical and sexual abuse, poverty, unstable housing and stigma. In tandem, women are often confronted with barriers to accessing high quality and appropriate health care both in and out of carceral settings.[25]

As a result, there is a need for the adoption of a stronger gender-lens in health care responses to women who are incarcerated. A supportive, trauma and violence-informed approach to STBBI identification that removes stigma and improves access to health care, combined with an emphasis on clear and ongoing communication regarding the confidentiality of medical privacy[20] is essential to promote trust between women who are incarcerated and HCWs, and improve health outcomes.

Women who are incarcerated in Canada also tend to be highly mobile (e.g., have shorter sentences and move back into community relatively quickly), negatively impacting health care access.[26] A coordinated and accountable program of reintegration that facilitates the continuity of health care for STBBIs, as well as safe housing, harm reduction and other supports, is also important in improving the STBBI health of women[26].

10.4.1.3 LGBTQ2S+

BC Corrections' policy on transgender inmates (2018) states that "transgender inmates are to be placed in a correctional centre on a case-by-case basis with consideration of individual factors such as their self-identified gender, housing preference, nature of current offence, criminal history, risk of victimization, and custodial history"[91]. Transgender inmates are to be involved in making the decision on where they will be placed, and their views on their own safety must be considered.[91] At intake, individuals who identify as trans are to be asked their gender pronoun and name that should be used to refer to them. Staff are required to use the name and pronoun identified by trans people who are incarcerated, and all other information should be kept private and confidential.[91]

BC Corrections' Transgender/Gender Diverse Inmates guiding principles document provides guidelines for the health management of transgender PWAI, including that all trans patients should be provided "…confidential HIV and STI testing," but provides limited information on how to deliver culturally safe sexual health care for this population. There are currently no policies or guidelines about providing culturally safe care to lesbian, gay, bisexual, queer, transgender or two-spirit people who are incarcerated. There are, however, a number of guidelines and best-practice resources for health care providers in general (who are not working in correctional centres) that offer information that remains applicable in a correctional health care context.

Trans Care BC houses comprehensive resources for care providers working with trans and gender diverse individuals,[92] including specific guidelines for sexual health screening.[93] The Fraser Health Authority has

published a handbook of best practices titled: *Providing Diversity Competent Care to Gay Clients,* that includes information on providing care to LGBTQ2S+ individuals in a variety of health care settings[94] These documents are a good starting point for health care providers who are working in a correctional context. Given LGBTQ2S+ people are overrepresented among PWAI, familiarity with culturally safe approaches to sexual health care for LGBTQ2S+ individuals are especially important in a correctional context.

10.4.2 *Rationale for Grouping of LGBTQ2S+ Respondents in this Document*

The LGBTQ2S+ community includes individuals of many diverse genders and sexual orientations. Our sample included a small number of people who identified with specific sexual and gender minority identities, the number of responses that were linked to specific identities was not large enough to provide an adequate sample. Given these small numbers, we chose to apply a community lens to our analysis of the survey data to capture experience across the broader LGBTQ2S+ community. We recognize that gender and sexual identity are distinct from each other, and further research is needed to identify specific needs and considerations for each group under the LGBTQ2S+ umbrella (e.g. considerations specific to bisexual individuals; considerations specific to trans women, etc.).

People were considered to be a part of the LGBTQ2S+ community if they selected/completed one or more of the **bolded** options below (for either gender or sexual orientation):

Survey response options for gender (check all that apply):

- Man (n=136)
- Women (n=39)
- **Non-binary** (n=2)
- **Agender** (n=0)
- **Genderqueer** (n=1)
- **Transgender** (n=2)
- **Two-Spirit** (we understand Two-Spirit as an identity for Indigenous peoples) (n=6 people who identified as Indigenous people)
- Prefer to self-describe (n=1; not relevant "Cree and German").

Survey response options for sexual orientation (check all that apply):

- Straight (n=146)
- **Gay** (n=4)
- **Lesbian** (n=5)
- **Bisexual** (n=15)
- **Queer** (n=3)
- **Prefer to self-describe** (n=7; valid: Pansexual =1; "trans F-M" =1); "Do not want to be discriminated to answer").

Of individuals who indicated their gender and sexual identity (n=168), 29 participants (17%) identified as belonging to at least one gender minority group and/or one sexual orientation minority group. A higher percentage of LGBTQ2S+ individuals identified as Indigenous (65%), compared to non-LGBTQ2S+ respondents (53% identified as Indigenous). While these numbers are relatively small, they reflect an overrepresentation of LGBTQ2S+ people among PWLE compared to the general population in Canada.[95]

Stakeholder Input

There were several notable differences in the responses among LGBTQ2S+and non-LGBTQ2S+ respondents.

For reasons not explicitly listed as stigma-related:

- A greater percentage of LGBTQ2S+ respondents cited dislike of medical procedures (21% vs 8% non-LGBTQ2S+)
- A higher percentage of LGBTQ2S+ respondents reported that fear of being judged or stigmatized would prevent them from being tested or treated for STBBIs while incarcerated (48% LGBTQ2S+ vs 41% non-LGBTQ2S+)
- Mistrust of health care workers was not a main barrier to STBBI testing. Only 10% of LGBTQ2S+ and 15% of non-LGBTQ2S+ reported it as a barrier.

The relatively high percentage of LGBTQ2S+ people in our sample suggests the need for STBBI care that is culturally safe for LGBTQ2S+ individuals, and for LGBTQ2S+ Indigenous people as a specific population.

Responses from LGBTQ2S+ participants indicate that this population has specific needs and concerns around maintaining confidentiality and privacy from other PWAI.

Trans and gender-diverse people in correctional centres are at a heightened risk of violence, sexual violence, and discrimination which reiterates the importance of policies that improve confidential access to STBBI testing and treatment for the safety and well-being of all people who are incarcerated.[40,80]

10.5 Other Recommendations and Future Directions

10.5.1 Collaborative Development of Guidelines

10.5.1.1 Literature: Existing Recommendations/ Current Evidence

Existing recommendations find it imperative to engage PWLE in the development of STBBI-related health services in correctional centres. Incorporating the diverse lived experiences of PWAI as key stakeholders can enhance the effectiveness of health programs and policies.[96,97] A participatory research study in BC demonstrated that engaging PWLE in focus groups was beneficial in going above and beyond the medical topics at hand to explore the underlying social determinants to create a more holistic health program.[98]

10.5.1.2 Stakeholder Input on Collaborative Development

In alignment with the existing recommendations, most stakeholders expressed that input from PWLE in the development of STBBI testing guidelines is important or very important (100% of HCW, 84% of PWLE, 68% of CO)[t].

When asked "What is one thing you want policymakers to know about providing STBBI testing and/or STBBI care to people who are incarcerated?", there was a consensus among PWAI, PWLE, HCWs, and COs to increase STBBI education for both PWAI and staff. Other frequently mentioned topics were stigma, the need for more resources, and calls to change policies regarding testing and treatment. One HCW respondent clearly summarized the necessary components to improve testing and care- "...education, equipment, clear policies, time, and buy in from corrections."

PWLE voiced their concerns regarding privacy and stigma: one respondent wrote that "...bullying happens and people do find out other residents' health information. Confidentiality is huge." HCWs also expressed their need for "...time and staffing" resources to "provide good quality STI counselling and care." COs noted the importance of information and education on STBBIs for staff and PWAI to improve care and safety. One respondent commented that: "If staff are informed as to why the tests are being done and the positive impact it would have on staff knowing that the transmission of possible STBBI's are greatly reduced it would make them feel safer doing their job."

These opinions across stakeholder groups highlight the importance of collaborative development to "...ensure that the policies are realistic and achievable given the operational needs of the centre", as expressed by one CO survey respondent. Overall, engaging stakeholders in policy and program development is beneficial to both policymakers and stakeholders. In a focus group discussion with PWAI in April 2021, one participant noted: "This is the first time in my 30 ... years going to jail where I've been asked to give input."

10.5.2 Testing Alternatives

10.5.2.1 Preferred Method of Testing

PWLE were asked: "If you wanted to get your blood tested for an infection like HIV or hepatitis C while in a correctional centre, which method would you most prefer?" Of the 173 PWLE who answered the question, responses were as follows:

- 51% A blood sample from a vein
- 40% A blood sample from a finger-prick
- 9% Unsure.

For both methods (vein and finger-prick), the top reason for preferring that method was because "...it is quick" (66% for people venous preferred; 54% for finger prick preferred).

t Response options: Not at all important, Only a little important, Neither important or unimportant, Important, Very important, Prefer not to answer

Comfort was an important reason for almost 40% of people who preferred the finger-prick method: 27% said this method was preferred because of pain; 12% because people had trouble taking blood from their veins.[u] *

10.5.2.2 Self-Testing Kits

Stakeholders were also asked: "Do you think there should be self-testing STBBI kits on all units so people can get a STBBI* test without having to ask for a health appointment?" Responses, in order of overall popularity, were:

- No (HCW 40%, PWLE 16%, COs 65%)
- Yes (HCW 31%, PWLE 60%, COs 18%)
- I don't know (HCW 29%, PWLE 24%, COs 17%).

HCWs and COs expressed several concerns about having self-testing STBBI kits on all units, including:

- PWAI are "likely to waste supplies, (be) unsure of their results, or might use their results against each other on the unit" and that it is "more likely for corrections staff to see results" (HCW)
- Concerns regarding contraband issues, risks to safety, and the necessity of HCW supervision (COs).

In contrast to HCW and Co participants, most PWLE thought self-testing STBBI kits should be available. In a PWAI focus group, participants suggested having kits available in cells, bathrooms, and program rooms to ensure sanitation and privacy.

10.5.3 Access to Safer Sex Supplies

10.5.3.1 Literature: Existing Recommendations/ Current Evidence

In some correctional centres, access to safer sex supplies is challenging because inmates have to either request them from health care workers and guards or pick them up from visible locations.[19] As a result, most recommendations require that condoms, lubricants and dental dams be made available and easily accessible to all inmates.[19,83,96,99] Also, that they should be placed in at least three discreet areas[19] and getting them should be very confidential.[83]

10.5.3.2 Stakeholder Input

There were mixed results regarding how accessible condoms were in correctional centres. While most of the stakeholders agreed that people who are incarcerated can get access to condoms without having to ask a corrections officer (40% of PWLE, 62% of COs and 16% of HCW), a significant number of stakeholders reported that condoms were accessible only when PWAI have asked COs (37% of PWLE, 31% of COs and 24% of HCW). The mixed stakeholder input was due to the fact that, different correctional centres have different policies regarding safer sex supplies.

Comments about safe sex supplies from PWAI included:

- "They used to have male/female condoms and dental dams in the drawer of the programs room, but now there are just dental dams. We have to ask the nurse for condoms."
- "It was always awkward to ask a guard for condoms."

In other correctional centres however, condoms are easily accessible to PWAI with some of our stakeholders citing that they are usually placed in common areas such as the gym, laundry room, or the washroom.

When asked to select which of the safer sex supplies should be made available to PWAI, respondent choices were as follows:

- Condoms (85% of PWLE, 77% of cos, 82% of HCW).
- Lube (65% of PWLE, 47% of cos and 60% of HCW).
- Medical grade gloves (56% of PWLE and 25% of COs).
- Dental dams (36% of HCW).

Some HCWs and COs thought that no supplies should be available to people who are incarcerated citing that:

- "Due to some history of hiding drug paraphernalia with gloves and condoms, it might not be best to leave [condoms] in unit but with health care and for clients to ask for it when needed."
- "Sexual relationship are not allowed in Corrections."
- "Sex is extremely rare in provincial correctional centres, however inmates using condoms to hide dangerous drugs like fentanyl in their anal cavity is very common."

u Note that 7% of PWLLE who preferred a blood sample from a vein chose this method because nurses/people have trouble taking blood from their veins. This is counterintuitive and it may have been a result of miscommunication in the interviewing process.

10.5.3.3 Existing BC Corrections Policies/Guidelines/Protocols

Table 10.14 Existing BCMHSUS Policies on Safe Sex Supplies

PHSA HAS-210X Contraband
It is the responsibility of an employee of Corrections Health Services to immediately report the inadvertent discovery of contraband materials to BC Corrections staff.
BCMHSUS-CHS Policy #HAS-210X Contraband
Contraband is not: unopened condoms or lubricant packages

10.5.4 Drug use + Harm Reduction

Safer drug use/harm reduction tools should be available but should only be used under the supervision of a staff, considering the success of the model for Overdose Prevention Sites that has been implemented in a CSC institution and will be rolled out nationally.[28]

OAT and Safer Supply should be available in the same way it is in the community, with HCWs who work with PWAI trained on how to initiate OAT.

10.5.4.1 Literature: Existing Recommendations/ Current Evidence

STBBI transmission through shared equipment continues to increase in correctional centres.[80] In some correctional centres, drug equipment is shared among about 500 people.[100] In order to reduce STBBI spread, frequent testing and linkage to care should be implemented in all correctional centres to improve the health of PWAI.[80] Efforts should also be made to increase the accessibility and availability of sterile injection equipment in correctional centres.[19]

Another effective way of reducing the risk of HCV and other STBBIs is through OAT. OAT on its own is known to reduce the risk of HCV infection by 50%.[100] Current recommendations emphasize the importance of making OAT available in all correctional centres across BC, as well as training HCWs who work with PWAI on how to initiate OAT.

10.5.4.2 Stakeholder Input

PWLE

More than half of PWLE (75%) reported that they had used any criminalized drugs in the 6 months prior to their incarceration, indicating a large proportion of people incarcerated will likely use drugs while incarcerated.

When asked about shared equipment in correctional centres, 55% of PWLE said they did not share any drug use equipment while in correctional centres (currently or when last incarcerated). 21% of PWLE said they shared meth pipes, 15% shared straight pipes, and 10% shared needles for injection drugs.

Regarding the use of shared needles, comments from PWLE included:

- "There was one needle between 12 of us."
- "It's really hard to get a needle in prison so people want to use it as much as possible."
- "I have witnessed 3 guys sharing the same rig. I told him, don't you have Hep C?! Doesn't matter, we've all got it!"

Some people will find alternatives to the lack of safer drug use/harm reduction supplies by using the materials they have on hand. One PWLE noted that they used "…chicken bones as syringes!"

When asked about which safer drug use equipment should be made available in correctional centres, most PWLE selected:

- Needles for injection drugs (56% of PWLE, 3% OF COs,11% of HCW)
- Meth pipes (e.g., bowl pipes, bubble pipes) (40% of PWLE,3% of COs, 11% of HCW)
- Tattoo equipment (50% of PWLE, 6% of COs, 6% of HCW).

Staff

For staff (COs and HCW), most selected:

- No supplies should be available to people who are incarcerated (21% of PWLE, 68% of COs, 21% of HCW),

- Vitamin C/Ascorbic Acid (34% of PWLE, 14% of COs, 32% of HCW).

When asked to explain why no supplies should be available in correctional centres, some of the staff mentioned that:

- ""These items in a centre can be used to harm staff."
- "... while [I] understand safer injection sites have value and are safer for inmates, the fact is within a correctional setting ALL drugs create security issues and should be actively removed by correctional staff."
- "One of the only places these people can detox thanks to the safe injection sites is in prison. If you tell inmates drugs are not allowed in prison but offer drug paraphernalia it sends the wrong message."

Although supplying drug use equipment may pose a safety threat to staff, it is a very essential and effective in reducing the spread of HCV and other STBBIs in correctional centres. PWAI should therefore be able to access safer drug use/harm reduction tools.

10.5.4.3 Existing BC Corrections Policies/Guidelines/Protocols

Table 10.15 Existing BCMHSUS Policies on Drug Use

BCMHSUS-CHS Policy #HAS-210X Contraband

List of Contraband:

- An intoxicant;
- If possessed without prior authorization, a weapon, any component of a weapon or ammunition for a weapon, or anything that is designed to kill, injure or disable or is altered so as to be capable of killing, injuring or disabling;
- An explosive or bomb, or any component of an explosive or bomb;
- If possessed without prior authorization, any currency;
- If possessed without prior authorization, tobacco leaves or any products produced from tobacco in any form or for any use;
- If possessed without prior authorization, any other object or substance that, in the opinion of an authorized person, may threaten the management, operation, discipline or security of, or safety of persons in, the correctional centre.
- Loose, non-issued, tampered or expired medications.

BCMHSUS-CHS Policy #HAS-210X Contraband

Contraband is not: A single 30-60 ml bottle of filtered bleach, although clients who possess larger quantities are considered to be in possession of contraband"

Corrections Act Section 20 - Urinalysis

- An authorized person may demand that an inmate submit to urinalysis:
- at any time, if the authorized person believes on reasonable grounds that the inmate has taken an intoxicant into the inmate's body, or
- if abstention from an intoxicant is a condition of a temporary absence, work program, voluntary treatment program or conditional release and urinalysis is required to monitor an inmate's compliance with the condition,
  - at regular intervals, or
  - at any time, if the authorized person believes on reasonable grounds that the inmate has breached the condition.
- An authorized person who makes a demand under this section must
  - first inform the inmate of the basis of the demand and the consequences of failure to comply with the demand, and
  - carry out the demand and take the sample in accordance with the regulations.

11 APPENDIX F: REFERENCES

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