Final Report

HIV/AIDS IN YOUTH CUSTODY SETTINGS: A COMPREHENSIVE STRATEGY

A Brief from the

PRISONERS' HIV/AIDS SUPPORT ACTION NETWORK (PASAN)
489 College Street • Suite 500 • Toronto • Ontario • M6G 1A5
(416) 920-9567 • info@pasan.org

to the

Solicitor General of Canada,
Ontario Minister of Correctional Services,
Ontario Minister of Health,
and Ontario Minister of Community and Social Services

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prepared by

Lydia Batelaan
HIV/AIDS Education Coordinator
PASAN

Organizations supporting the findings and recommendations in this brief include

Africans in Partnership Against AIDS
AIDS Committee of Toronto
AIDS Action Now!
Alliance for South Asian AIDS Prevention
Black Coalition for AIDS Prevention
Justice for Children & Youth
Peel Youth Substance Abuse Program
Shout Clinic
Positive Youth Outreach
The Boys' Home
Street Outreach Services
Toronto People With AIDS Foundation
Voices of Positive Women
Youthlink-Inner City

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Sheena Scott, Justice for Children & Youth

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Terence Beal, Peer Educator, PASAN
Jim Cullen, Peel Youth Substance Abuse Program
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Ralf Jürgens, Canadian HIV/AIDS Legal Network

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SUMMARY OF RECOMMENDATIONS

PREVENTING HIV/AIDS IN YOUNG OFFENDER FACILITIES

HIV is transmitted through unsafe needle use and unsafe sex. Young offenders are engaging in these activities and are putting themselves at risk for HIV infection because they either do not know these activities are unsafe, they do not know how to engage in them safely, or they do not have the means to engage in them safely. Comprehensive education is the first step to preventing HIV infection in young offenders.

But not only young offenders need to be educated. Stopping the discrimination against those with HIV/AIDS and those engaging in behaviours associated with HIV/AIDS requires that HIV/AIDS education be directed at everyone involved with the young offender system.

Therefore:

1. **HIV/AIDS education should be compulsory for all young offenders (male and female) and all staff providing services for incarcerated young offenders (all workers at the Ministry of Community and Social Services, of Correctional Services, Clinical Support Staff, members of the staff union, e.g. OPSEU, Open Custody facilities staff and their union members, etc.)**

2. **Education must be comprehensive for both young offenders and staff.**

3. **All educational presentations and materials must recognize and respond to the needs of young offenders with disabilities, from different ethnic and linguistic backgrounds, with varying language skills and schooling, and of different races, sexes, and sexual orientation.**

4. **In addition to group HIV/AIDS-educational sessions, information should be made available to young offenders individually upon entering and exiting the custody facility.**

5. **External, community-based AIDS and health organizations should lead educational sessions. Peer education should also be promoted.**

6. **Condoms, dental dams, latex gloves, appropriate lubricants, and other safer sex materials must be made available to all young offenders.**

7. **Consensual sex between young offenders should not be an institutional offence.**

8. **A public relations campaign should be initiated to combat anticipated resistance by parents, staff or the public to condom distribution, safer sex education and sexual**

activity.

9. **A confidential needle exchange program should be implemented.**

10. **Bleach kits should be distributed in a non-identifying manner.**

11. **A public relations campaign should be initiated to combat anticipated resistance by parents, staff, or the public to a needle exchange program.**

12. **Community-based workers, in conjunction with custody staff, should educate offenders about substance use as a health issue.**

13. **Treatment programs for young offenders with substance use concerns should be accessible and programs for youth under the age of 16 should be established.**

14. **Tattoo and body piercing equipment and supplies should be covered under 'hobby/ craft'; extra safety precautions should be established.**

CARE AND SUPPORT FOR YOUNG OFFENDERS LIVING WITH HIV/AIDS

Young offenders living with HIV/AIDS are entitled to all of the medical and support services available to people living with HIV/AIDS outside of custody. Specifically:

15. **Young offenders living with HIV/AIDS must be guaranteed access to medical and dental workers of their choice. In particular, they must have access to experienced and expert HIV primary care physicians.**

16. **The services of community-based workers serving young offenders living with HIV/AIDS must be made available to all young offenders who desire them.**

17. **Young offenders living with HIV/AIDS must have access to alternative therapies and non-approved treatments.**

18. **The special dietary needs (because of either illness or therapeutic programs) of young offenders living with HIV/AIDS must be met.**

19. **The comfort needs (e.g. extra clothing, blankets) of young offenders living with HIV/AIDS must be met.**

20. **Young offenders living with HIV/AIDS should be given sensitive, humane, and compassionate treatment when being escorted outside the custody facility.**

21. **Special programs must be established for young offenders living with HIV/AIDS who are suffering from AIDS-related illnesses and who are ineligible for medical parole/ probation.**

22. **Sentencing guidelines for judges and prosecutors regarding young offenders living with HIV/AIDS need to be developed.**

23. **A compassionate release and/or medical parole/probation program should be developed for young offenders living with HIV/AIDS.**

24. **HIV-related information in the possession of medical providers should be released to custody staff only under extraordinary circumstances and only with the consent of the young offender.**

25. **The confidentiality of all young offender's HIV-antibody status (whether positive or negative) must be respected. Staff members who break the confidentiality of young offenders should be disciplined or fired.**

26. **The distribution of medications should not require a breach of the confidentiality of young offenders living with HIV/AIDS.**

27. **Young offenders who want access to supportive counselling, medical treatment, etc., must be guaranteed that their confidentiality will be respected.**

28. **Young offenders living with HIV/AIDS should not be voluntarily isolated or segregated.**

29. **HIV-antibody testing of young offenders must be done voluntarily and anonymously.**

30. **Testing should be carried out by "outside" community-based agencies.**

31. **HIV-antibody testing must be accompanied by access to medical monitoring and treatment (when necessary).**

32. **Parole Officers, Probation Officers, group home workers, and other aftercare workers must be educated about HIV/AIDS.**

33. **Exit kits with HIV/AIDS information, contacts with community-based organizations, condoms, bleach kits, etc., must be made available to young offenders when they are released from custody facilities.**

34. **Programs providing continuity of care after release must be established for young offenders living with HIV/AIDS.**

35. **Any special programs used by a young offender living with HIV/AIDS must remain available to her or him outside of custody.**

36. **Community-based groups must be involved with the development and implementation of aftercare strategies.**

37. **The Ministry of Community and Social Services and Correctional Services should work with community-based HIV/AIDS housing agencies and service organizations to ensure that they meet the needs of young offenders.**

INTRODUCTION

The Prisoners with HIV/AIDS Support Action Network (PASAN) is a community-based network of prisoners, ex-prisoners, organizations, activists, and individuals working together to provide advocacy, education and support to prisoners and young offenders on HIV and related issues. We are the only organization in Canada working specifically to provide HIV/AIDS education and support to prisoners and young offenders., and since 1992 we have advocated for the development and implementation of suitable provincial and federal policies on HIV/AIDS in prisons and young offender custody facilities (Phase 1 and Phase 2).

Although issues surrounding HIV/AIDS in prisons has been studied recently, no major Canadian study has focused on HIV/AIDS in young offender institutions. If our goal in comprehensive HIV/AIDS services is a comprehensive strategy, including prevention, education, and early release, then the need for action to stem the spread of HIV/AIDS infection, and for those young offenders currently living with HIV, is even more pressing in facilities housing youth than in adult institutions.

This is a complementary brief to the original PASAN brief focusing specifically on young offenders who are infected or affected by HIV/AIDS and the institutions/ facilities in which they reside.

A 1993 study by the Hospital for Sick Children in Toronto found that street youth have a higher rate of infection than do their age-mates. Of the fifteen subjects testing positive, four reported having recently been in custody and three of these "provided strong circumstantial evidence that HIV infection occurred while they were incarcerated (negative HIV results at admission, incidents of risk behaviour occurring during incarceration, very recent release dates)." (Read, S. et al. 1993)

Gathering precise information on HIV/AIDS and youth is difficult for the following reasons:

1. AIDS as a disease has only been known/identified for over 10 years;
2. The incidence of this disease is changing so rapidly that official statistics soon become dated;
3. National statistics are kept only on the number of AIDS cases- not on the number of HIV-infected individuals;
4. Not all cases of AIDS are reported to public health authorities;
5. There are no statistics available for youth (age range of 12-18 years) . The age groups for national AIDS statistics are 0 to 14, 15 to 19, 20 to 29, 30 to 39, 40 to 49, and over 50 years of age.

Also, provincial and territorial governments differ in the age categories they use to record

statistics. But what we do know is that HIV/AIDS is affecting all sectors of society in Canada, including youth. Many people that work with youth, believe that youth because of their experimentation with sex, alcohol and other drugs that youth are at increasingly high risk of becoming infected with HIV/AIDS.

PASAN proposes that a comprehensive HIV/AIDS strategy be developed, one that acknowledges the interconnections between HIV/AIDS education, distribution of prevention materials (condoms, needles, and bleach), and services for young offenders infected or affected by HIV/AIDS. It is impossible to address any one facet of the AIDS crisis adequately unless the other facets are also addressed. For example, condoms have been made available to adult and secure custody facility young offenders (16-17 year olds) since October 18, 1993. Dental dams have been made available to female offenders. They are available from health-care staff upon request. The availability of condoms in open custody facilities is left to the discretion of the operators of the residences. (Jürgens, R., 1994)

GUIDING PRINCIPLES

In formulating our recommendation, we have followed the lead of our original brief recognizing that:

- Young offenders living with HIV/AIDS have a basic right to maintain their health. Young offenders are in custody to rehabilitate, not to avenge society. The principal of rehabilitation is even more prominent in the structure of Young Offender legislation and institutions than in general law and institutions for adults. This right can best be satisfied through the development of medical parole/probation and compassionate release programs. At the very least, all the medical and social supports available to those living with HIV/AIDS outside of the custody system must also be made available to those "inside".

- Young offenders have a right to protect themselves against HIV infection, through education and access to proper protective materials (such as condoms, bleach and needles.)

- Young offenders have a right to keep their health status private. This means that HIV-antibody testing should be done anonymously and that young offenders with HIV/AIDS should be able to keep their status confidential.

- Young offenders have a right to informed consent with respect to HIV-antibody testing and HIV/AIDS treatment. In order for consent to be informed, a young offender must have received all the information about the procedure, its possible effects, and alternatives to it, necessary to make a decision. Information can only be received if it is provided in a manner suited to the young offenders age, literacy and language skills.

- HIV/AIDS support, education, treatment programs should be run by "outside" community based organizations brought into the custody facilities rather than by institutions' staff; young offenders are more trusting of and receptive to "outside" workers and peer models (ex-young offenders who are HIV+).

We recognize the concerns of custody staff and administrators around safety and security issues. But we believe that the promotion of health in the young offender population and education of both young offenders and staff are the best ways to create safety and security. When looking at both our original and current briefs recommendations, there is no real conflict between the needs of the young offenders and the needs of the custody staff with respect to HIV/AIDS.

COMMUNITIES CALL FOR A RESPONSE

PASAN members include ex-prisoners, both HIV positive and negative, and representatives from a variety of community based organizations involved with prison and youth issues and/or HIV/AIDS. The diversity of PASAN's membership has helped us recognize that a viable strategy for confronting HIV/AIDS in the prisons must address the various communities in the prison including young offenders. Throughout the original brief, we stressed that HIV/AIDS programs must be sensitive to culture, gender, race, sexual orientation, and disability, and we strongly urge that the same be applied to young offenders. Prisoners and young offenders speak many languages and have various levels of literacy skills; a mental or physical disability may restrict a person's ability to communicate. These differences must be acknowledged and valued in the design of all HIV/AIDS programs.

Our recommendation for the development of a comprehensive young offender HIV/AIDS policy are aimed at both the provincial and federal governments. At the provincial level, we propose that a joint ministerial task force, including members from the Ministries of Community and Social Services, of Health and of Corrections, be formed to consult with young offenders, community groups, and custody staff's unions while implementing our recommendations.

We also propose the same process be undertaken at the federal level with the Solicitor General's Office, Correctional Services Canada and the Ministry of Health and Welfare. We urge these federal ministries to coordinate their response to our recommendations with the provincial task force.

Although the majority of adult offenders were once young offenders there are at no statistics available. Only now are ministries beginning to address the fact there is some evidence to make this link. For a variety of reasons, prisoners of all ages are considered a group at high risk of becoming HIV positive. Not only are vulnerable segments of our populations and those who engage in high risk behaviours over represented in jails and prisons, but incarceration itself is increasingly likely to give rise to the additional risk of exposure to HIV. In recognition of this

fact, Public Security Minister Doug Lewis appointed an advisory group in 1992 to study and make recommendations on HIV/AIDS issues in correctional systems. The Expert Committee on AIDS in Prisons (ECAP) released its final report in February 1994. The document, like the original PASAN brief which helped spur its beginnings and which it frequently quotes with approval, is comprehensive and yet sensitive to the urgencies and complexities of the problem and their solutions. It adopts a pragmatic, harm-reduction approach to HIV/AIDS issues. Its conclusions are based on the assumption that preventing harm to society from the spread of HIV is more serious and pressing than any harm caused by mixed messages emitted by correction facilities which take action to prevent the spread of HIV, such as providing prisoners with safer sex materials and clean injection equipment. (Jürgens, R.,,1994)

Recommendation

An HIV/AIDS policy for young offender facilities must address two issues: the prevention of new HIV infection, and the care and support for those who are already infected with HIV or have AIDS. (A majority of these recommendations are similar if not the same as the recommendations we put forth for adult offenders, and some have been changed to address specific needs or issues that are specific to young offenders).

PREVENTING HIV/AIDS IN YOUNG OFFENDER FACILITIES

HIV is transmitted through unsafe needle use (sharing needles through injection drug use, tattooing, body piercing..) and unsafe sex. Young offenders are engaging in these activities and putting themselves at risk for HIV infection because they either do not know these activities are unsafe or they do not know how to engage in them safely. P. Millson found in her study of injection drug users in Toronto that 81% had been incarcerated, 25% of these people shared for the first time while in custody, and 65% of these people admitted to this being the only situation where they shared injection equipment. (Millson, P., 1991) Comprehensive education is the first step to preventing HIV infection in young offender facilities.

Recommendations

1. **HIV/AIDS education should be compulsory for all young offenders (male and female) and all staff providing services for incarcerated young offenders (all workers at the Ministry of Correctional Services, Community and Social Services, Clinical Support staff, members of Correctional Officers' union, e.g. OPSEU, Open Custody facilities staff and their members of unions, etc.).**

Education for young offenders should begin at the time of admission, at the medical unit or as part of the general orientation process. Since the transmission of HIV requires only a few minutes, the Ministries' will have to consider how to deliver this service so that all offenders, even those admitted for only a few days, can participate. Young offenders should have access to staff who are able to answer questions, provide additional information, and respond to personal HIV/AIDS issues in a competent and confidential manner. (If need be maybe this could be arranged through the Child's Advocate's Office).

To enable both Ministries' (Corrections and Community and Social Services) as well as Open Custody staff to address HIV/AIDS issues comfortably, staff education should be a distinct and separate part of their orientation program at the beginning of employment. Ongoing mandatory updating sessions should be offered yearly, and included in the facilities yearly Ministry licensing expectations.

2. **Education must be comprehensive for both young offenders and staff.**

The coalition recommends that the following topics be included in AIDS educational programming for both young offenders and staff:

1. Definitions of HIV and AIDS, discussion of how they differ, and the possibilities of living with HIV and AIDS.
2. A review of how HIV is transmitted, focusing on unprotected sexual intercourse and needle sharing for injecting drugs, tattooing, and piercing.
3. How HIV is not transmitted.

4. The means of protection against HIV infection, identifying safer sex options and advocating for young offenders' access to condoms, needles, and bleach.
5. Clarification that it is the behaviours in which a person participates, rather than the groups to which a person belongs, that place someone at risk for HIV infection (risk behaviour vs. risk group model).
6. Sexual assault and the risks of HIV transmission, advocating for improvements in the young offender system to reduce the incidence of sexual assault.
7. Issues concerning homophobia, heterosexism, and oppression.
8. Testing options (anonymous, confidential), issues of pre- and post-test counselling, confidentiality, and the necessity of informed consent.
9. Treatment options for those with HIV/AIDS.
10. Community resources (such as community based AIDS organizations and local health clinics) available to youth with HIV/AIDS within the facilities and upon release.
11. Universal precautions, reinforcing for staff and young offenders that if these precautions are followed by everyone, there is no need to know a person's HIV status.
12. The availability of additional educational resources such as audio tape and pictorial materials (comics and cartoons).

In addition to group HIV/AIDS education sessions, individual counselling should be available to young offenders and staff whenever they request it.

3. All educational presentations and materials must recognize and respond to the needs of young offenders with disabilities, from different ethnic and linguistic backgrounds, with varying language skills and schooling, and of different races, sexes, and sexual orientations.

Education can be useful only if it is actively received by young offenders. The differences among young offenders must be acknowledged in the creation of educational programs. It is important not to overlook the education of disabled young offenders. A mental or physical disability may restrict a person's ability to speak in a manner which is readily understood. People who are non-verbal sometimes learn alternative means of communication, such as Bliss symbolics. The deaf and the hard of hearing communicate in a variety of ways: sign language, speech, lip reading, and/or very basic gestures.

4. In addition to group HIV/AIDS educationals sessions, information should be made available to young offenders individually upon entering and exiting the custody facility.

At the beginning of incarceration, each young offender should be given kits at the point of entry which would include condoms, bleach kits, information about the topics mentioned above (items 1-12), and information regarding the HIV/AIDS services available to them in the custody facility.

Exit kits (containing condoms, bleach, written information about HIV/AIDS, needle

exchange sites and anonymous test sites) are recommended for distribution at the time of release. Again, the written material should cover the topics listed above with added emphasis on community resources (eg. youth specific services providing HIV/AIDS information and support, where to get condoms, location of needle exchanges, etc.). The kits should also include information about obtaining identification, Welfare, SIN and Health Card; options for safe and affordable housing; information about accessing HIV-knowledgeable counselling, addiction counselling, and support groups.

Exit kits should be distributed privately and young offenders should be free to choose whether or not to take one. For example, the kits could be available in the changing stall at the discharge area in every secure custody facility, or in open custody, it could be distributed through the youth's primary worker. In order to avoid rejection of these kits, it is recommended that written materials come from agencies external to custody facility and ministry.

5. External, community-based AIDS and health organizations should lead educational sessions. Peer education should also be promoted.

Education is better received by young offenders when provided by health and HIV/AIDS -education workers from agencies outside of the Ministries. (this may not be true in Phase 1 facilities where youth, because of their age, may develop a strong relationship with a particular worker and are strongly influenced by what he/she says/feels. Because of this the importance of staff training is again very necessary.) The input of young offenders should be sought when developing HIV/AIDS education programs with the intent of implementing peer training. In this way, young offenders could educate young offenders.

Training of staff, as well, should be done through external organizations and community groups to ensure that the program and information both remain current, unbiased and accurate, and discourage phobias and misinformation. Both Ministries should also recognize and make use of the educational expertise of agencies outside the corrections field on a consultative basis when planning any HIV/AIDS programs.

Not all local communities will have adequate resources to facilitate HIV/AIDS education in young offender custody facilities. To deal with these cases, we recommend the development of a mobile HIV/AIDS education unit, which would allow community-based workers to travel to custody facilities in under-served areas and to deliver consistent AIDS education throughout the young offender system. Already existing AIDS hotlines should be promoted for young offenders and staff to use between visits. In phase 1 secure custody youth do not have unsupervised access to the telephone unless calling their lawyer or the Child's Advocates Office. To ensure confidentiality perhaps arrangements should be made with the Child's Advocate's Office for them to provide a link between the youth and the services they are requesting.

6. Condoms, dental dams, latex gloves, appropriate lubricants, and other safer sex

materials must be made available to all young offenders.

As we stressed, education is only successful if young offenders are enabled to use the information they are given. Safer sex education must be accompanied by safer sex materials. In late 1991, Douglas Lewis, the minister responsible for Correctional Services Canada, announced that condoms would be distributed in federal prisons. The provincial Ministry of Correctional Services followed suit in 1993 in making condoms available in provincial prisons.

For many years, custody facilities housing young offenders would refuse to even acknowledge the possibility that there was any kind of sexual activity taking place, let alone provide protective products such as condoms, dental dams and lubricant to the young offenders. As with adult institutions, sexual activity between inmates has long been considered an institutional offence. In the past, many adult institutions would refuse to provide protective equipment on the grounds that it would be sending a mixed message to the inmate population, and that it would be condoning the commission of an institutional offence. In youth institutions this argument was strengthen by the fact that consensual anal intercourse between unmarried people under the age of 18 years of age was a criminal offence. Institutions for males under 18 years of age could point to the Criminal Code provision as justification for not providing any condoms or other items to its prisoners. They would argue that this would not only be sending a mixed message regarding a commission of a institutional offence but also a criminal offence. Since Madame Justice Abella's decision with regards to s.159 of the Criminal Code, young offender institutions will have to come to terms with the fact that young offenders, like the population of an adult institution, are capable of consenting to sexual activity.

Even where condoms are available, we are concerned with the method of distribution through health care services; they should also be made available in public places and bathrooms. The locations of condom sources should be safe and allow for confidentiality. Condoms must be available free of charge and must be available in both men's and women's facilities.

But condoms alone are not enough. Dental dams (latex barriers used for protection in oral-vaginal and oral-anal contacts) must also be easily available and free of charge to both young men and women. Young offenders also need water-based lubricant (such as K-Y) to use with the condoms. Condoms used without lubricant (even so-called "lubricant" condoms) can tear and break and can cause harm to their users.

7. Consensual sex between young offenders should not be an institutional nor a criminal offense.

We recommend that consensual sex be allowed not only because this change will increase the effectiveness of HIV prevention but also because we see sexuality as an integral part of human nature and that youth do participate in sexual activity.

8. A public relations campaign should be initiated to combat anticipated resistance by

parents, staff or the public to condom distribution, safer sex education and sexual activity.

Safer sex education and condom distribution on the "outside" of custody facilities are more common. Experience has shown us that the few opponents they encounter in the community can be overcome through consultation and education. Harm reduction is the framework in which we promote condom distribution and safer sex education to the outside community. Some Boards of Education are perfect examples of having to deal with sexual health education and condom distribution within the high schools. A similar strategy should be pursued in supporting condom distribution and safer sex education. The strategy must be developed in all facilities and should include birth control, sexually transmitted diseases, growth and development in conjunction with HIV/AIDS education.

SUBSTANCE USE AND HIV

The link between substance use and transmission of HIV and other STDs can be direct- through injecting with contaminated needles - or indirect - when impaired judgement leads to unplanned or unprotected sexual intercourse. We advocate a multifaceted approach to dealing with substance use and risk of HIV infection. This approach should include a needle exchange program, bleach kit distribution, education on drug use as a health issue, and treatment for addictions.

Recommendations

9. A confidential needle exchange program should be implemented.

It is generally recognized that the supply of clean needles to the drug using population will help reduce the spread of HIV/AIDS. Outside the confines of a young offender facility clean needles are available from various sources. These needles are provided regardless of the fact that drug use is not approved of by any of the organizations supplying the needles.

Adult institutions are coming to terms with the fact that there is drug use within the prison environment. As with the idea of sexual activity in prisons, these institutions should accept that the concept that the supply of needles neither contributes to nor condones the conduct of young offenders. Institutions should recognize that it is their responsibility to provide those that are entrusted to their care with the necessary means to protect themselves from potential health risks. In a 1993 survey of street youth and HIV done by the Hospital for Sick Children, of the 15 subjects testing positive, four had recently been in custody and three of those four had admitted to taking part in "high risk" behaviour, including drug injection and using shared needles. (Read, S., et. al. 1993) David Roy, Director of the Center for Bioethics, Clinical Research Institute of Montreal when asked for an ethical analysis of issues raised by needle

exchange programs for very young people (less than 14 years old) (who are) IV drug users, states"it would be unwise and ethically dubious to cancel or block a needle-exchange programme when this is the immediately needed protective intervention." He further states,"Based upon the ethical principal of first avoiding the greatest evils when not all evils can be avoided at the same time. It is more important that we protect these vulnerable, socially disorganized youth from HIV infection and eventual death; more important that we have surviving youth for eventual rehabilitation-than that we immediately insist on ideal ways of living that these youth cannot now understand, adopt, or achieve. This is, in other words, the principle of harm reduction. This principle, in the context of youth whose lives are marked by psychological, familial, and social disorganization, justifies needle-exchange programmes for youth who are within or on the fringes of IV drug use." (David Roy, 1996)

10. Bleach kits should be distributed in a non-identifying manner.

Bleach Kits containing condoms, bleach, resources for needle exchanges and anonymous test sites should be distributed universally. Young offenders who do not need a kit may simply return it or dispose of it.

11. A public relations campaign should be initiated to combat anticipated resistance by parent, staff, or the public to a needle exchange program.

Needle exchange programs on the "outside" are becoming more common. Experience has shown us that the few opponents they encounter in the community can be overcome through consultation and education. Harm reduction is the framework in which we promote needle exchanges to the outside community. A similar strategy should be pursued in supporting a custody exchange program.

12. Community-based worker, in conjunction with custody staff, should educate young offenders about substance use as a issue.

An educational component regarding drug use is an essential part of the health care model we are proposing. Recognizing that some of the youth develop strong relationships with custody staff, we are suggesting that an educational program be developed by an appropriate pool of community resources in conjunction with custody staff.

13. Treatment programs for young offenders with substance use concerns should be accessible and programs for youth under the age of 16 should be developed.

Very few, if any, agencies who address the issue of substance use work with youth under the age of sixteen. The ones that do would not put it in their mandate as that age group falls under the Child and Family Services Act.

14. Tattoo and body piercing equipment and supplies should be covered under "hobby/craft"; extra safety precautions should be established.

Even though the risk for HIV infection in both these practices can be high, tattooing is an art form in which some young offenders engage. Body piercing also is a practice in which some young offenders engage. It can be practiced safely if new needles are used for each tattoo and piercing and if safety guidelines are followed.

SUPPORT SERVICES

Young offenders living with HIV/AIDS are, like all young offenders, serving a sentence during which they are forced to sacrifice their freedom; there is no justification for them also being forced to sacrifice their health and well-being. Accordingly, all support services available to people living with HIV/AIDS outside of custody must be made accessible to young offenders.

Counselling, medical care, and access to the full range of therapies are minimal requirements for all people living with HIV/AIDS, including inmates. The comfort requirements of young offenders living with HIV/AIDS also must be addressed. For example, special dietary needs must be met and comfortable bedding must be provided.

Recommendations

15. Young offenders living with HIV/AIDS must be guaranteed access to medical and dental workers of their choice. In particular, they must have access to experienced and expert HIV primary care physicians.

Decent health care is a fundamental right of all Canadians. To ensure this right is respected for young offenders living with HIV/AIDS, the custody facility's policy should include a guarantee that young offenders have access to HIV primary care physicians and dentists. Any required therapies or vaccines must be available free of charge.

16. The service of community-based workers working with young offenders or youth must be made available to all young offenders who desire them.

In particular, medical and psycho-social support services should be available to HIV-positive young offenders. These services need to be coordinated and integrated with service on the "outside" where follow-up can be continued after release. Community AIDS workers take an active role in the young offenders' concerns by considering their HIV status to be top priority. Given the proper monitoring, information, and the means, young offenders living with HIV/AIDS are able to take care of themselves.

17. Young offenders living with HIV/AIDS must have access to alternative therapies and non-approved treatments.

It has become standard for the medical care of people living with HIV/AIDS on the "outside" to include alternative therapies and non-approved treatments. These options must also be available to young offenders. This means that they must have access to information about such therapies and medications. Contacts with community-based groups such as Toronto's Community AIDS Treatment Information Exchange (CATIE) must be facilitated.

18. The special dietary needs (because of either illness or therapeutic programs) of young offenders living with HIV/AIDS must be met.

Nutrition is fundamental to the health and well-being of a person living with HIV/AIDS. Custody food is often high in calories and fat; young offenders living with HIV/AIDS wishing to eat more healthily should be allowed to do so. Vitamin and diet supplements should be made available on a regular and continuing basis.

Food is usually served at designated times only. Thus, if a young offender does not have an appetite at those times, she or he has no choice but to wait until the next meal. In some facilities, removing food from the dining room for eating later is an offense and there are no provisions for alternate eating times. As people living with HIV/AIDS often have suppressed or erratic appetites, young offenders living with HIV/AIDS must have food available to them when they are hungry.

Steps taken to meet the food needs of prisoners living with HIV/AIDS must not compromise the confidentiality of their HIV status.

19. The comfort needs (eg. extra clothing or blankets) of young offenders living with HIV/AIDS must be met.

Young offenders living with HIV/AIDS must be provided with warm cells/rooms, enough clothing, and adequate bedding. Their privacy must be respected. Given the susceptibility of an Immuno-compromised person to illnesses others would easily fight off, a single occupancy cell/room should be made available to young offenders living with HIV/AIDS upon their request.

20. Young offenders living with HIV/AIDS should be given sensitive, humane, compassionate treatment when being escorted outside the custody facility.

Handcuffs should be avoided. Escorts should not wear undue protective clothing or gear such as gloves and masks. Any fears about infection should be alleviated through education. The HIV status of the young offender, if known, should not be revealed; her or his confidentiality must be respected.

21. Special programs must be established for young offenders with HIV/AIDS who are suffering from AIDS-related illnesses and who are ineligible for medical parole/probation.

People with AIDS often are in need of practical assistance but are not sick enough to require hospitalization. Elsewhere, we have recommended that most young offenders with HIV/AIDS be given medical parole/probation so that they can have access to the various levels of support available in the community (see recommendation 23). But the needs of young offenders ineligible for medical parole/probation must also be met. A special area should be set aside where young offenders with medical needs could have the support they require (such as help with bathing and meals etc.). Of course, participation in such a program must be optional to the young offender.

We recognize that when the medical needs of a young offender living with HIV/AIDS becomes more demanding, it seems difficult to provide both the necessary services and maintain the confidentiality of the young offender's health status. This difficulty can be avoided if support services are provided on the basis of the young offender's needs as they manifest themselves, not on the basis of her or his medical diagnosis. If workers do need to know medical information, it should be released only with the young offender's consent. Workers should be required to keep any such information confidential. (see recommendations 24-27)

HUMAN RIGHTS, COMPASSIONATE RELEASE, AND CONFIDENTIALITY

One of the main reasons that a young offender will not want to disclose his/her HIV/AIDS status is to avoid public knowledge of this status within an institution.

There exists no clear guidelines or policies defining how "strong" the suspicions of a Medical Health Officer must be before a young offender can be forced to submit to any testing. This fact alone raises concerns of how well or how poorly the rights of youth in institutions are being maintained in regards to consent to treatment.

It is our position that *any* conflict regarding the consent to, or refusal of, treatment *must* be resolved in favour of the individual. However, according to sections 22(5.1) and 35(7.1) of the *Health Protection and Promotion Act*, any order to submit to an examination or treatment made under these sections are binding on the person even if consent is not given in accordance with the *Health Care Consent Act, 1992*.

Recommendation

22. Sentencing guidelines for judges and prosecutors regarding young offenders living

with HIV/AIDS need to be developed.

It is unacceptable to sentence HIV-positive youth to custody solely in order to "protect the public health". The criminal system must not try to do the job of public health authorities. In one case, a young offender who normally would have been given a suspended sentence was sent to custody because the judge knew she was HIV positive and sexually active. Education rather than incarceration is the best way to reduce HIV transmission and increase safer sex practices.

The Ministry of Correctional Services and Correctional Services Canada should urge the Office of the Attorney General and the Ministry of Justice to develop educational programs around HIV/AIDS for judges and attorneys.

23. A compassionate release and/or medical parole/probation program should be developed for young offenders with HIV/AIDS.

Such a policy already exists for adult prisoners. One needs to be developed for young offenders.

24. HIV-related information in the possession of medical providers should be released to custody authorities only under extraordinary circumstances and only with the consent of the young offender.

Staff must be trained to protect the privacy of a young offender's medical data. Work rules prohibiting release of HIV-related information must be strictly enforced. An HIV-positive young offender should be consulted and his or her consent must be obtained before medical information is given to custody authorities, support workers, or parents.

25. The confidentiality of all young offenders' HIV status (whether negative or positive) must be respected. Staff members who break the confidentiality of young offenders should be disciplined and/or fired.

Custody administrators and staff should have access to the HIV-antibody status of young offenders only when it is absolutely necessary and with consent. When this information is shared, it must be held in the strictest confidence. This policy and the penalties for breaking it must be made widely known amongst the young offenders and staff.

26. The distribution of medications should not require a breach of the confidentiality of young offenders with HIV/AIDS.

Custody staff should not have any knowledge of the medications young offenders are taking. This means that custody staff should not be distributing medications (as is the case in some facilities). We recommend the distribution method where medications are distributed by medical staff to young offenders, or allowing young offenders to keep their medical supplies in private

lockers; this allows for young offenders' confidentiality to be maintained.

27. Young offenders who want access to supportive counselling, medical treatment, etc., must be guaranteed that their confidentiality will be respected.

Requests for access to counselling, medical treatment and other services should be made through the Child's Advocate's Office. Custody staff/guards do not need to know the reason for a young offender's meeting with an outside worker, nor should they be present at such meetings.

28. Young offenders with HIV/AIDS should not be involuntarily isolated or segregated.

Involuntary isolation of young offenders living with HIV/AIDS is not justifiable nor in the best interests of either that person or the general population of the institution. The isolation of HIV positive young offenders is often a reality, if not official policy, of many institutions. The reasons given for the punishment of isolation vary, but they share a common theme: the person living with HIV/AIDS somehow jeopardizes the "good order of the institution", either because of the infection itself, or because her or his behaviour (when coupled with the knowledge that she or he is HIV infected) is deemed a threat to either staff or other young offenders. Sometimes it is thought by institutional authorities that segregation, if not isolation, is in the best interest of the person living with HIV/AIDS, who may otherwise be subjected to threats of violence by staff or other youth.

Isolation heaps depression and anxiety on to the person isolated. The resulting stress, depression, and anxiety actively suppress the immune system, hastening illness in the youth living with HIV/AIDS. It must be made clear that involuntary isolation serves no one's interests. Rather, it presents to the population of the institution a false sense of security - that infectious people are removed from their lives and, therefore, they need not take proper safer sex and safer needle use precautions.

If special housing requirements do present themselves, such as when a youth living with HIV/AIDS is jeopardized by viruses and opportunistic infections transmitted by others in the population, the choice to pursue special housing arrangements must be the informed choice of the individual. "Special housing" should translate to supportive medical care and not punishment or hardship.

ANONYMOUS HIV-ANTIBODY TESTING

On January 1,1992, the provincial government of Ontario began implementing a program

whereby people who are not in custody can be anonymously tested for antibodies to HIV. Young offenders should also have access to this service.

ECAP and PASAN have made clear the need for anonymous testing for prisoners of all ages. It is necessary that prisoners are able to anonymously determine whether or not they are infected with HIV so that they can make their own decisions regarding disclosure and treatment.

When anonymous testing is not provided, *there will be a greater reluctance on the part of prisoners of any age to come forward for testing*. Ironically, those individuals who would subsequently not test will often be the ones most in need of finding out their HIV status.

At present, according to Dr. Paul Humphries of the Ontario Ministry of Correctional Services, *there is no anonymous testing available to youth in provincially run institutions.*

29. HIV- antibody testing of young offenders must be done voluntarily and anonymously.

"With anonymous testing, no personal identifiers are used. There is no link between the person's name and test. Individuals book their own appointments using a first name only. The HIV test itself is ordered and conducted using a number code rather than a name. Those ordering or conducting the tests cannot match the test results to the person's name. No names are reported. Working with experienced health care providers, the Ministry of Health has established rigorous guidelines for anonymous HIV testing including pre- and post-test counselling and evaluation. "(College of Physicians and Surgeons of Ontario, 1992)

Young offenders must be provided with information about high risk behaviour, symptoms, and available treatments, in order to judge for themselves whether or not to test. Proper pre-test counselling is absolutely necessary. This allows the individual to prepare in advance for the possibility of a positive test result. Post-test counselling should include a discussion of the meaning of the test result (whether positive or negative), possible sources of error, and ways in which to make behaviour changes concerning health, sexual practices, and drug use techniques. Proper counselling regarding precautions (eg. the use of condoms, bleach to clean injection equipment) and the availability of necessary prevention materials would have an impact on transmissions both within the custody facility and 'outside' when the young offenders are released.

Hassle Free Clinic, a Toronto agency specializing in sexually transmitted diseases, birth control, and HIV testing, has produced a document on anonymous testing procedures for the Ministry of Health. This document, as well as material for staff training regarding anonymous testing, are available through the AIDS Bureau of the Ministry of Health.

30. Testing should be carried out by "outside" community-based agencies.

Having testing administered by outside health care agency better protects the confidentiality of youth in custody. Young offenders are more likely to trust a counsellor from a community-based health care agency, with whom they would not have to worry about a breach of confidentiality (which could lead to discrimination from fellow prisoners and/or staff). A "safe" testing environment would likely lead to more young offenders choosing to be tested, and would therefore allow them to avail themselves of information, counselling, and treatment to delay the onset of HIV-related illnesses.

Given that "outside" health care workers coming "inside" are well received by youth in custody, permitting those workers to offer counselling and anonymous testing would increase institution security. Staff would benefit from an informed population who begin to change their behaviour voluntarily.

31. HIV-antibody testing must be accompanied by access to medical monitoring and treatment (when necessary).

When someone knows her or his HIV status, she or he is able to make decisions regarding possible medical interventions to prevent and/or delay the onset of serious illness. Young offenders will more likely choose to be tested if they know they have options should they test positive.

See the Support Services section of this brief for further recommendations concerning medical treatment.

AFTERCARE

This brief has recommended that numerous services, supports, and treatment be available in custody settings. Currently, these services and supports are only offered outside of custody. In order to ensure the success of the Ministry of Corrections and the Ministry of Community and Social Services efforts to provide such services and care, mechanisms must be implemented to ensure that these programs can be continued upon a young offender's release. It is essential that the Ministries provide the links necessary to facilitate a continuation of care and support.

Recommendations

32. Parole Officers, Probation Officers, workers in group homes, and other aftercare workers must be educated about HIV/AIDS.

As has been recommended in the Education and Prevention section of this Brief (see Recommendation 1), aftercare workers should attend mandatory and comprehensive educational sessions on HIV/AIDS, community resources for youth with HIV/AIDS, and the special needs of youth with HIV/AIDS.

33. Exit Kits with HIV/AIDS information, contacts with community-based organizations, condoms, bleach kits, etc. must be made available to prisoners when they are released from custody facilities.

See recommendation 4 for details.

34. Programs providing continuity of care after release must be established for young offenders with HIV/AIDS.

Young offenders with HIV/AIDS who are receiving health care during their custody stay, should be supported in continuing the care they require after release. To maintain continuity of care during the transition from custody to community, every young offender living with HIV/AIDS should be assisted in finding medical care and support services in the community. This should include helping young offenders to register with related community-based services prior to release where such services are available and if the young offender so desires.

35. Any special programs used by a young offender living with HIV/AIDS must remain available to her or him outside of custody.

The Ministry of Community and Social Services and Ministry of Corrections must provide special programs (counselling, support, education) to meet the needs of young offenders who are HIV-positive or living with AIDS. These agencies should collaborate with community services agencies which serve young offenders in order that programs accessed in custody are also available outside of custody.

36. Community-based groups must be involved with the development and implementation of aftercare strategies.

In order to facilitate the continuity of HIV/AIDS programs in the transition from custody to community, the Ministry of Community and Social Services and the Ministry of Correctional Services should consult with community groups and agencies which provide services and education to youth living with HIV/AIDS, and current and former young offenders, in an attempt to provide a comprehensive aftercare strategy. These agencies and groups must be allowed access to provide such services in custody, in order that a link can be established for the young offender prior to release into the community.

37. The Ministry of Community and Social Services and Correctional Services should work with community-based HIV/AIDS housing programs and service organizations to ensure that they meet the needs of young offenders.

Community-based housing programs (such as, in Toronto, McEwan House, Fife House, Casey House) and service organizations should be helped to adapt their services to the needs of recently released young offenders living with HIV/AIDS. Special houses for youth living with HIV/AIDS could also be developed.

BACKGROUND INFORMATION

Who is in Young Offender Custody Facilities?

Currently there are approximately 12,000 youth who have been sentenced or are residing in young offender custody facilities in Canada. (The Toronto Star, 1991) The young offender system is divided into two phases, separated by funding source and age. Phase one is for youth who are charged while they are between the ages of 12-15 years, and are funded by the Ministry of Community and Social Services; phase two is for youth who are charged while they are between the ages of 16-17 years; these facilities are funded by the Ministry of Corrections. This split jurisdiction between Ministry of Corrections and Ministry of Community and Social Services is in Ontario, other provinces have different systems. In 1993-1994, 116,000 cases involving 213,000 charges were heard in youth courts in Canada. (Statistics Canada, 1995) Overall, the Canadian young offender population has not increased in 1993-1994. There are 148 young offender custody facilities in Ontario alone. Approximately 8 out of 10 youths were male and one half of the youth court case load involved 16 and 17 year olds. (Statistics Canada, 1995)

Why are they in custody?

The majority of youth being incarcerated are convicted of theft under 1,000 (17%), break and enter (13%), offenses against the Young Offenders Act (10%), failure to appear/comply (9%), and minor assault (9%). Since 1992-1993, the number of property cases has decreased by 5% while the number of cases in all other offence categories has either increased or remained at the same level. The number of cases involving violence has increased by 8% with two thirds of this increase due to the increase in minor assault cases. (Statistics Canada, 1995)

Youth are at risk for HIV.

In North America the proportion of adolescents who are sexually active is now so large that sexual activity among adolescents can no longer be considered socially deviant from a statistical point of view. (Croft, C., et al. 1990)

According to Dr. Karen Hein, a respected researcher/physician who works with HIV-infected adolescents, "there are three new features that distinguish the second decade of HIV from the first decade: 1) HIV has entered the teenage population around the world; 2) HIV prevention messages developed for adults are not appropriate and have not worked with adolescents; 3) there is a critical gap in HIV- related services for at-risk and HIV infected teens created by the increased availability of HIV antibody testing without age-specific follow-up services. (Hein, K., 1991).

According to Hein, "geographic differences in seroprevalence may be marked at the

moment but the set-up for wide spread infection among youth is undeniably present and unprotected sexual intercourse is now and will remain the leading mode of HIV transmission among adolescents." (Hein, K., 1991)

According to researchers in the U.S. (Stiffman, A., et al.1990), regular condom use for prevention of pregnancy or STD's is not a social norm and remains infrequent among sexually active teenagers and young adults. A complicating factor in adolescents' adoption of condom use and other self-protective behaviours is believed to be related to their level of psychosocial development, which manifests itself in "feelings of invulnerability, concrete rather than abstract thinking, denial of risks associated with actions, and the need for peer approval. "(Stiffman, A., et al. 1992).

Why the concern for young offender custody facilities?

HIV infection affects all sectors of Canadian society, including youth. Many HIV/AIDS activists and public health workers recognize that young people are at increasing high risk for HIV infection due to their experimentation with sex, drugs and alcohol common during adolescence.

Statistics show that 20% of people living with HIV/AIDS in Canada are between the ages of 20-29. Given that HIV is known to have a latency period of up to ten years, it is clear that many of these people became infected as teenagers.

Although Dr. Diane Rothon's B.C. study, Determinants of High Risk Behaviours for HIV Infection among Young Offenders: A Window of Opportunity (Rothon, et al, 1994), revealed a "low HIV prevalence (0.25%)" among young offenders, it also found that

> Patterns of high risk behaviour were evident. IDU and sex with someone of the same gender were equally prevalent among youth 12-15 and 16-19. (p. 2)

The study concludes that

> Patterns of high-risk activity begin early and selective pressures appear to differ for younger versus older offenders. Youth in detention provide a window of opportunity for enhanced education on HIV/AIDS. (p. 2)

Many adolescents are at risk of contracting and transmitting HIV. Pregnancy and sexually transmitted disease in adolescence indicates that young people are engaging in behaviours that put them at risk of contracting HIV. In addition to high risk sexual behaviours, teens may or do experiment with drugs, especially alcohol, which impairs their judgement. The combination of drug use and sexual activity put adolescents at risk for HIV infection. The link between the lack of enthusiasm for condom use amongst street youth, and the link between substance abuse and the transmission of HIV and other STD's through injecting contaminated needles or when

judgement is impaired, leading to unplanned or unprotected intercourse, was established by the three studies done on Canadian street youth. (Read, S. et al, 1993; Radford, J., 1991, A. R. F., 1990).

Adolescents often have difficulty changing their behaviours because of the three mythical I's of adolescence - immortality, infertility and invulnerability. This "AIDS-cannot-happen-to-me" thinking places youth at risk. Not only do adolescents engage in high risk activities and or behaviours but they frequently deny that these put them at risk of HIV infection. Because of the risk to youth, young offender facilities need to be concerned with the following:

1. Mandatory education of young offenders and staff about HIV/AIDS.
2. Mandatory use of universal precautions (anyone could be infected young offender or staff).
3. Comfort level of the facility and staff to work with young offenders who are HIV-positive.
4. Clear and well written policies.

HIV/AIDS is a serious problem that facilities must face. Along with the reality of HIV/AIDS is the reality that our youth participate in activities such as prostitution, where negotiating safer sex/condom use goes hand in hand with less money, drug use/misuse, sex.... Facilities and staff need to recognize that adolescents have sex and that denial of this in this era of HIV/AIDS may be a contributing factor to the spread of infection. A custody facilities' HIV/AIDS policy should clearly state that sex and sexuality education, along with the provision of information and tools to prevent HIV transmission, are essential to the proper care of youth.

Information about sex and sexuality is an important part of education about HIV/AIDS. This information can help young people choose sexual behaviours that protect their own health and that of their partners. Education about sex and sexuality should include information about the physiological aspects of sexuality, relationships, birth control (abstinence, safe sex negotiations), prevention of STD's (including HIV/AIDS), and unplanned pregnancy. However, providing sex and sexuality education is typically a low priority for most facilities, as some feel that it is beyond their mandate or that "sex does not exist in our institution."

The topic of sexual orientation usually arises out of and discussion about HIV/AIDS. Facilities must develop a clear policy supporting the acceptability of talking about homosexuality to their clients. Too often the subject is ignored in the belief it can be dealt with when the need arises. Staff need to feel comfortable that they can bring forward issues and concerns around homosexuality and find answers. Young heterosexual people need to understand the realities of the relationship between homosexuals and HIV/AIDS in order to stem the growth of homophobia. The myths about the relationship of homosexuality to HIV/AIDS must be challenged.

We don't need HIV seroprevalence studies to know that HIV/AIDS is threatening young offender's lives.

Seroprevalence studies on the "outside" of custody (Read, S., 1993, Radford, J., 1991; King, A, 1989) show us that youth are at risk of HIV-infection. Kendall is his 1994 Health Status Report: Snapshots of Health in Toronto found that cases of sexually transmitted diseases were fairly stable although the highest rates were among adolescent females. Females aged 15-19 had consistently higher rates than males of the same age groups. In 1993, the female rate was over double the male rate and was highest of any age group, male or female. He also found in 1992, there were 1,314 live births, 8 stillbirths and 2,401 abortions in Metro, to women in the 15-19 years age group. With this information we know that youth are engaging in high-risk sexual activities.

The 1994 Diane Rothon study of young offenders in B.C. further demonstrates not only the existence of people living with HIV/AIDS within the system but more importantly documents the prevalence of high risk behaviours of youth in both the 12-15 and 16-19 ages groups.

HIV/AIDS has already reached the adult institutions. Youth are at risk whether they are in young offender facilities or out on the street.

We are into the second decade of the HIV epidemic, yet efforts to reduce transmission and educate young offenders have been few and haphazard. Efforts to counsel and treat those who are infected are left at the discretion of the individual facilities. While the reasons for the lack of action are numerous and complex, the lack of scientific data and research in the area of young offenders has made it easier to ignore the problem. Lack of data on the number and characteristics of HIV-infected are not needed to mobilize action. We are optimistic that this brief will facilitate future work and much needed action.

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