POINTS OF PERSPECTIVE

RESEARCH REPORT ON THE FEDERAL PRISON NEEDLE EXCHANGE PROGRAM IN CANADA

HIV LEGAL NETWORK
RÉSEAU JURIDIQUE VIH

Toronto Metropolitan University

“LOST SOUL”

Illustrated by Joey Toutsaint in honour of Prisoners Justice Day (August 10, 2019).

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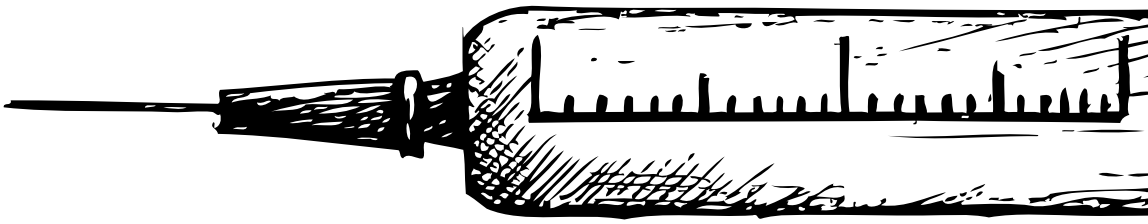

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INTRODUCTION

People who are incarcerated have long been recognized as disproportionately affected by HIV and hepatitis C, with injection drug use a major contributing factor to the spread of these viruses (OHTN, 2014). In response, prison-based needle and syringe programs have provided people who are incarcerated with access to sterile injection equipment in more than 60 prisons in over 10 countries since 1992 (HRI, 2020; UNODC, 2014). Evaluations over the past three decades have consistently shown that such programs reduce new HIV and hepatitis C infections, reduce injection-related injuries such as abscesses, reduce the sharing of needles, and do not increase in-prison drug use overall (for example, see Lazarus et al., 2018; Moazen et al., 2020; UNODC, 2014).

Prison-based needle and syringe programs tend to employ one of the following four models: distribution via automatic dispensing machines; distribution by health care staff; distribution by peers (i.e. trained fellow prisoners); and/or distribution by external organizations that specialize in harm reduction (UNODC, 2014). Each model has advantages and disadvantages with regard to anonymity, confidentiality, accessibility, feasibility, ease of implementation, cost, and effects on interpersonal relationships, for example between people who use drugs in prison, and with other prisoners, prison staff, and external staff (PHAC, 2006; Stöver & Nelles, 2003; van der Meulen et al., 2016).

Yet, despite ample empirical evidence demonstrating the effectiveness of needle and syringe programs, the federal Correctional Service of Canada (CSC) refused for decades to implement this essential prison harm reduction program. After years of inaction, in 2012 the HIV Legal Network along with Steve Simons, a man formerly incarcerated in a federal prison, and three HIV organizations — **PASAN, CATIE,** and **CAAN** — launched a constitutional challenge to compel CSC to provide people in prison with access to sterile injection equipment.

The **HIV Legal Network** promotes the human rights of people living with HIV or AIDS and other populations disproportionately affected by HIV, punitive laws and policies, and criminalization, in Canada and internationally. They do this through research and analysis, litigation and other advocacy, public education, and community mobilization.

Visit hivlegalnetwork.ca

PASAN is a prisoner rights organization that provides support, education, and advocacy to people who are incarcerated, their families, and communities. PASAN's work focuses primarily on prison health, harm reduction, HIV, and hepatitis C virus.

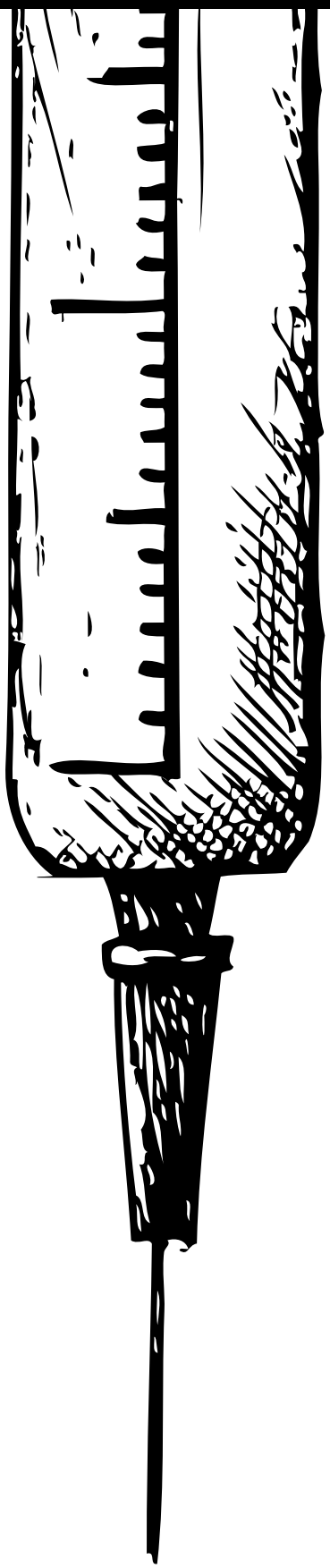
Visit pasan.org

CATIE is Canada's official knowledge broker for information on HIV and hepatitis C virus. The organization connects healthcare and community-based service providers with the latest science, and promotes good practices for prevention and treatment programs. It provides up-to-date, accurate, and unbiased information about these topics on its website.

Visit catie.ca

CAAN provides a national forum for First Nations, Métis, and Inuit Peoples to wholistically address HIV and AIDS, hepatitis C virus, sexually transmitted and blood borne infections, tuberculosis, mental health, aging, and related co-morbidities.

Visit caan.ca



As the lawsuit was making its way through the court process, the HIV Legal Network, PASAN, and a criminologist from Toronto Metropolitan University undertook a study exploring the perspectives of former prisoners, community-based harm reduction workers, and prison health care providers on the provision of sterile injection equipment in the federal prison system. Research participants were strongly in favour of this harm reduction approach, with some distribution models deemed more advantageous than others. The themes that emerged focused on the following program needs: anonymity and confidentiality; ease of access to equipment; and trust in the providers who administer the program. The research resulted in six recommendations:

- Access to prison-based needle and syringe programs and sterile injection supplies should be easy, confidential, and not subject to disciplinary consequences;
- People in prison should receive regular information, education, and support from trained personnel regarding safer drug injection;
- Prison needle and syringe programs should adopt a hybrid or multi-model approach to distribution within each institution;
- Program implementation and delivery should include ongoing and meaningful consultation with, and education for, relevant stakeholders to ensure the accessibility and positive health outcomes of the program;
- People in prison should have an active role in determining syringe distribution programming, structure, and policy; and
- The justice system, including the Correctional Service of Canada, should move toward addressing drug use as a social and health issue.

For more information about the study, see van der Meulen, Claivaz-Loranger, Clarke, Ollner, and Watson (January 2016). *On Point: Recommendations for Prison-Based Needle and Syringe Programs in Canada*. Toronto, ON: Canadian HIV/AIDS Legal Network.

"FACE"

Illustrated by Steve Zehr

THE CORRECTIONAL SERVICE OF CANADA'S PNEP

In June 2018, in response to the lawsuit, the federal government announced its intention to introduce a Prison Needle Exchange Program (PNEP), which was to gradually roll out to all federal prisons across the country. Originally, CSC's stated plan was to implement the program in 11 prisons by 2019, but as of the writing of this report, the PNEP is still operating in only nine federal institutions. CSC commissioned a faculty member from the University of Ottawa to conduct an interim evaluation of the existing PNEPs in 2020. The resulting report detailed the structure of the program, rates of participation, barriers to access, recommendations for improvements, and plans for expanding harm reduction services (see Leonard, 2020).

The report also outlined the steps involved in accessing the PNEP, namely that people in prison must first make a request to visit health services, where their participation in the PNEP is assessed by a nurse. Next, they submit an application to the prison's assistant warden who conducts a "Threat Risk Assessment" to ostensibly determine whether the applicant's participation in the PNEP is a manageable security risk to the institution. Within 10 days of the initial request, the warden or deputy warden needs to provide a decision and return the assessment to health services. Those who are approved must sign a contract that outlines behavioural expectations for them to remain in the program. After these steps are completed, PNEP participants receive a kit that contains one syringe, one cooker, three water bottles, one vitamin C, and filters. The kit and all enclosed items are to remain visible in the person's cell when not in use, and are subject to frequent checks by correctional officers. Kits can be exchanged at health services as needed (Leonard, 2020).

The approach adopted by CSC was criticized by the HIV Legal Network and others for serious deficiencies that are not in keeping with public health principles or professionally accepted standards for such programs (HIV Legal Network, 2019). Most fundamentally, CSC's PNEP violates the confidentiality of people in prison at many points without reasonable justification, by requiring individuals to subject themselves to an assessment based on security rather than clinical need and to daily visual inspections to verify accountability for the equipment distributed — contrary to program models and accepted practice elsewhere around the world. As Canada's Correctional Investigator noted in his 2018–2019 Annual Report, "Harm reduction strategies can only be successful if there is uptake on the part of users, and the way that the PNEP has been developed and implemented thus far seems to have built-in restrictions to enrollment" (OCI, 2019, p. 15) citing in particular the Threat Risk Assessment as a condition of PNEP participation, the fact that access to equipment is not determined by need, and lack of multiple access and distribution points (OCI, 2019, p. 16).

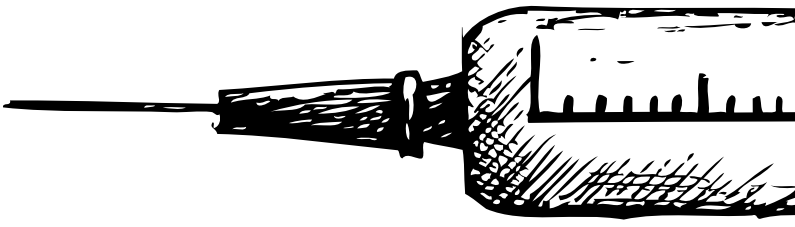
According to the interim evaluation commissioned by CSC, the PNEP has had very low rates of participation since its inception: a total of 42 participants were enrolled at just four of the nine institutions from 2018 through to 2020. As of June 2022, that number had risen slightly to 53 participants nationally (Smith, 2022). While individuals at two other prisons with a PNEP had expressed interest, no applications were submitted; there were no reports of interest in the program in the remaining three institutions. Several barriers were identified in the interim evaluation, which presumably affected uptake, including lack of knowledge of the program, difficulties with the needle exchange process, discrepancies in program implementation by institution, and the parole board's knowledge of PNEP participation. Institutional staff raised concerns about needle stick incidents, although the evaluation noted that only three needle pricks occurred after program implementation, none of which were related to the PNEP (Leonard, 2020).

The interim report offered several concluding recommendations, including that CSC:

- adopt measures to increase awareness of the PNEP among prisoners and staff;
- standardize program implementation and operation across federal prisons;
- ensure that all prisoners and staff are aware that CSC removed the requirement to share PNEP participation with the Parole Board of Canada; and
- expand harm reduction in prisons to include safer tattooing, safer snorting, access to naloxone. (Leonard, 2020).

However, the report did not address the shortcomings of the PNEP related to its lack of confidentiality and nor did it suggest a reconsideration of the security-oriented "Threat Risk Assessment" model, despite the Correctional Investigator's recommendation that "CSC revisit its Prison Needle Exchange Program purpose and participation criteria in consultation with inmates and staff with the aim of building confidence and trust, and look to international examples in how to modify the program to enhance participation and effectiveness" (OCI, 2019, p. 18).

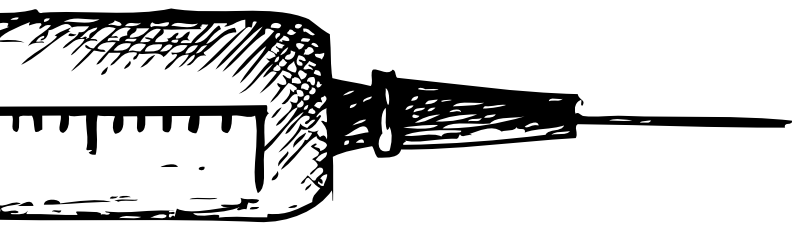
Two years later, in his 2021–2022 Annual Report, the Correctional Investigator noted persistent barriers to access and concluded "the program has failed to generate much interest, trust, or confidence from either prisoners or front-line staff. It remains a program largely in name only" (OCI, 2022, p. 7). As such, the Correctional Investigator recommended that PNEP criteria "be significantly revamped to encourage participation consistent with actionable recommendations of this Office and the external interim evaluation, with a view to full national implementation within the next 12 months" (OCI, 2022, p. 12).



FORMERLY INCARCERATED PERSONS' PERSPECTIVES ON THE PNEP

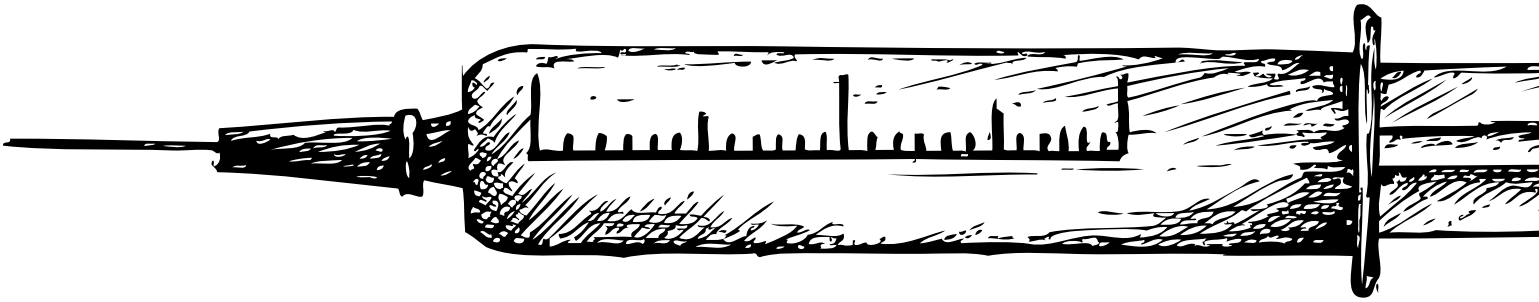
Given the urgent need for effective and appropriate harm reduction programs in prison, and the value of carceral research that is not commissioned by CSC, Sandra Ka Hon Chu from the HIV Legal Network and Emily van der Meulen from the Department of Criminology at Toronto Metropolitan University, supported by Research Coordinators Rhiannon Thomas and Ann De Shalit, and in partnership with PASAN, developed a study to solicit formerly incarcerated persons' perspectives on the PNEP. The research was funded by the Social Sciences and Humanities Research Council of Canada and was approved by Toronto Metropolitan University's Research Ethics Board.

Between September 2021 and April 2022, the research team conducted 30 interviews with eligible participants across Canada about their knowledge of and experience with the PNEP. Recruitment emails and study posters were sent to a wide range of agencies and individuals that were located close to a prison with a PNEP and who support or come in regular contact with people who are recently released. These included prisoner rights, women's health, harm reduction, HIV and AIDS, and Indigenous organizations, as well as halfway houses (i.e. transitional and structured residences for people who are released from prison and deemed to require support and/or surveillance) and numerous university- and community-based carceral researchers.



To be eligible, participants had to be at least 18 years of age, agree to an audio-recorded interview, and have been released post-program implementation from one of the federal prisons listed on CSC's website in September 2021 as having a PNEP. We collected socio-demographic information about each participant at the start of the interview, including how they self-identified in terms of their gender, age, race, and sexual orientation, which federal prison(s) they had been incarcerated in, and the number of years they had spent in prison. We then proceeded with a series of questions related to the frequency and types of drug use in federal prisons, their knowledge and/or experience of the PNEP, their perspectives on different syringe distribution approaches, and their recommendations for improvements to CSC's PNEP model. Interviews were conducted by phone or Zoom and each participant was given a $50 honorarium for their time and expertise, plus a $10 travel subsidy if they needed to take public transit to a quiet location.

After transcribing the interviews verbatim, the research team read each of the transcripts and collectively developed a code book for conducting an in-depth analysis. Participants shared a diversity of experiences and accounts about their time in federal prison, their use of drugs or observations of others using, and their treatment by prison staff and authorities. We provide excerpts from the interviews below to showcase participants' own narratives, reflections, and suggestions for change. We have grouped these into four sections beginning with the general context of drug use inside (e.g. types of drugs being used and frequency of use), followed by the main barriers to accessing the PNEP. The final two sections describe the impacts of COVID-19 on prison experiences in general and the functioning of the PNEP in particular, and participants' suggestions for how to improve the PNEP. Along with each quote we include the person's self-identified gender and race, and the province in which they were living at the time of the interview (Ontario, ON; British Columbia, BC; Nova Scotia, NS; Alberta, AB).



PARTICIPANT DEMOGRAPHIC TABLE

Gender	Male (15), Female (14), Trans (1)	
Age	Average 42 (range from 23 to 60 years old)	
Race/ethnicity	White (15), Indigenous/Métis (11), Black (2), Latina/white (1), Minority/Racialized (1)	
Sexual orientation	Straight (18), Bi/Pansexual (10), Lesbian (1), no answer (1)	
Federal prisons in which they had been incarcerated	**Designated for Men** • Archambault Institution • Atlantic Institution • Bath Institution • Beaver Creek Institution • Bowden Institution • Collins Bay Institution • Donnaconna Institution • Dorchester Penitentiary • Drumheller Institution • Joyceville Institution • Kent Institution • Kingston Penitentiary • Millhaven Institution • Mission Institution • Mountain Institution • Saskatchewan Penitentiary • Warkworth Institution	**Designated for Women** • Edmonton Institution for Women • Fraser Valley Institution • Grand Valley Institution for Women • Joliette Institution for Women • Nova Institution for Women • Okimaw Ohic Healing Lodge for Aboriginal Women
# who used drugs while in federal prison	21 (of whom 11 injected drugs in prison)	
Drugs used inside (illicit use of prescription meds and/or drugs smuggled in)	Cannabis (marijuana and hashish), powder and crack cocaine, speed, Suboxone, Wellbutrin, Vyvanse, crystal meth, MDMA, shatter, nabilone, gabapentin, pregabalin, heroin, benzodiazepines, Adderall, Robaxin, alcohol (brewed on premises), codeine, fentanyl, LSD, methadone, Dilaudid	
# of years spent in federal prison	Average eight years (range from one year to 30 years)	
# of times received a federal prison sentence	Average approx. three times (range from one to 11 times sentenced)	

CONTEXT OF DRUG USE INSIDE

As detailed in the socio-demographic table, interviewees described a wide range of drugs being used in prison, both prescribed and illicit. When asked how many people were using drugs, participant estimates ranged from 10% of the prison population to 80% or more. However, most suggested that 60% to 80% of people who are incarcerated used drugs regularly.

Modes of use

Types of drugs, as well as how often they were consumed, varied by institution and availability, though prescription drugs issued within the prison (such as Suboxone, Wellbutrin, gabapentin, methadone, Dilaudid, morphine, Adderall, pregabalin, and Robaxin) were most commonly and routinely used outside their prescribed purposes. Alcohol, tobacco, and cannabis products, which are considered contraband in the prison system, were also regularly acquired and consumed. Frequently mentioned illicit drugs included fentanyl, crystal meth, cocaine, methamphetamine, heroin, and "shatter" (THC). As one interviewee explained, people in prison would use *"any prescribed medication that they could buy off another person, and anything that was smuggled in"* (Interview #1, Métis woman, ON).

Common modes of drug consumption in the community (e.g. injection, ingestion, and inhalation) were described as similarly prevalent in prison, in addition to other modes of use such as "booty bumping," or dissolving drugs in water and inserting them as a suppository. Participants made many comments about the range of drug use practices, for example saying: *"...some snort it, some smoke it, some inject it...and some just take pills, and some just swallow them..."* (Interview #11, white man, ON). Others indicated that while incarcerated, people used *"any way they could, like snorting, smoking, drinking"* (Interview #21, white woman, NS) or *"would inject pills, they would smoke cocaine, snort cocaine, inject crystal meth...snort pills, smoke pills, inject them into their finger"* (Interview #13, white man, ON) and that *"...whether they were snorting it or injecting it...there was always somebody on the hustle to use drugs"* (Interview #1, Métis woman, ON). Some suggested that snorting was the easiest method to consume drugs, since sterile syringes were not available and smoking would draw attention from correctional officers.

Modes of drug use were also influenced by the drug itself, as well as individual preference and experience. Because many interviewees reported being unable to access the PNEP, or being deterred from applying to the program for fear of punishment and other reprisals, their usual preference for injecting meant that they used homemade injection equipment, reused needles, and/or shared equipment among a group of people. As one participant recalled, *"I saw them take one needle and pass it down to another range, and the whole other range use it. And they shared a needle for like three months"* (Interview #15, Métis man, ON).

Concealing drug use

Most of the interview participants said that drug use in prison was easily detectable and could result in a range of sanctions and consequences, including the increased likelihood of having to undergo frequent urinalysis. Thus, many reported that it was important for people in prison to conceal their drug use from correctional officers and at times from other prisoners as well. The need to hide drug use was especially acute for those who were injecting, due to the stigma associated with this mode of consumption. A participant explained: *"It poses a challenge when the guards know about drug use, especially IV stuff"* (Interview #12, white man, ON). People looked for ways to conceal their usage, for example by hiding their equipment or flushing it down the toilet. However, some suggested that this could lead to other problems, such as rushed injection practices that can heighten the possibility of overdosing, saying that people in prison were *"basically just overdosing because they're hiding it [injection drug use]"* (Interview #13, white man, ON).

Needle stick incidents and potential security issues

Being stuck or intentionally stabbed by a used needle are two of the main concerns raised by correctional officers and prison administrators in relation to PNEPs. The assumption is that incarcerated people will either hide PNEP needles in their cells, which would increase health and safety risks for correctional officers when conducting cell searches, or use the needles to attack staff. Regarding the former, we asked participants in this study if they had heard about needle stick incidents, and if so, how common they were. About one-third of the interviewees said they were aware of these incidents occurring during random cell searches, but that they always involved needles that were acquired illicitly and not through the PNEP. As one participant explained: *"I guess the person...the guard was searching his cell, and there were sharps, and he didn't identify it, and I guess the guard got poked. And yeah, the guy pretty much got his whole cell ripped apart, and it was bad"* (Interview #14, white man, ON). In terms of the weaponization of injection

equipment, interviewees stressed that people who inject drugs would much prefer to keep needles for their personal use and that the threat of needles being used as weapons was a scapegoat, noting: *"They're [using] that as an excuse to not do it... We have knives, we have everything you want... If a man wanted to do that, he does not need a needle do that... Most guys, if they have a needle, they're going to use it for whatever they do and...that's it, they'll throw it away"* (Interview #30, Indigenous man, AB).

KEY BARRIERS TO USING THE PNEP

Study participants discussed many interrelated challenges to accessing the PNEP in federal institutions. The three most commonly identified were: 1) issues with confidentiality, privacy, and surveillance; 2) punishment and the removal of privileges; and 3) lack of knowledge or misunderstanding about how the program works.

Issues with confidentiality, surveillance, and privacy

Across all the interviews, there were clear concerns around confidentiality, surveillance, and privacy with regard to the PNEP. Specifically, interviewees noted that correctional officers had various methods of identifying PNEP participants. When asked if they thought that officers knew who was using the program, the majority of participants believed that they did, with many suggesting that correctional officers were getting information from medical staff: *"Guards know everything that's going on... there's nothing confidential about medical"* (Interview #20, white woman, NS). Actual or perceived sharing of information between health care staff and correctional officers meant that many felt that PNEP participants' confidentiality was not respected. One person pointed out: *"The guards aren't supposed to know who's on the program, but then...they're allowed to call, 'I want to see your sharps.' So you have to produce your PNEP kit to show that it's intact, but then they know you're on the program"* (Interview #3, Métis woman, ON).

For many, confidentiality was noted as being crucial to successful harm reduction programming, arguing that it should be maintained in the same way that it would be in the community. Breaches in confidentiality act as a major deterrent for program uptake. Indeed, correctional officers' knowledge of individual PNEP participation, via other prison staff or direct observation (e.g. seeing PNEP kits during cell count and visual inspections) affected peoples' willingness to apply to the program since that would lead to an increase in the degree and intensity of surveillance, as these two participants explained:

> ***[Prison staff] make you feel like you're going to be safe with [the PNEP], but in the end, it's not. They wreck your cell, they lock you down, they give you trouble for it, so that's probably why no one uses it.*** (INTERVIEW #15, MÉTIS MAN, ON)

> ***Those people [PNEP participants] do get a lot more attention from the guards, and constantly get their rooms flipped and...all that stuff. So, those are the people that don't want their name on paper for having a needle kit. So, they go and borrow someone else's, which is just... cause for concern, because it could be potentially spreading disease.*** (INTERVIEW #4, WHITE/LATINA WOMAN, ON)

Many others likewise reported that in addition to more closely surveilling and scrutinizing PNEP participants, correctional officers also target people known or suspected to use drugs more generally. One of the former prisoners with whom we spoke told us that he had applied to join the PNEP but was not granted access since the program was never fully implemented at his institution. Despite that, correctional officers knew of his PNEP enrollment request, which resulted in more aggressive surveillance: *"When you first apply for the program to get the needle exchange, they never gave you the needles but the guards had access to the list...of people who all wanted to get on it...so they knew you were using needles"* (Interview #22, Indigenous man, ON).

Technologically mediated surveillance practices, such as CCTV cameras, were also frequently mentioned. As an interviewee underscored, *"there's no place in the jail that you can go where there's no camera, except the... staff office"* (Interview #23, white man, BC). Participants further observed that bio-medical surveillance by way of urinalysis intensified barriers to accessing the harm reduction program. In their view, links were clear between participating in the PNEP and being targeted for additional urine screening, as well as other consequences: *"If they did find something in the urinalysis, then your cell was tossed, more than once"* (Interview #23, white man, BC). Another explained that *"the second you go get a needle...the next day you're getting called in for a piss test, and you're charged, and your security drops, and you owe them a bunch of money [in fines]"* (Interview #24, white woman, BC).

And finally, interviewees reported that a lack of privacy among and between incarcerated individuals affected their engagement with the PNEP, saying: *"Even guys that want to use, they want to keep it low, right? So, they...would... keep it very, very personal. You're not going to advertise in prison that you're an intravenous drug user"* (Interview #16, white man, ON). With limited privacy, stigma from other prisoners can be more felt more intensely, again deterring people's willingness to enroll in the program. For example, a participant noted that *"people talk...and it just wouldn't... be kept quiet... There'd be too much talking involved and it would get around. People wouldn't want that at all... People frown a lot on the drug users in the prisons"* (Interview #13, white man, ON). The requirement to present the PNEP kit during cell count further means that fellow prisoners in a house or range are made aware of one's program participation.

Punishment, removal of privileges, and other negative ramifications

Related to concerns with confidentiality, surveillance, and privacy, study participants questioned CSC's intentions behind the development and implementation of the program, stating for example that *"people think it's a trap"* (Interview #13, white man, ON). CSC's broader "zero tolerance" policy on drugs, coupled with the lack of information disseminated to people in prison about the PNEP, meant many interviewees found it difficult to trust that they would not be punished for applying to enroll, as that would instantly expose them as a person who uses drugs: *"If someone's getting a needle, they're getting it for a reason, it's to use it, right? ... If you use it, then you're in trouble because then they know there's drugs in the prison"* (Interview #18, Indigenous woman, NS). An interviewee highlighted the perceived contradiction with having a PNEP in an institution with a zero-tolerance drug policy: *"They don't want safe injection... Literally the language reads zero tolerance for drug use, so why would they want a needle exchange in their prison?"* (Interview #24, white woman, BC).

Interviewees were acutely aware that the tension between the prohibition of drugs and the PNEP created conditions for harassment by correctional officers. Since people who want to join the PNEP are screened for eligibility, and their participation (and possibly even any expression of interest) is registered in their files, study interviewees almost universally expressed concern about punitive implications and hesitancy to enroll in the program. One interviewee explained it like this: *"I feel like the biggest issue is the guards and the staff. Don't make a program that's supposed to make people feel safe if you're not going to make them feel safe, you know? What was the point in all of this if you're just going to be...harassing people... And it really contradicts itself because it's like saying you can have a needle kit but you can't have drugs"* (Interview #4, white/Latina woman, ON).

Stigma was mentioned as a consequence of drug use in general and participation in the PNEP specifically, especially as experienced in relation to interactions with prison staff and correctional officers. Study interviewees suggested that those enrolled in the PNEP experienced significant judgement from correctional officers, saying, *"they're so anti-drug...you just are shamed"* (Interview #24, white woman, BC). Notably, virtually all the formerly incarcerated people with whom we spoke anticipated that unsupportive prison staff would engage in punitive behaviours towards PNEP participants. According to one interviewee, *"if the guards are aware that people are participating in that program, they are coming for them"* (Interview #12, white man, ON). Another suggested, that *"if the guards found out, [PNEP participants] would be locked up or searched...so a lot of people are scared to use* [the PNEP]" (Interview 13, white man, ON). As noted previously, because correctional officers are responsible for checking PNEP kits and know who is enrolled in the program, this ultimately opens the door to a variety of bullying behaviours, from stigmatizing comments and targeted additional surveillance to disruptive searches of persons and cells.

Some of the interviewees believed that institutional privileges or access to programming may be revoked if they enrolled in the PNEP, while others thought that it could have consequences for parole or affect their release conditions. As an interviewee stressed, *"nobody's going to come and ask for a needle and ruin their parole"* (Interview #30, Indigenous man, NS). There also remained the looming possibility of receiving institutional drug charges, which could result in a fine and be recorded on one's file. To avoid these and other perceived or actual consequences of using the PNEP and being known as someone who injects drugs, people in prison considered sending a proxy person to collect a needle kit for them or stayed out of the program altogether, leading to equipment sharing: *"I know there was a few people that really were not okay with...getting their own, that would share with other people that had needles, just because...they felt like it would put them on some radar, and that it would hinder them in some way"* (Interview #26, Indigenous woman, BC).

Lack of knowledge or misunderstanding about how the PNEP worked

Most participants were aware that the PNEP existed at the institutions from which they had been recently released; however, the majority knew very little about how the program worked. One person said, *"I never had it advertised or presented as an option to me at any point in either institution"* (Interview #26, Indigenous woman, BC). While three of the interviewees were told about the program by the prison nurses, most learned about it from a poster in the health care office. Some study participants indicated fellow prisoners informed them about the program. Coupled with fear of surveillance and punishment, this general lack of awareness and limited information about the PNEP meant that even people who inject drugs in prison who knew sterile equipment could be available to them did not apply to enroll. The interviewee above explained, *"there was...a group of people that were all using the one needle... But obviously they didn't know enough about the program to go and get themselves registered"* (Interview #26, Indigenous woman, BC).

Study participants felt that consultation with people who are incarcerated about the PNEP prior to its implementation would have helped to clarify how the program worked and could have improved both its design and participation rates. Interviewees believed prisoner expertise, particularly from those with injecting drug use experience, was crucial for program success: *"Before you put something in as serious as a Needle Exchange Program, wouldn't it be better to start the conversation with, 'We're thinking about doing this, we've been approached to do this, what do you guys think? How do you guys think it would work better?' ...Then you would include the guys who have firsthand knowledge on how a pen works 24 hours a day"* (Interview #7, white man, ON). By engaging with people in prison in advance of the program rollout, design flaws that may not have been visible to prison administrators could have been avoided. Study participants felt that consultation in general should be a central component of CSC's program and policy development processes: *"Because we are their biggest partner. We are their only partner inside, because everybody else works for CSC"* (Interview #7, white man, ON).

COVID-19 IMPACTS

Almost all interviewees reported that COVID-19 restrictions and resulting programmatic changes caused serious disruptions to daily life inside the prison. As these participants recalled, lockdowns, other constraints on one's movement, and the limited ability to access various supports had particularly detrimental effects:

> ***COVID shut down everything. Initially we were all quarantined, each to their own room. And basically, the guards would only come around every four hours to check....*** (INTERVIEW #1, MÉTIS WOMAN, ON)

> ***You had to be escorted to health care, you had to be escorted everywhere you went... One house was allowed to go at a time, there would have been zero anonymity and zero chance to get to go when you needed to go. You would have been with staff... And if you were at home and needed a needle, there was no way you could get one... Definitely couldn't call and say...'Hi, I need to go get a needle from my Needle Exchange Program.' They'd be like, click.*** (INTERVIEW #24, WHITE WOMAN, BC)

> ***We are very restricted on movement within the institution. There was a long period of time there where we only had one day a week... to move within the institution to all of our appointments, to see the doctor, to see the dentist, to see social worker, to see mental health... So, if we had multiple issues, we had to basically choose which one to deal with....*** (INTERVIEW #11, WHITE MAN, ON)

Visits from family, friends, community workers, and others were suspended, as was group programming, particularly if it was being facilitated by an outside organization. For some, the cancellation of programs meant that they were unable to secure an earlier release that they would otherwise have been entitled to: *"They have all the programs that you can't get out until you finish your program. That's why I was in there for 11 months. I should have been in there for six months, but COVID hit, and they couldn't let the teachers in to do the programming, so I had to stay 11... I had to stay almost double my time because I didn't get my programming to get out"* (Interview #29, white woman, NS).

Substance use also changed during pandemic-related lockdowns. Many participants reported increased boredom, in part related to suspended programming, leading to increased drug use. One person explained, *"So, the sheer boredom happens, and what happens when you're bored? You just do all the wrong things you're not supposed to do, because it's like, I've got to have… I've got to do something. So, things like brew use [alcohol] got increased. There was tons of brew being made. It was in my house, it was in many other houses. And I regularly saw drug deals going down, you knew that was what was going on"* (Interview #20, white woman, NS). Another interviewee shared: *"When COVID hit, [people were using] every day. It seemed like… [with] the decrease in staff, packages became very frequent, and the drugs became rampant. There was more drugs in once the onset of COVID than I had seen in that prison in my entire 12 years"* (Interview #3, Métis woman, ON).

Troublingly, participants reported that visits to health care were severely limited during the pandemic. Clinicians would instead visit each range once per day, sometimes less frequently, to distribute prescription medication and provide any necessary health assessments or treatments: *"Health care would come around every day to dispense drugs and stuff, medication. But that's the only time you saw health care unless you really needed to see them"* (Interview #27, white man, BC). In some institutions, the frequent modifications to the timing of when medications were distributed had a significant impact: *"I found for the first month or so people were…screwed up in the head really by all the time changes constantly… The first month that [medication distribution] got changed…people were… screwy and grumpy…and then you just start getting into the new routine, and then it changed again… So, I found it really affected the mood of the jail"* (Interview #17, Indigenous trans person, NS).

Decreased availability of health care and other supports meant that access to the PNEP was also restricted, despite increased drug use: *"We were not able to go to health care all the time, health care came to us. So, I think it really changed their [PNEP participants] availability to get needle exchange all the time. I'm not sure even how they were doing it"* (Interview #3, Métis woman, ON). Some suggested that lack of access to the PNEP meant that injection equipment was being shared and reused by people in prison, explaining: *"Because of the pandemic, we were in cohorts, so [if] somebody would need a needle…they would go and scream outside for so and so to borrow their kit… It was basically like everybody who had a kit was sharing it"* (Interview #4, Latina/white woman, ON). Another interviewee described how injection equipment was necessarily shared during lockdown: *"We got locked down for three months. I seen them passing the needles through the hallway like on strings, like fishing it back and forth. At that point, they [prison staff] should've explained that they would've gave out the needles, you know what I mean?"* (Interview #15, Métis man, ON).

IMPROVING THE PNEP

A variety of ideas about how to remove barriers to the PNEP and increase program access and enrollment were mentioned across the interviews, with anonymity and confidentiality noted as being of the utmost importance. Study participants were clear that the program *"has to be… anonymous"* (Interview #30, Indigenous man, AB) and sterile injection equipment should be available without repercussion: *"no questions asked, like there's no consequence for being safe for what you're doing"* (Interview #26, Indigenous woman, BC). One interviewee underscored that confidentiality is compromised by in-prison surveillance practices, and that it is necessary to *"get rid of the cameras and the guards"* in relation to the administration of the program (Interview #23, white man, BC). Numerous former prisoners described approaches to injection equipment distribution that would enhance confidentiality, which we discuss further below.

In addition, many mentioned that increasing PNEP education and awareness for prison staff was key. They indicated that staff attitudes about the importance and benefits of the PNEP through educational workshops and trainings would help to increase its uptake. One interviewee stated that staff are *"very aware of all the drugs that's on the go in the jail right now. They're very aware that as much as they tried and tried, they're not going to stop it. So, I think they need to be more open minded towards the Prison Needle Exchange Program"* (Interview #17, Indigenous trans person, NS). In their view, mandating training for health care and correctional officers would not only improve staff knowledge of HIV and hepatitis C prevention vis-à-vis injection drug use, but would also enhance the safety of individuals who access the program. As another study participant indicated: *"They have to be sensitive and compassionate to people… They have to…alter the program in some way that people won't be scared to have their name on the [PNEP]. Because all that's doing is potentially spreading…infectious disease,"* adding that prison staff *"need to be more educated… They need to be more policed on how they're dealing with people who have these addiction issues, and we do use needles, that they can't bully"* (Interview #4, Latina/white woman, ON).

As previously noted, study participants reported hearing minimal, if any, information about the PNEP while they were in prison. Thus, education about the PNEP's existence

and its benefits for people who are incarcerated is also necessary. This could be done by providing PNEP orientation materials to all new prisoners upon reception, through peer education, and through external partnerships with organizations that specialize in harm reduction. For example, interviewees suggested including an *"information package in…[the] welcome package…that explained that it was an option, how it works, who to contact"* (Interview #26, Indigenous woman, BC), or have *"one of the [external community] groups…come in and explain the Needle Exchange Program to all the inmates, all at one time"* (Interview #27, white man, BC). Another thought the best approach was to have the prison nurse provide education about the program: *"I would have a nurse come on every range when the range first gets together, and have them explain [the PNEP] a little better, and let them know that they don't have to be afraid to use it, you know? Maybe have the nurses talk to the guards about it and maybe get them back off a little, you know?"* (Interview #15, Métis man, ON).

Study participants further recommended removing administrative barriers to PNEP enrollment, as the application process was seen to be overly burdensome in an already heavily bureaucratic institution, particularly for those who may face challenges navigating or understanding technical and complex policies and practices. Several interviewees spoke of people who had to wait for weeks for a response to their application, with a few indicating that they were rejected without explanation. Some suggested that anyone interested in joining the PNEP should be automatically approved: *"I would say, make it accessible to everybody, without having to jump through hurdles"* (Interview #2, Black man, ON).

In addition to providing sterile injection equipment, a few study participants indicated that the PNEP could be improved by diversifying the types of harm reduction materials available, for example by providing sterile equipment for tattooing, such as gloves and needles, as well as items for snorting and smoking drugs, like stems, screens, foils, and straws:

> ***… offer straws for snorting drugs, which is a thing… That's part of the whole harm reduction, not sharing any drug equipment. That option, I don't remember reading if they had that, but if that was there, I would've done that for sure.*** (INTERVIEW #12, WHITE MAN, ON)

> ***Why not stems and Brillo? … Why aren't they providing papers for rolling joints and stems for smoking crack?*** (INTERVIEW #29, WHITE WOMAN, NS)

Moreover, some recommended that CSC introduce and expand supervised consumption services to complement the PNEP, *"like a safe shoot-up spot where they would keep their needles, or they would have to go down and use it there, and then then leave it there"* (Interview #29, white woman, NS). This would provide an overdose prevention option for people who are willing to carry their drugs to access the physical site of the service. Indeed, offering a range of harm reduction items and services would better serve the diverse needs of people who use drugs in prison, enable them to mitigate the risk of transmission and overdose, and better protect their health — all of which should be in line with the principles underlying the PNEP.

Another suggestion raised by a number of interviewees was to provide all incarcerated individuals, or at least those who self-identify as someone who injects drugs, with sterile injection equipment upon prison entry:

> ***I think that everybody that goes in that prison, and that is a needle user, should be given the option to have one or not. If there's drugs in the institution or if there isn't drugs in the institution, to have one just to be safe.*** (INTERVIEW #18, INDIGENOUS WOMAN, NS)

> ***People wouldn't have to use other people's if you would give everyone one.*** (INTERVIEW #21, WHITE WOMAN, NS)

> ***I think it could definitely work if everyone was given a kit. And if you never use it ever in your entire bit, and it just sits in a lockbox in your cell or whatever, it just sits there, that's fine, but if everyone had a kit, then that kind of a system, I think, would be super beneficial.*** (INTERVIEW #26, INDIGENOUS WOMAN, BC)

Ensuring everyone has access to sterile injection equipment would decrease the likelihood of equipment sharing, further diminishing the risk of contracting HIV, hepatitis C, and other infections, as well as promote confidentiality, since individual PNEP participants would not be singled out. It would also decrease the value of needles and syringes in the prison's underground economy. Relatedly, some study participants suggested providing several needles at a time rather than only one to prevent people from reusing or sharing for fear of punishment or stigma related to requesting more supplies. An interviewee explained, for example: *"then when they got 25 and used those, then you give them another 25, you know? That kind of thing"* (Interview #23, white man, BC).

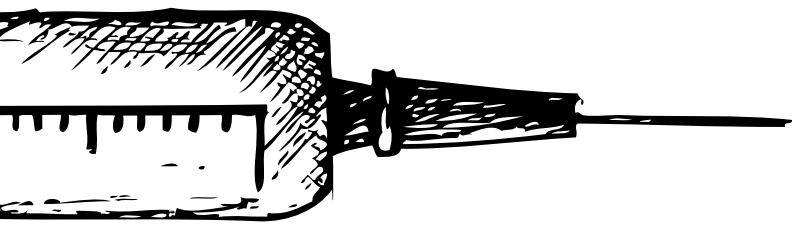
For those who are unwilling, uncomfortable, or uncertain about officially enrolling in the PNEP, due to the myriad issues noted throughout this report, the most commonly preferred supply access point was automatic dispensing machines. These have been adopted to great success by some prisons in other jurisdictions globally. When placed in inconspicuous areas, dispensing machines allow access to people who might not otherwise acquire supplies, since they wouldn't *"have to go through staff, because staff has all the control. They have the control over you getting your clean syringe or not, right? Or you getting the syringe, period"* (Interview #18, Indigenous woman, NS). Other interviewees similarly reflected that dispensing machines preserve anonymity:

> ***There's no interaction, so it's easier for a prisoner to get access to it and it could be done in a more anonymous way. That way, if the guards don't see it happening, then the guards aren't necessarily aware that people are involved in it...and it gives inmates an opportunity to be more discreet about it.*** (INTERVIEW #12, WHITE MAN, ON)

> ***Remember the old condom machines that they used to be in bathrooms? Maybe you could put machines like that in bathrooms, because there's no cameras in bathrooms, so they wouldn't be able to monitor.*** (INTERVIEW #27, WHITE MAN, BC)

When asked about their thoughts on the potential role of external community and harm reduction organizations in facilitating or helping to facilitate the PNEP (a supply distribution model that some prisons have adopted elsewhere), most were supportive but also acknowledged the possible challenges with this approach, particularly when it came to lockdowns and visitor restrictions. Interviewees suggested that community-based harm reduction workers would improve prisoners' trust in the program because they are seen as more likely to maintain confidentiality, able to offer appropriate and reliable health and harm reduction information, and could advocate on behalf of people in prison. As a participant elaborated: *"a lot of prisoners...don't like the CSC system in the first place, so they're kind of hesitant...but if an outside entity comes in [that]...hasn't got any bias either way. Like I say, the prisoners and the guards and the doctors, they all talk together, so they might say, 'oh, this guy's a junkie, or this guy is this whatever'... So they might feel more comfortable with someone that they don't know that just comes in"* (Interview #8, Black man, ON).

Distribution of PNEP equipment by peers was also favoured by some interviewees, with issues of trust again being front and centre: *"Because we trust each other...there's an honour system in there that has been there for years with other inmates...."* (Interview #11, white man, ON). Another commented: *"There's a lot of respect towards the peer mentors, and the peer mentors are really able to negotiate with the other prisoners in a way that the guards wouldn't be able to"* (Interview #1, Métis woman, ON). As CSC already oversees peer support programming, implementing a PNEP peer distribution model (as seen in prisons in other countries) is seemingly a natural extension of the role peer support workers already play.

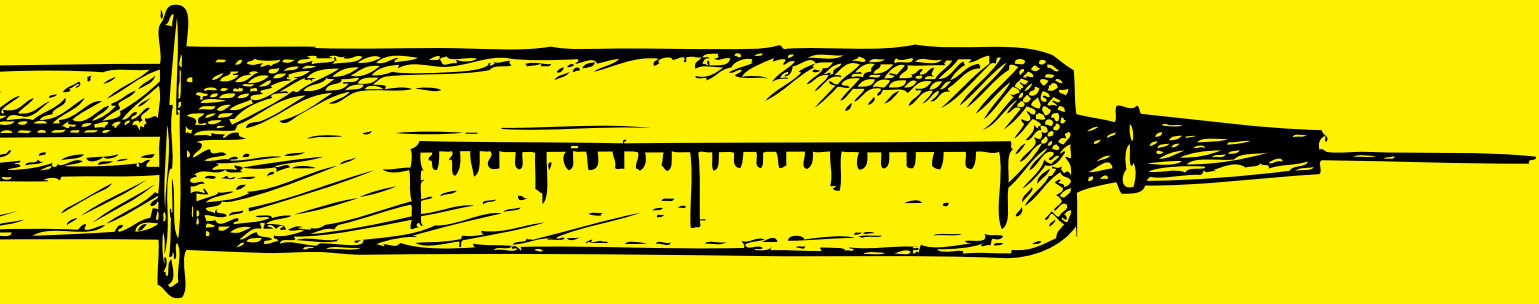


Underscoring all the interviewees' suggestions for improvement was the central tenet that prisoners themselves need to be actively and regularly consulted on program development in order for it to be successful: *"It's very important that CSC or whoever's running it talks to the people who are going to use it... It's not dictated to us"* (Interview #7, white man, ON). Indeed, if people in prison are involved in the design and implementation, people who use drugs are able to help create a program that works for them.

RECOMMENDATIONS

To ensure the PNEP is accessible and available to all people who use drugs in federal prisons:

- Remove administrative and other barriers to enrollment, including by eliminating the "Threat Risk Assessment," which requires multiple institutional approvals, and disseminate sterile injection equipment in secure kits to all people in prison upon request;
- Enhance confidentiality for program participants by ceasing daily visual inspections of PNEP kits, and ensure that program participation is not recorded in the individual file of incarcerated persons;
- Diversify the distribution of sterile injection equipment, including via peer distribution and automatic dispensing machines installed in locations without CCTV cameras or other forms of surveillance;
- Provide other harm reduction materials and services for people who use drugs in prison, including smoking and snorting equipment, naloxone, safer tattooing supplies, and overdose prevention services;
- Implement mandatory training for prison authorities, correctional officers, and health care staff about the benefits of the PNEP and the impacts of drug use stigma; and
- Engage in meaningful consultation and regular engagement with people in prison about how to improve the program design, which may be adjusted based on the specifics of each prison, as the PNEP continues to rollout nationally.

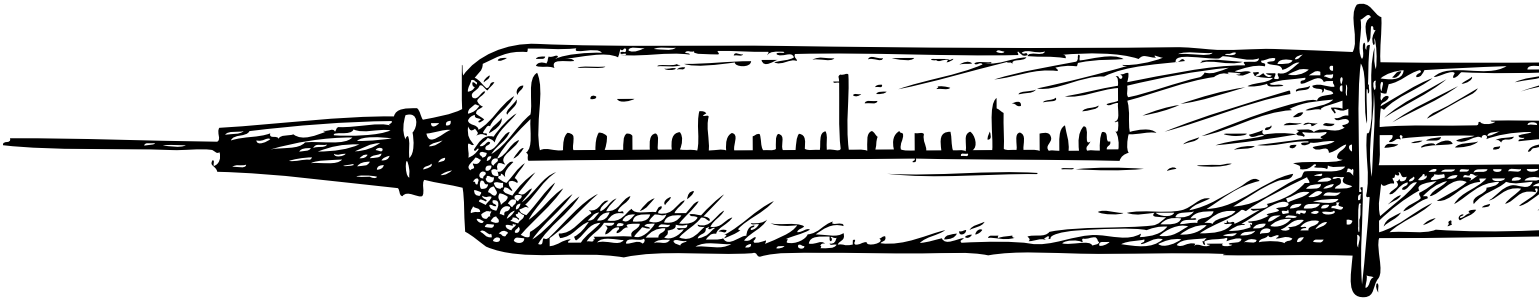


CONCLUSION

Based on the knowledge and experiences generously shared by our interview participants, it is clear that the distribution of sterile injection equipment is an essential carceral harm reduction service due to widespread and frequent injection drug use in federal prisons. In the face of punitive drug laws and policies, resulting in a significant number of incarcerated people who use drugs, syringe distribution programs are urgently needed. However, CSC's current PNEP model requires improvements to promote program uptake. Various restrictions and challenges identified by the people we interviewed significantly hinder PNEP enrollment and ongoing participation.

Whether or not the interviewees had themselves injected drugs while in prison, most were clear that barriers to enrolling in the PNEP were numerous and overwhelming. Many knew very little about the program's existence, or how to apply. For those who were aware of the PNEP, the application process, including the Threat Risk Assessment, was seen as onerous, unnecessary, and an insurmountable barrier. As previous research on the need for syringe distribution in federal prisons underscored, easy and confidential access is critical to program success (see van der Meulen et al., 2016). In the current study, the lack of confidentiality was frequently cited as a major problem. Indeed, the people we interviewed shared an almost universal belief that having a PNEP kit visible in their cell would expose their drug use to correctional officers, other people in prison, and prison authorities, which could lead to various negative consequences. Study participants further identified concerns about potential and actual punishment from prison staff for participating in or even inquiring about the PNEP.

Decades of research have confirmed that harm reduction services have the greatest benefits when they are low threshold, non-stigmatizing, preserve users' confidentiality, and provide a diversity of distribution points (Lee & Zerai, 2010; Marlatt, 1996). Much like community-based harm reduction programs, people who are incarcerated require anonymity, confidentiality, peer-based support, and input into design and implementation to have confidence in programs that are intended to benefit them. Our study, especially when paired with global empirical evidence on the many successes of prison-based syringe distribution programs, suggests that people who use drugs in prison can and should be engaged in co-creating solutions. Removing unnecessary breaches of confidentiality and expanding the current PNEP to include multiple distribution methods (e.g. automatic machines, peer-to-peer, external organizations) and a diversity of harm reduction equipment and other services for people who use drugs has the potential not only to reduce HIV and hepatis C transmission, but to further engage people who use drugs and who are incarcerated in supportive and meaningful ways.



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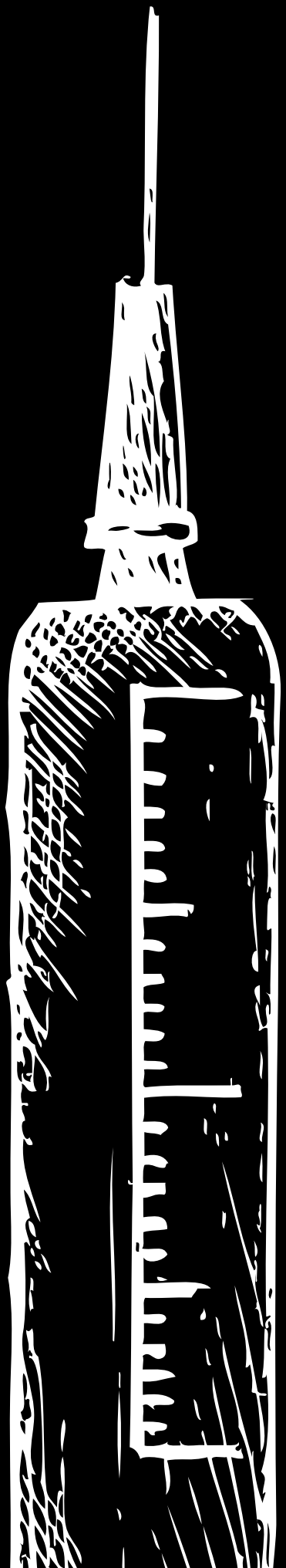

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