Canada's Adoption of Prison Needle Exchange Programs: To What Extent Does Canada Uphold International Commitments for Prisoner Care?

by

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Dalhousie University is located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq.

We are all Treaty people.

Dedication Page

I want to thank Dalhousie University for the opportunities in the past two years, and to both Halifax and Toronto for the most amazing and growth-filled time in two different cities. I am grateful for the extensive funding I received during my first year, as well as for all of the enriching courses I had the opportunity to take.

I thank Dr. Crystal Dieleman for her guidance and support over the past two years as my supervisor. I feel incredibly lucky and humbled to have worked with someone so influential within a field I hold such passion for. I would also like to thank Julia for the wine nights that made this thesis possible – I am lucky to have met such a great friend during my Masters.

I would like to thank my family for everything throughout these past two difficult years. Dad – thank you; I can not put into words how grateful I am, you just know. To my late grandmother and my Mum – thank you for continual life lessons I carry with me.

"Either write something worth reading, or do something worth writing" – Benjamin Franklin

It is now time to *do* something worth writing.

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Abstract

This thesis examines the opportunities and challenges for implementing substance-related harm reduction techniques within Canadian federal prisons. The thesis investigates how harm reduction strategies in Canadian federal prisons differs from the implementation of harm reduction strategies in Canadian communities and focuses on the role of Prison Needle Exchange Programs and Canada's introduction of these programs in 2019. The central research question asks: what are the opportunities and challenges of implementing substance-related harm reduction strategies within Canada's federal prisons? In addition, how does implementing harm reduction strategies in Canadian communities differ from Canadian federal prisons? This thesis utilizes a realist review approach and a comparative contrast method to reveal the reasons why harm reduction programs struggle within the realm of the prison environment to reveal how countries can best uphold their international commitments to prisoner care.

List of Abbreviations and Symbols Used

AIDS = Acquired Immune Deficiency Syndrome

CSC = Correctional Service of Canada

HCV = Hepatitis C

HIV = Human Immunodeficiency Viruses

PNEPs = Prison Needle Exchange Programs

UN = United Nations

Chapter 1: Introduction

The Central Problem

Over 10 million people are imprisoned worldwide, with rates steadily increasing since the 1960s (Lines, 2006; "World Prison Population List," 2016). Prisons exhibit a faction of society with disproportionate rates of mental illness and substance use, where countries may struggle to align with international obligations of protecting citizens' rights while simultaneously dealing with the difficulties faced by the prisoner population. This includes Canada, where the country holds over 14,000 prisoners in federal facilities nationwide, with over 80% of prisoners citing mental health and substance use concerns (Kouyoumdjian et al., 2016; "Correctional Services," n.d.). These individuals are seven times more likely to overdose on substances or die by suicide in comparison to the general population, and face increased health risks compared to the general community (Office of the Correctional Investigator (OCI), Yo2020). The Correctional Service of Canada (CSC) is the entity tasked with carrying out Canadian federal policy on correctional care, where the organization separates mental health care and substance use (Dieleman, 2022). Moreover, CSC has a dual mandate to both care for and control prisoners. This dual mandate poses potential issues for Canada to align with international commitments on prisoner care—especially concerning the principle of equivalence of care which explains how prisoners must be afforded equivalent care to what community-dwelling citizens receive (Cesaroni, 2020; Downie et al., 2019; Iftene, 2017, 2018).

CSC is responsible for delivering and upholding essential mental health and addiction care for federal prisoners, yet when literature on Canadian prisoner care is reviewed, CSC is often inconsistent in upholding these aims. The healthcare delivery that CSC presents on paper is often inconsistent with how programs are actually run once evaluated, primarily because the

entity must deal Canada's dual mandate and system of control and care (Lee et al., 2021; Dieleman, 2022). The CSC's central problem of insufficient mental healthcare alongside its zero-tolerance drug policy—also known as Commissioner Directive #575—is inconsistent with international human rights legislation surrounding how CSC must care for the people in their custody. The drug-free policies CSC contends with are incompatible with international documents and evidence that discuss the importance of harm reduction care to provide equivalent care to prisoners that community-dwelling citizens receive. Harm reduction is defined and discussed at length within Chapter 3 of the thesis.

Zero tolerance policies for CSC are seen within the *Controlled Drugs and Substances Act,* which maintains prohibition conditions within Canadian federal prisons (Cesaroni, 2020). The *Controlled Drugs and Substances Act* emphasizes zero-tolerance for drugs within CSC facilities and enables the existence of a prison system that uses both punitive and prohibitive conditions surrounding factors in criminal risk, such as substance use concerns (Dieleman, 2022). The *Controlled Drugs and Substances Act* articulates Canada's approach to drugs, which involves the criminalization and punishment of substance users (Cesaroni, 2020). CSC exists to prohibit, criminalize, and punish those who receive custodial sentences; therefore, CSC has aligned with general frameworks employed in broader society surrounding the persecution of substance users in order to stop the spread of drugs within their prisons. CSC is further tasked with assessing, mitigating, and managing the risk of prisoners, where substance use is indicated as a criminogenic factor in each risk assessment tool CSC employs (Cesaroni, 2020). Consequently, CSC must further deal with substance use in relation to how prisoners treat each other and themselves once imprisoned. Despite the existing *Controlled Drugs and Substances Act*, there is evidence that zero-tolerance is less effective at preventing the spread of drugs and

correlated disease in comparison to harm reduction ideology that gained prominence in the late 1990s (Lines, 2004). There is now widespread evidence indicating that harm reduction techniques more effectively provide prisoners with access to sufficient care in comparison to zero tolerance. CSC is effectively inconsistent with the principles of harm reduction that now exist, although there is evidence to support both zero tolerance and harm reduction in some regards.

Prisoner care also affects public health concerns. Media often sensationalizes crime, portraying to citizens that prisoners enter prison for a long time and have a small likelihood of returning to their communities. However, this is *not* the case, as countries hold low average sentencing rates, where most prisoners are released back into society to their local communities in a short period of time (Canada, 2023). This means that concerns for prisoners surrounding mental health and substance use are public health issues, given that when prisoners return to communities, these issues are subsequently the responsibility of community and public healthcare.

In connection with this public health issue, CSC must also contend with the internationally recognized principle of equivalence of care, which affords prisoners equivalent care to what citizens within the nation's general society receives (Lines, 2006). Equivalent prisoner care decreases the responsibility for community services, where because prisons represent a sector of the population with exacerbated mental health and substance-related issues, countries must strive for not only this principle of equivalence but to uphold equivalent *objectives* for healthcare policy that are seen for the non-imprisoned population (Lines, 2006). If this occurred, the burden for the public health system once these individuals are released would decrease.

As Canada is a signatory state to the World Health Organization and United Nations (UN) policies on prison care, it is essential to review if Canada upholds its international commitments while caring for its prisoner population. Specifically, this project looks at the degree to which the implementation of harm reduction strategies within Canada's federal prisons differs from community counterpart programs to reveal opportunities and challenges for the implementation of harm reduction strategies within CSC's policies and practices. This project aims to understand and explain the implementation of substance-related harm reduction strategies within Canada's federal prisons while emphasizing the introduction and role of Prison Needle Exchange Programs (PNEPs) compared to other harm reduction techniques. CSC currently utilizes various harm reduction techniques within federal prisons, including varying services and education on safer drug use and safer tattooing and sex practices, primarily in an effort to reduce the spread of disease (van der Meulen et al., 2016; Chu et al., 2022). The current status of harm reduction within federal prisons has seen CSC introduce standardized basic medical care for testing and treating communicable diseases, as well as sexually transmitted infection prevention services through providing condoms, dental dams, lubricants, and more. Furthermore, specifically related to drug harm reduction, CSC introduced bleach kits to reduce the harm associated with sharing unsterile needles, as well as access to opioid agonist therapy. The international surge of the opioid epidemic and the increase of imprisoning individuals relating to drug crimes, however, has led to widespread introduction of PNEPs, including within Canada. This introduction is based on scientific evidence that PNEPs manage and decrease overdose and death rates related to substance use, all while emphasizing transitions away from zero-tolerance policy and towards harm reduction recognition.

The Purpose

The purpose of this research project is to illustrate how literature and scholarship highlight the inequitable care federal prisoners receive in Canada surrounding drug usage and outline why there is stagnancy and minor change in employing harm reduction techniques as opposed to the zero-tolerance policy CSC primarily holds (van der Meulen et al., 2016). Thus, this research project investigates what has changed surrounding harm reduction policies in Canada through reviewing the harm reduction strategies that CSC has implemented to mitigate drug usage within federal penitentiaries. The project focuses heavily on PNEPs that have been introduced both internationally as well as domestically in Canada to reveal how PNEPs echo care received within general society, as seen through community-based needle exchanges. PNEPs are similar to what is termed safe injection sites or needle exchange programs within local communities, but they are specifically for imprisoned drug users to support safe drug use with medical oversight. In sum, the project seeks to reveal how literature and scholarship discuss the inequitable care prisoners receive, where issues arise surrounding balancing harm reduction ideology with a zero-tolerance policy. Thus, the thesis concludes by revealing the tensions that arise from the integration of PNEPs, revealing why there are difficulties in adapting harm reduction strategies in prisons that succeed within Canadian communities.

Research Questions

The idea of what "works" and what "does not work" for harm reduction techniques relates directly back to the principle of equivalence that is supposed to guide Canada and CSC. Canada is a signatory to international documents that require signatories to afford prisoners equivalent care to what is received by the non-imprisoned population. The project reviews the opportunities and challenges of implementing PNEPs, and how Canada aligns with the international community. In particular, the project reviews the opportunities and challenges for

implementing harm reduction techniques within Canada's federal prisons, with an emphasis on the difficulties in caring for intravenous drug users within prisons compared to local communities. Two key research questions arise for this project surrounding the opportunities and challenges of implementing PNEPs, and how Canada aligns with the international community.

1) What are the opportunities and challenges of implementing substance-related harm reduction techniques within Canada's federal prisons?
2) How does implementing harm reduction strategies in Canadian communities differ from that within Canada's federal prisons?

Hypothesis

At the research proposal stage and at the beginning of brainstorming this thesis, I hypothesized that harm reduction strategies within Canadian prisons do not meet the principle of equivalence surrounding providing prisoners with the care that is afforded to non-imprisoned citizens. I contended this would be primarily because harm reduction ideology is inherently incompatible with the institutional structure and policies of Canadian prisons that must uphold both care and control alongside Canadian drug legislation. I also hypothesized that implementing substance-related harm reduction techniques in Canadian prisons would be more challenging than in Canadian communities. This is because harm reduction contradicts the traditional prison culture that standardizes the push for zero tolerance and control rather than meeting the dual mandate of control *and* care that is possible by introducing harm reduction at the forefront. There were no anticipated ethical issues with the project except being conscious of assumptions and biases, as the topic is politically and socially controversial.

Potential Challenges

I anticipated multiple challenges for this project. This is primarily due to the extreme

confidentiality of CSC, wherein researchers are rarely afforded access to information through CSC. External research has become increasingly restricted in recent years, and CSC has become increasingly closed-off to external scrutiny. I sought to respond to these concerns by working with the Office of the Correctional Investigator, but accessing information is extremely difficult and presents insurmountable challenges. In addition, I will be referencing a limited amount of research as the angle of my study differs from most of the existing literature on PNEPs and, furthermore, PNEPs in Canada are very recent. There are potential methodological obstacles surrounding authenticating findings and providing accurate and complete statistics due to confidentiality concerns and the nature of the research. In addition, the project has limitations insofar as what is manageable to write for a Master's thesis, where data will be missing as multiple search terms with synonyms cannot occur due to the scope of the research, which is a limitation or challenge for data collection.

Why this project is important

This project is crucial as it offers insight into society's relatively closed-off faction—the prison. Ultimately, this thesis advocates for the care of all citizens in society, regardless of whether they have committed a crime. Aside from the media's tendency to sensationalize crime, the general population is often unaware of, or are not privy to, details about correctional supervision. Often 'not in my backyard' concerns are prevalent regarding harm reduction and substance use, and mental health concerns, where most Canadians, and citizens globally, are ambivalent to issues that do not affect them directly. However, discussing proper human rights and upholding of dignity for citizens is imperative, even if restrictive policies only impact a small percentage of the population.

This project was recommended as being of utmost importance and desirability by the Office of the Correctional Investigator of Canada, where the Director of Research and Policy identified how conducting a thesis on this topic would yield immense value for the Office as a body of governance (Hooey, 2022). CSC and other research reveal how harm reduction strategies work, but there is a lack of discussion specifically on why these fail to flourish in Canadian *prisons*. In addition, I am personally motivated to complete this project based on my experience as a previous employee of CSC within Community Residential Facilities (commonly known as halfway houses) and my exploration of Bill C-83 on solitary confinement within my undergraduate degree, which revealed how impactful mental health concerns and substance use issues are for clients. This led to my desire to pursue a Master's degree so that I could interrogate complex subjects like imprisonment, addictions, and substance use further. However, this project is primarily motivated by my own personal connections and ties with those close to me who have struggled with substance use, mental health, and the criminal justice system.

Chapter Outline of Thesis

The thesis begins with Chapter 1, the Introduction, then turns to Chapter 2, which outlines the thesis' theoretical background and methodology. Chapter 3 delineates what harm reduction is, and Chapter 4 outlines the historical and legislative context of PNEPs. Chapter 5 further investigates the specifics of PNEP programming, and Chapter 6 looks at how Canadian PNEPs are delivered in practice. The thesis concludes with Chapter 7, to discuss tensions for this issue that arose from the research, as well as posits recommendations for PNEPs in Canada, and future research opportunities for this topic.

Chapter 2: Theory and Methods

Theoretical Background

Critical Social Theory

A critical theory is an approach to social philosophy that emphasizes how to critique, challenge, and reveal different power structures within society and culture ("Critical Theory," 2022). Critical Theory is a school of thought derived from Frankfurt School theoreticians, wherein the focus is to liberate people from different oppressive structures they face. The theory's purpose is to reveal how to change society from the broader structures that constrain individuals (Horkheimer, 1982; Bohman et al., 2019). Regarding influential thinkers, Frankfurt School theoreticians Max Horkheimer, Herbert Marcuse, Theodor Adorno, Erich Fromm and Walter Benjamin were influential, alongside how Critical Theory became one of the widespread theories to align with postmodernist thought (Tyson, 2023). Second-generation Frankfurt School scholars, primarily Jurgen Habermas, as well as Antonio Gramsci, also influenced Critical Theory surrounding critiques of the world based upon oppression (Tyson, 2023).

Critical theory contrasted traditional theory, which only sought to understand or explain things by instead critiquing how to change society as a whole. Critical theory is valuable because it allows researchers to look at a society in its historical specificity, as well as critique how a society's values and norms that shape the oppression individuals face. Critical theory is applied in the social sciences as a way to critique the social construction of a postmodern society in an effort to situate injustices in their historical contexts and social structures that constantly change.

Critical *social* theory, in particular, originated from critical theory and is evident within Greek thought from Plato, the Frankfurt School's study of a Kantian theory of knowledge, alongside a Freudo-Marxist theory of how society is viewed; moreover, critical social theory sees this in light of a broader framework of theories seeking to view how to create change institutionally and conceptually (Leonardo, 2004, p.11). At its core, critical social theory, aligns with social theory and criticisms regarding both the emancipation and oppression of people (Leonardo, 2004, p.11). It seeks to advance the "emancipatory function of knowledge" by criticizing institutional and conceptual dilemmas (Leonardo, 2004, p.11). These criticisms are viewed through the lens of challenging social alignments and status by revealing the genuine relationships people have with social systems through looking at their domination and oppression (Leonardo, 2004, p.11). The role of criticism in this theory is essential regarding how contradictions and disagreements about criticisms occur based on differences in interpretation. Criticism is not meant to reject how everything exists but instead is intended to open debates on social issues and create engagement in ideas seeking to create institutional change (Leonardo, 2004, p.13). The theory in an educational context allows for a critique of social issues and problems without the presence of actual answers and does not always focus on what the true "solution" is (Leonardo,2004, p.13). Critical social theorists argue that certain groups experience greater oppression and have less access to opportunities for success. As such, critical social theorists accept the reality of oppression while simultaneously believing there can be a reality of less oppression.

This thesis applies the lens of critical social theory. Specific to this project, scholars commonly utilize critical social theory to understand why prisoners continually suffer despite lengthy historical pushes for social reform. For this thesis, the theory is applied to highlight the

actual structure of the institution of the prison and prison environment insofar as how this construction has social impacts and consequences for those within its walls as well as within the general community. This theory offers insight into the dilemma of insufficient healthcare despite international and federal legislation for reform by looking at how the structure of the prison produces oppression (Leonardo, 2004). Ultimately, this theory was used as the lens for this project through recognizing how social institutions affect individuals and by recognizing the deliverance of an institution cannot happen in isolation of the people who suffer at its hands (Van den Brink & Owen, 2007; Leonardo, 2004; Lynn, 2021; Renault, 2020; Schlosser, 2012). As this project looks at the social reality of harm reduction in prisons, and what assumptions are brought about by the construct of this specific social reality, the theory lends itself to inquire how prisoners' standing and relations to those within the general community either persist or change.

The strategy CSC uses for harm reduction must be reviewed to determine if it improves prisoners' standing within society upon their release. A critical social perspective can also aid in our understanding of why these methods for change through education, employment, substance use, and other positive programs may fail. As this project's research objective is to reveal the opportunities and challenges of implementing substance-related harm reduction techniques in Canada's federal prisons, this theory was chosen to reveal the struggles prisoners face in relation to greater social structures that cause oppression or disadvantages for this group. Critical social theory provides a lens that allows for a review of broader ideas that outline why Canadian prisoners suffer in comparison to community-dwelling citizens and what overarching power dynamics enable this.

Given that many prisoners belong to multiple marginalized groups, critical social theory further lends itself as people who are imprisoned are oppressed by not only their prisoner status,

but also by their intersectional position within society. For example, there is a disproportionate representation of both Black and Indigenous people in Canadian prisons, caused by overarching social oppression that exists both within and outside the prison walls. As this thesis further focuses on harm reduction and intravenous drug use, these individuals are further oppressed than just their imprisonment as they sit within the vulnerable population of those who are dependent on drugs. The different struggles individual prisoners face showcases the importance of looking at this issue from overarching social forces at play, alongside a recognition for a lack of progress of providing for these peoples despite historical pushes for social reform.

Realist Review/Synthesis

A realist review is a method for critically reviewing literature that is rooted in realist philosophy by looking at causal mechanisms (often theories) that underly distinct types of interventions that share the same overall goal (Tricco et al., 2016). This project utilizes a realist review as this approach aligns with critical social theory insofar as focusing on understanding the reasons an intervention may or may not work and under what conditions (Rycroft-Malone et al., 2012). A realist review begins with a literature search through a purposive sampling strategy to identify essential theories, published studies, and gray literature on a specific topic. This method involves identifying eligibility criteria for evidence, using notetaking to collect data, annotating and tracking, and examining the quality of information that has been collected. Researchers then synthesize the information to establish a clear output for recommendations and conclusions.

Realist synthesis seeks to explain why programs or interventions that align with similar ideas of social change work or do not work within differing contexts by identifying causal mechanisms (Tricco et al., 2016). A realist review begins by identifying a research question with an explanatory main goal. This involves identifying a review question, the nature and context of

the intervention, the circumstances or context for its use, as well as the different policy intentions or objectives of the intervention, in addition to asking which theories of change fit best (Tricco et al., 2016). The process of searching through the literature then involves purposive sampling based on the identified eligibility criteria (Tricco et al., 2016). This process begins with scoping searches to develop an understanding of the overall available literature, where then the focus becomes refining inclusion and exclusion criteria with data; subsequently, the focus turns to purposive sampling and snowball sampling to explore other information, alongside searching for any additional studies and unpublished literature on the subject (Tricco et al., 2016). For data collection, there are numerous collecting points where different sections and exclusions are carried out through reviewing articles and tracking ideas, where practical thinking moves "from divergent to convergent…when theories underpinning the intervention gain clarity" (Tricco et al., 2016). Different exclusions are carried out based upon the identified inclusion and exclusion criteria the research defines as essential for their individual project. A quality appraisal is seen through the relevance of the applicability to the research question as well as the rigour of the material. Data synthesis is done by looking back to what works for who under which circumstance; where for this thesis, the constant comparative method was utilized to organize data into groups according to similarities and differences. The constant comparative method is detailed on page 20.

This thesis used a realist review to understand how, and under what specific conditions, harm reduction interventions work or do not work in prisons versus community contexts. This method was selected because it allows for contextual understanding of an issue. This approach aligns with critical social theory by looking at the setting of the prison in relation to broader social structures and ideology, as well as the disadvantages prisoners face surrounding

oppression compared to others. As this thesis looks at PNEPs within the context of federal Canadian prisons in relation to community-based needle exchange programs in Canada, the realist review is an appropriate method with the inclusion of the constant comparative analysis method under the lens of critical social theory.

The aim of a realist review is "to articulate underlying programme theories and then to interrogate this existing evidence to find out whether and where these theories are pertinent and productive" (Rycroft-Malone et al., 2012). For this thesis, the theory of harm reduction underpins ideas surrounding specific techniques that can be employed within prisons. A robust discussion of harm reduction occurs in Chapter 3 to establish this connection. As the focus of this thesis is on PNEPs, the theory that underpins this technique is harm reduction, as this is also the basis of community needle exchange programs. As the project focuses on an implementation intervention – specifically PNEPs – a realist review focuses on what makes PNEPs work or not work within the specific context of Canadian prisons. Thus, the lens of critical social theory assists in revealing why broader social issues present oppression and problems for people, in this case, prisoners, and how the implementation of PNEPs is seen in light of the theory of harm reduction that underpins PNEPs and drives the realist review to reveal challenges and opportunities for implementation and the emancipation of suffering for people.

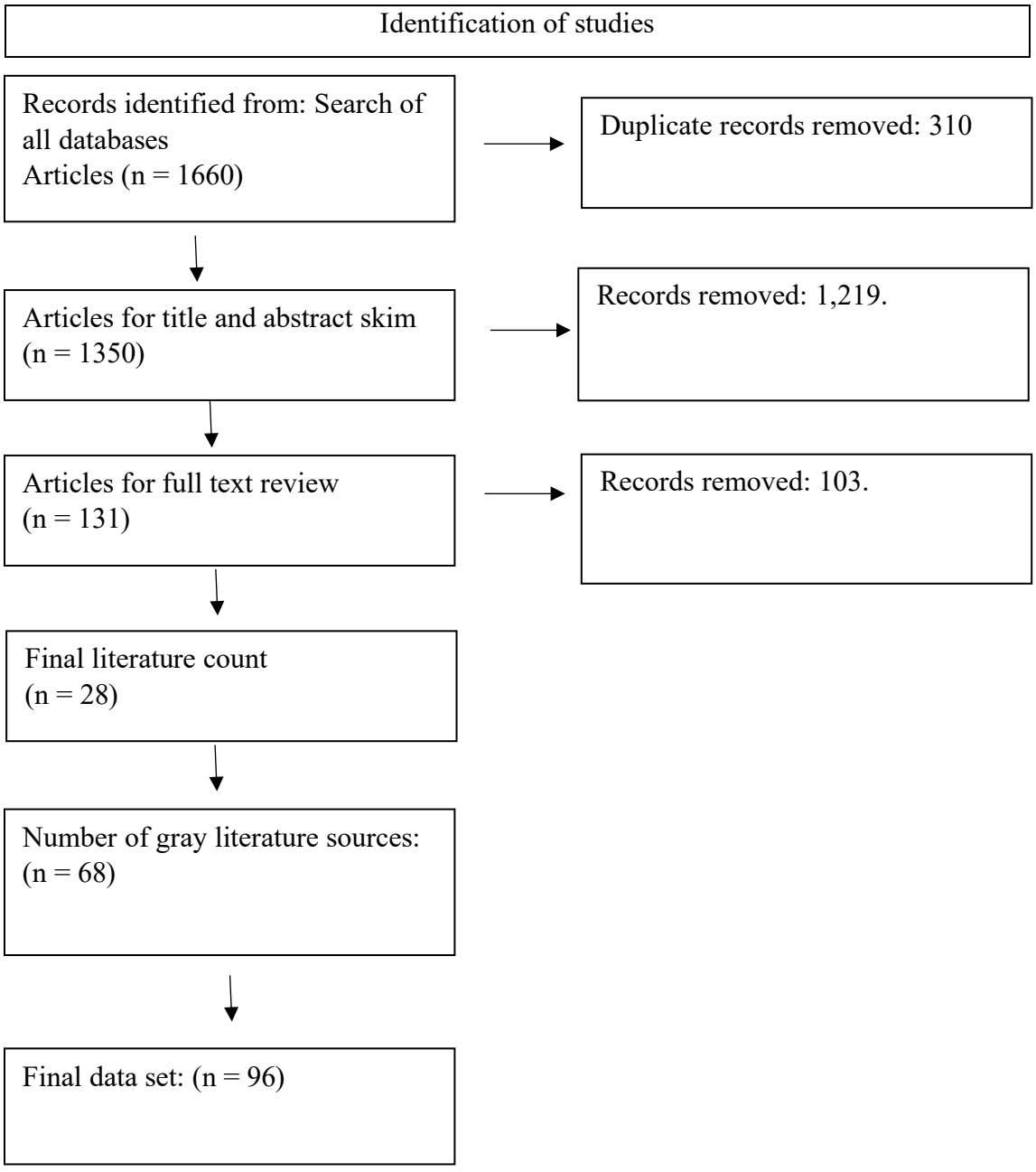
My Process

Collection of data

I began my search by liaising with a research librarian at Dalhousie University regarding what search terms would be best to begin with, as well as essential areas to search for literature for my project. A PRISMA chart summarizing my research strategy is presented in Figure #1.

Figure 1

PRISMA Chart



I began by searching within the Novanet system in Dalhousie's library service using the keywords prison* AND needle exchange* that was specified to only English language articles – the only exclusion criteria I had at this point. These terms were chosen as they are broad, and the

scope of a Master's thesis meant I had to limit the amount of data possible for review, so no other terms or synonyms were used – a limitation to this thesis. The search yielded 558 results, which was expected with such a broad search. There were 81 duplicates, which I removed to a separate folder entitled 'duplicates', thus the total number of working articles became 477 articles. I repeated this process two times over, and the numbers matched my original conception. Thus, the 477 working pieces at this point were transferred into Zotero under my first working folder entitled 'Novanet Advanced Search prison* AND needle exchange* duplicates taken out.' After this, I exported the list onto a Microsoft Word document to see if I missed any duplicates of articles while reviewing on a computer, seeking to increase the reliability since this would be the most extensive data set I would work with. After reviewing the Word document, four additional duplicates were removed, resulting in a final article total of 473 pieces.

I then turned towards which subject guides on Dalhousie's library website would be beneficial and necessary to include in my search. The librarian highlighted subject guides on Dalhousie's website that would be helpful, including addictions, Canadian politics, criminal law, criminology, health administration, health and human performance, health law, international development studies, international human rights law, international law, and social work. I hit a barrier with six of the subject guides, where for criminal law and health law, I needed a Dalhousie law student identification number to log in, and the international human rights law and international law guides were specific to only legal concerns, which were not relevant to my thesis. The health administration guide, which focused on health outcomes versus program outcomes such as disease rates, and the health and human performance guide were not applicable to this thesis either.

Working with the remaining five subject guides, I recognized that once I went into the subject guides, there were overlaps in the databases. Thus, I turned my search towards searching specific databases that these guides had in common. These included PsycINFO, CINAHL, PAIS Index, Canada Commons, Public Affairs Index, and the Social Services Abstract Database. I worked with the exact keywords of prison* AND needle exchange* within these six databases.

Beginning with PsycINFO, I used the terms prison* AND needle exchange* and specified the search mode to find all search terms without applying any related words or subjects. I also specified the articles to English language only, yielding 88 results. These 88 results were saved under a different folder entitled 'Search #5 Addictions Subject Guides – PsycINFO.' At this point, I wanted to create a master reference list to keep track of my final bibliography in both Zotero and Word. I then compared the 88 new articles to my current working 473 articles, where there were 66 duplicates. Thus, the 20 new articles were moved into the master reference list for a new total of 493 articles, where the 66 duplicates were moved to the 'duplicates' folder. For CINAHL, I used the same terms as well as specifications for the search. This yielded 114 results that were then saved under the folder 'Search #5 Addictions Subject Guides – CINAHL' and exported these onto a separate page on Microsoft Word to best see duplicates. Seventy-one duplicates from this search were then moved to the 'duplicates' folder. The 43 new articles were moved into the master list, where now the total number of articles is 538.

For the Canadian Research Index, the same terms were used, but specifications included only English language articles. This yielded one result, which was not a duplicate, and was saved under 'Search #6 Canadian Research Index' and added to the master reference list, bringing the total working articles to 539. For the PAIS Index, the same terms and specifications were used as in the Canadian Research Index database. This yielded 261 articles moved to the folder 'Search

#7 PAIS Index' and were exported to the Word document, revealing 15 duplicates. The remaining 246 articles were added to the master reference list, where the total number became 785 articles. Turning to the Canada Commons Database, the same terms and specifications were used, which yielded 280 results saved under 'Search #8 Canada Commons Database.' Five duplicates were found, where the remaining 275 were exported to the master list, making the total number of articles 1060. For the Public Affairs index, the keywords were prison* AND needle exchange* with the English language specified, as well as not to apply related words or equivalent subjects and include all search terms yielding 30 results. These were saved under 'Search #9 Public Affairs Index' where 20 duplicates were seen, moving the ten remaining to the master list, bringing the total number of articles to 1070. Lastly, for the social service abstracts, the keywords were prison* AND needle exchange* with English specified, yielding 278 articles. These were saved under 'Search #10 Social Services Abstracts', and when reviewing for duplicates, 24 were found. The remaining 254 articles were moved to the master list, where the total number was now 1234 articles.

At this point, I completed my data collection of articles from Novanet's advanced pre-title and abstract skim, where it was then suggested I should look at google scholar on the first five pages when searching the exact keywords of prison* AND needle exchange*. The first five pages were 50 articles, saved under 'Search #11 Google Scholar' that had 24 duplicates with the master list. I added the remaining 26 articles to the master list of articles, and I had the final data set I had to work with to go through the title and abstracts of the articles next, not including gray literature. I created Table 1, which is in the Appendices of this thesis under Appendix 1, to illustrate a table of articles divided depending on the database.

Title and Abstract Review stage

At this point, I then met with my supervisor to ensure I was ready to transition to the title and abstract review stage. I questioned if I needed to include why I was removing articles and how we would go about this process, where we identified the benefits of creating six different folders during this process, aligning with realist review. These were: “title and abstract skim yes,” “title and abstract skim no,” “title and abstract skim maybe,” “title and abstract skim context,” “title and abstract skim Canadian context,” and “title and abstract skim non-English articles.” I delineated my inclusion and exclusion criteria at this point, where the inclusion criteria were any article in the English language related to needle exchange programs in prison, with no specific time frame. All other articles were excluded. The “title and abstract skim context” and “title and abstract skim Canadian context” categories were then created as I transitioned towards the title and abstract skim phase in order to distinguish which articles addressed how PNEPs are implemented as a program versus health outcomes from them.

Once these folders were created, I then revisited the master reference list folder of 1350 articles for the title and abstract skim. I began to categorize the articles based on these six different folder ideas and tagged articles with ‘#overallcontext’ or ‘#canadiancontext’ to increase reliability, as I would also be categorizing the articles this way. Some articles were placed into multiple categories – for example, there are some ‘maybe’ articles in the ‘Canadian context folder’ and vice versa. During this process, 1219 articles were removed based on the inclusion and exclusion criteria at this point. The inclusion and exclusion criteria then became articles related to needle exchange programs in prisons that are written in English, with a specific focus on how PNEPs are implemented versus their outcomes. At the end of this process, the remaining total of articles was 131. I needed to organize these articles in relation to my research questions at this stage of the realist review process, which I then did.

I created a separate folder entitled ‘post title and abstract skim Canadian context yeses’ as my thesis focuses solely on the adoption of PNEPs in Canada, where gray literature would look broadly at international agreements on this issue. Once the articles within this folder were reviewed, the number was 26. I then looked at the ‘Title and abstract skim maybe’ folder to see if any would indeed apply, where two articles were added, making the total 28. I then created three subfolders: ‘post title and abstract skim no,’ ‘post title and abstract skim news reports,’ and ‘post title and abstract skim gray literature.’ The gray literature was collected throughout the entire year of my data collection surrounding my topic within this broader search, as some gray literature did appear. The gray literature I collected is primarily from influential researchers on prison and drug policy in Canada, CSC’s website, information directly from the Office of the Correctional Investigator, and publications by prominent organizations working outside of the government on harm reduction. At this point, I had 28 articles to work with, 52 news reports, and 16 pieces of gray literature.

For my final data set, I constructed Table 2 (from database search) and Table 2(A) (gray literature) to summarize my data and explore its relation to my thesis through categories important for a realist review, which are found in the Appendices of this thesis under Appendix 2. Conclusions on data were drawn using a constant comparative method of similar headings that all of the final data set information was classified under.

Constant Comparative Method

A constant comparative method is a method of comparing different pieces of data and information, wherein ideas are grouped for ideas that are conceptually similar to each other as well as conceptually different (Glaser & Strauss, 1967). For a constant comparative method, ideas are grouped together that are similar under established groups that become codes, and if a

piece of information does not fit within an already conceptual category, a new code is created (Glaser & Strauss, 1967). This allowed the project to take on a thematic analysis role in an effort to explore how PNEPs work or do not work in prisons.

I worked with 12 codes that became the themes for the thesis. I categorized my information from my final data set under:

1. International Law
2. Principle of Equivalence
3. PNEP information on specifically disease transmission
4. Harm Reduction
5. How PNEPs are run and operated
6. History of PNEPs
7. Overdose Prevention Site Information
8. Positives of PNEPs
9. Apprehension/Potential Negatives of PNEPs
10. Correctional Service of Canada information
11. Prisoner voices and opinions
12. Suggested recommendations for PNEPs

Under code #4 of Harm Reduction, there were three subthemes identified: harm reduction with a specific PNEP focus, harm reduction technique options, and the origins of harm reduction and this as a theory. In addition, code #6 of the History of PNEPs had two subthemes of international history and Canadian history.

As I worked through thematic analysis, I began to construct my thesis based on these themes and subthemes. I recognized harm reduction needed a robust explanation, especially as it underpins the research, which I created as Chapter 3 to connect to my theory and methods section. I then identified I could group together background information, primarily the legislative and historical backing of PNEPs, discussions of the principle of equivalence, international and national legislation relevant to the project, as well as how CSC operates, which became Chapter 4. I then recognized the need to discuss PNEPs specifically, where I created Chapter 5 on the rise of PNEPs internationally and within Canada, how PNEPs operate, surrounding method of distribution, as well as the positives and negatives discussed surrounding PNEPs. As I had information from literature on scholars on suggestions for recommendations for PNEPs as well as gray literature on evaluations of PNEPs and the overdose prevention site in Canada, I created Chapter 6 as a way to discuss the data I extracted surrounding improvements for PNEPs. Lastly, I maintained my research objective by constructing these Chapters in relation to leading to answering the question of how harm reduction strategies work or do not work in prison, culminating with my final chapter that highlights tensions that create difficulties for the adoption of PNEPs, as well as areas for future research for this topic.

Chapter 3: Harm Reduction

As harm reduction underpins this project, it is important to first discuss the meaning of this terminology. One of the most challenging issues surrounding harm reduction concerns the definition of the concept; however, the international community has tried to clarify best practices and fundamental principles for harm reduction principles and techniques. Harm reduction can apply outside of the context of drug usage, surrounding other criminalized and moralized activities, or in any situation where a tool is utilized to prevent foreseen harm to a person; however, for this thesis, harm reduction refers to "policies, programmes and practices that aim to minimize negative health, social and legal impacts associated with drug use" (Jeon, 2020, p.11). At its premise, harm reduction contends with a few principles in this regard, seen through its aims to reduce economic, social and health consequences of intravenous drug use while maintaining a commitment to evidence, respect for the rights of those who use, and upholding of principles of pragmatism and public health by decreasing stigma surrounding this population (Jeon, 2020, p.12; Sander et al., 2019, p.107).

International guidelines on harm reduction and techniques of harm reduction arose within the international community due to concerns of the acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) epidemics. The World Health Organization, the Joint United Nations Programme on HIV/AIDS, and the United Nations Office on Drugs and Crime subsequently all provided guidelines on how to apply harm reduction ideology and techniques within a prison environment and the duty of care nations have for these peoples (Sander et al., 2019, p.108). In 2015, the special rapporteur on the right to health at the time, Dainus Puras, noted how "the provision of harm reduction is not merely a policy option, but a legally binding human rights obligation…[that is] particularly important in prison settings where

heightened vulnerability, marginalization, ill health and poor conditions converge" (Sander & Murphy, 2017, p.187). The international community views harm reduction as an inherent right citizens and prisoners have that is not forfeited by the condition of imprisonment.

Evidence has shown which techniques are effective at managing prisoner care that prisons must adopt widely. One of the critical international entities in this discussion is Harm Reduction International, which regularly reports on up-to-date harm reduction techniques to provide states with a clear outline for the design, monitoring, and overall implementation of harm reduction services (Sander & Murphy, 2017, p.189). Sander & Murphy (2017) argue that this organization aids states in supporting equitable and robust healthcare systems conducive to upholding prisoners' human rights (p.189). In addition, The Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the International Guidelines on HIV/AIDS and Human Rights (specifically Guideline 4) outline the obligations of countries to introduce PNEPs to maintain adequate standards of healthcare in relation to preventative disease service delivery (Pearhouse, 2006, p.9; Lines et al., 2004, p.17). These covenants provide best practices concerning public health issues within varying contexts, including the prison (Lines et al., 2004, p.17). The World Health Organization's guidelines on HIV in Prisons further recommend that countries that have operating Needle Exchange Programs must also have PNEPs, reflecting the principle of equivalence that will be discussed at length in Chapter 4, where these programs are widely endorsed by all major international medical organizations, in addition to the World Health Organization, the United Nations Office on Drugs and Crime, and the Joint United Nations Programme on HIV/AIDS (Thomas, 2005, p.11; Pearhouse, 2006, p.2).

The Rise of Harm Reduction

In the context of drugs, harm reduction arose as a response to policies that infringe on people's liberty and cause harm for people who use drugs who have been criminalized and prohibited by the state they reside in to do so. At its core, harm reduction theory recognizes that drug categories (ex., illegal, legal, prescribed) are social constructions of larger issues of origin that cause further harm to these people. Harm reduction seeks to manage the reality of the inability to decrease drug usage solely from abstinence-focused or zero-tolerance care. These traditional ideologies push for zero-tolerance for any illegal drug usage, where in order to manage those who intravenously use, the option is to abstain fully from the substance they are addicted to (Kerr et al., 2004, p.354; Lines et al., 2004, p.12). Zero tolerance policies are seen to be ineffective on their own at stopping the procurement and accessibility of drugs within prisons; increased penalties for drug use, security measures primarily focused on surveillance of individual users, and tightened security measures to reduce supply have all failed to mitigate concerns like widespread access to drugs, unsafe drugs, and disease concerns surrounding intravenous drug users (Lines et al., 2004, p.12). The 20th century saw an increase in literature surrounding techniques to mitigate concerns intravenous drug users face, but abstinence-focused care persists (Kerr et al., 2004, p.354; Erickson et al., 2014, p.49).

In the late 1980s, governments began to redirect drug policy to emphasize harm reduction to consider both the demand and, more importantly, the supply of the issue (Erickson et al., 2014, p.49; Lines et al., 2004, p.12). Countries began recognizing the limitations of zero-tolerance policy and abstinence, wherein the criminalization of intravenous drug users based on their drug usage created an influx of prisoners with substance use concerns where governments recognized the onus of drug usage is not solely put on the user, especially once the AIDS epidemic began (Lines et al., 2005, p.50). Thus, the first space for harm reduction within the prison came from an

effort to mitigate the concurring AIDS crisis seen in the general community. Regarding PNEPs, the Joint United Nations Programme on HIV/AIDS, the World Health Organization, the United Nations Office on Drugs and Crime, and the Office of the United Nations High Commissioner for Human Rights pushed for the adoption of PNEPs as both a mitigation and prevention tactic for disease control and other associated intravenous drug use issues since 1993 ("Companion Document," 2017, p.5). Nowhere within international law prohibits the possession of materials necessary for accessing a PNEP, where the international community has even urged states to stop punishing citizens for small amounts of illicit drugs to halt the over-imprisonment of intravenous drug users and overcrowding of prisons (Pearhouse, 2006, p.9). Community needle exchange programs are seen as an effective harm reduction measure to assist in care for intravenous drug use. As these programs exist in Canadian communities, if harm reduction measures are provided within prisons but without PNEPs, the healthcare provided may be sub-optimal and fail to meet best practice for prisoner care (Lines et al., 2004, p.61). Harm reduction is entrenched within international policy, sparking multiple international organizations to put forth guidelines and notices on harm reduction tools and PNEPs.

Lines et al. (2005) provide five primary reasons why prisons must consider harm reduction policies instead of focusing on reductionist zero-tolerance policies that persist in many countries, including Canada, where drug interdiction and the punishment of drug users are the priority. These include how:

1. HIV and HCV seroprevalence is present within most prison systems internationally, where rates of these diseases are much higher amongst the domestic prison population than the general community (p.50).

2. High-risk behaviours for transmission are further prevalent in prisons across the globe, and evidence cites that intravenous drug users often increase injection usage while incarcerated (p.50).
3. HIV and HCV transmission at high rates is cited within various countries across the globe and differing prison systems (p.50).
4. Harm reduction initiatives – specifically PNEPs – are proven effective in decreasing disease rates (p.50).
5. Failure to provide harm reduction to prisoners is a violation of prisoner's rights as they are afforded the highest attainable standard of physical and mental health under international law; moreover, the principle of equivalence is present, where failing to provide harm reduction violates states' international commitments (p.50).

Importantly, none of these reasons or principles of harm reduction *condone* illegal drug use but instead recognize how the public health concern of mitigating disease alongside the commitment's states have for prisoner care outweighs the effort to eradicate drugs (Lines et al., 2004, p.13). Harm reduction principles take a neutral moral stance on drug use insofar as neither condoning nor condemning the use of illegal and unregulated drugs, but instead recognizing the reality that people will use drugs. Accordingly, various harm reduction principles have been introduced since the 20th century to effectively assert harm reduction's core humanistic and rights value within policy discussions (Lines et al., 2005, p.50; Watson, 2014, p.921). The various harm reduction programs and techniques are detailed later in this chapter.

Many argue the best practice for employing harm reduction techniques in prison is to view this issue as a public health and social care issue in comparison to a correctional issue. Suppose those imprisoned do not access sufficient harm reduction care and are re-released to the

public. In that case, this poses further issues as they did not receive harm reduction care they could have received in the general community, leading to the public health system carrying the burden of delivering these programs post-release. In Canada, CSC conducted a study and found that prisoners who chose moderated use instead of abstaining from substances are subsequently reconvicted at a *lower* rate than those who put abstinence as their primary goal, although this is what CSC holds as its zero-tolerance policy (Weekes, 2004, p.9). Treating drug use in prison as a public health problem fundamentally means the goal is not necessarily abstinence but instead to improve these people's health; where if their health is not taken care of, this could cause burdens for public healthcare delivery (Weekes, 2004, p.9). Likewise to those living in general communities accessing community-based harm reduction programs, imprisoned people aspire for–and often require–confidentiality, anonymity, peer-based support, and to have their voices heard and incorporated into service delivery (Chu et al., 2022, p.18). Evidence widely notes how this is necessary within the prison, where people who use drugs while imprisoned must be engaged in co-creating solutions so the solutions are adequate to support intravenous drug users meaningfully (Chu et al., 2022, p.18).

Harm Reduction in Canada

It is crucial to discuss how CSC progressed to include harm reduction and PNEP programming over the years. As early as 1990, Canadian doctors, community workers and disease experts noted how the Canadian government must provide access to clean needles for prisoners without fears of added time to their sentence or other punishments in a primary effort to control rampant human papillomavirus and HIV outbreaks seen across Canadian prisons (Small et al., 2005, p.839). In 1992, PASAN, one of the leading Canadian organizations mitigating HIV concerns for prisoners, raised the topic of implementing PNEP pilot projects in

Canada (Thomas, 2005, p.13). CSC responded by creating the Expert Committee on AIDS in Prison, which reported in 1994 how disease rates skyrocketed at Canadian prisons primarily from sharing drug paraphernalia (Sapers, 2006, p.8). Evidence began to mount from prisons nationwide on rampant needle sharing that led to the spread of these diseases, coupled with surveys of prisoners CSC conducted about usage practices that confirmed this evidence (Lines et al., 2004, p.11).

CSC published the Expert Committee on AIDS and Prisons document entitled "1994 HIV/AIDS in Prisons; Final Report of the Expert Committee on AIDS and Prisons by the Expert Committee on AIDS and Prisons (ECAP)" that reviewed and assessed how to respond to needle sharing through providing harm reduction programs (Lines et al., 2004, p.58-59). The document noted how bleach – the standard harm reduction tool of this time – was insufficient to deal with the HCV and HIV crises happening in prisons and instead recommended that CSC provide access to sterile injection equipment (Lines et al., 2004, p.59). This document was one of the first to investigate zero-tolerance in relation to the spread of disease in prisons through working with Canadian prisoners. The publication recommended further research on the effects of a zero-tolerance policy on prisoners conducted by organizations and individuals outside of CSC in an effort to mitigate bias (Lines et al., 2004, p.59).

Due to surmounting evidence, in 1999, a delegation from CSC's Study Group on Needle Exchange Programs went to Switzerland to observe the first PNEPs that were enacted globally (Lines et al., 2004, p.45). The details of how international PNEPs came about are discussed further in later sections of this thesis (see 'International' section in Chapter 4). The study group was set up to investigate how PNEPs could align with Canadian federal prisons and argued a needle exchange project in Canadian prisons would advance "the government's promise of

building safer communities and reinforce the Solicitor General's commitment to public safety and protection," (Lines et al., 2004, p.59). They also argued PNEPs would help Canada by reaching out to prisoners who are at risk for these diseases to connect them with other health services and programs, as a PNEP is not a stand-alone program but acts as a part of a continuum of harm reduction programming (Lines et al., 2004, p.60). The study group noted how CSC should foremost "obtain ministerial approval in principle for a multi-site NEP [needle exchange program] pilot program in men and women's federal correctional institutions, including the development and planning of the program model and the implementation and evaluation of the pilot program," (Lines et al., 2004, p.60).

However, when stakeholders reviewed the publications by the study group, they were reviewed once, and the findings were never brought up again (Watson, 2014, p.919). During this time, criticisms occurred surrounding why the government would not instate PNEPs despite concrete evidence about their effectiveness in mitigating substance use issues that Canadian prisons face. Yet, at the time, the Union of Solicitor General Employees that represented correctional officers opposed introducing needle exchange programs in federal prisons. At the time, healthcare staff favoured implementing PNEPs in comparison to correctional officers, where 30% of healthcare staff were on board with the program in comparison to 15% of correctional officers. This number is still incredibly low, where over 70% of healthcare workers thus oppose a PNEP in addition to correctional officers. The difference in opinions furthers concerns previously discussed surrounding the role of providing control (correctional officers) versus care (healthcare staff) and the contradiction in opinion that often exists for harm reduction policies depending on the staff you are viewing (Lines et al., 2004, p.63). Yet, it is important to consider how this reveals the role of subjectivity and individual opinions of staff on the moral

and ethical workings of both healthcare and the prison system, wherein the majority of correctional healthcare staff *were* opposed to adopting needle exchanges within prisons.

In the early 2000s, the Canadian House of Common called on CSC to provide access to harm reduction for prisoners due to continual surges in HIV and HCV rates for this population (Lines et al., 2004, p.61). The House of Commons published two reports, the "2002 – Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy, Report of the Special Committee on Non-Medicinal Use of Drugs," and the "2003 – Strengthening the Canadian Strategy on HIV/AIDS, Report of the House of Commons Standing Committee on Health," (Lines et al., 2004). These documents noted how CSC must provide harm reduction strategies to prevent disease similar to what is employed in general Canadian communities (Lines et al., 2004, p.61). By 2004, the 1994 recommendations discussed in the Final Report of the Expert Committee on AIDS and Prisons by the Expert Committee on AIDS and Prisons were fully implemented, *except* for the recommendation of providing sterile needles to prisoners (Thomas, 2005, p.13). As this was the final recommendation not implemented, the Minister of Public Safety and Emergency Preparedness explored the possibility again of a PNEP in 2005, when CSC signed a memorandum of understanding with the Public Health Agency of Canada to further look at how PNEPs could benefit Canadian prisoners (Sapers, 2006, p.9).

At the same time, the Canadian HIV/AIDS Legal Network undertook a study of PNEPs in Switzerland, Spain, Kyrgyzstan, Germany, Moldova and Belarus to further the evidence found in the late 1990s by the Study Group in Switzerland (Chu & Elliott, 2009, p.8). As the conclusions were the same, insofar as the benefits PNEPs bring, a risk-benefit analysis of PNEPs for CSC was conducted in April of 2006 (Iafrate, 2015, p.26; van der Meulen et al., 2016, p.9). The 2006 risk-benefit analysis further concluded that PNEPs would effectively benefit prisoners

with zero risk to staff and with improvements noted for disease control (van der Meulen et al., 2016, p.9). The Office of the Correctional Investigator's 2005-2006 annual report indicated that CSC must implement a PNEP, yet the response from CSC was that they would primarily focus on reducing the supply of drugs at all federal prisons instead (Sapers, 2006, p.6; Watson, 2014). The Office of the Correctional Investigator has consistently requested that CSC have a comprehensive harm reduction plan that is individualized for a prisoner, echoing what exists in general Canadian communities – including the introduction of PNEPs as needle exchange programs are widely available in Canadian communities (Sapers, 2016, p.14).

During the mid-2000s, with the Conservative Party in power in Canada, there was an increase in legislation passed against drug users surrounding increased criminalization of this population that subsequently led to an influx of punishment for drug users. In 2012, the *Safe Streets and Communities Act* came into force, which incorporated different amendments into multiple laws that viewed drug use as solely criminal justice issue instead of a public health or social justice issue ("Companion Document," 2017, p.4; Iftene & Mason, 2013, p.888). In the *Safe Streets and Communities Act*, specific changes were implemented, such as how,

> "eligibility for conditional sentences has been reduced for an array of offences, and amendments to the *Youth Criminal Justice Act* make it easier for prosecutors to seek both custodial and adult sentences. In addition, many mandatory minimum sentences increased. For example, "trafficking in specified circumstances now carries a mandatory minimum of 1–2 years. [And] at the parole stage, the National Parole Board will no longer be guided by the 'least restrictive principle' (i.e., the use of the least intrusive disposition required to achieve public protection), and prisoners who are denied day or

full parole will have to wait longer before they can reapply" (Iftene & Mason, 2013, p.888).

Regardless of the passing of punitive, zero-tolerance legislation, substance use continued within Canadian prisons and within general communities (Iftene & Mason, 2013, p.888).

For most of Canadian history, actual harm reduction law was not in place; instead, experts hoped it would take off naturally from the *Controlled Drugs and Substances Act* (Erickson et al., 2014, p.64). This was not the case. However, with the election of Prime Minister Justin Trudeau in 2015, the Drugs and Substances Strategy was introduced, putting harm reduction at the forefront as a critical pillar for increasingly progressive drug policies; Trudeau even stated the Liberal Party would review PNEPs (Jeon, 2020, p.31-32; Webster, 2018, p.2095). In 2018, the Canadian Government revisited their strategies and developed the Canadian Drugs and Substances Strategy, introduced to commit the government to protect the health and safety of *all* Canadians, including prisoners, through access to evidence-based health services and harm reduction tools (Peternelj-Taylor, 2018, p.123; Correctional Service Canada, 2018). The Office of the Correctional Investigator noted how the federal government now holds an increasingly compassionate, collaborative, comprehensive, and evidence-based approach to drug policy, but CSC is still non-compliant with this ideology.

Economics

At a global level, harm reduction exists widely. In 2010, global investment in harm reduction sat around $160 million, but this is nothing compared to the $100 billion governments spend yearly on drug enforcement (Sander & Murphy, 2017, p.187). From 1998 to 2007, CSC increased expenditures for drug interdiction each year, yet drug usage rates declined less than 1%

during these years (Chu & Elliott, 2009, p.2). Harm reduction is less expensive than current policies on controlling the influx of drugs versus mitigating concerns. In Australia, every dollar the country invested in needle exchange programs returned four dollars in healthcare savings (Sander et al., 2019, p.108; Sander & Murphy, 2017, p.187). These savings are also echoed in analyses by the United Nations Office on Drugs and Crime, the World Health Organization and the Joint Programme on HIV/AIDS regarding a different harm reduction program of opioid substitute therapy, that "concluded that every dollar invested in opioid substitute therapy could yield a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft alone…[where] when savings related to healthcare are included, total savings can exceed costs by a ratio of 12:1" (Sander & Murphy, 2017, p.187). Therefore, as harm reduction is less costly and more effective in achieving population health outcomes in comparison to punitive or prohibition approaches, researchers and governments turned towards exploring how it could be integrated within the prison context.

What harm reduction is generally available? What does Canada mandate?

Commissioner's Directive 831 in Canada defines harm reduction as a "policy, a program or a measure aimed at reducing the negative health, social and economic consequences of harmful behaviours such as injection drug use and unsafe sex." CSC has harm reduction options available for prisoners and utilizes a continuum of responses to help intravenous drug users within prison through evidence-based treatment, drug detection and security measures and educational programming alongside this (Thomas, 2005, p.1). CSC has invested the most in increasing drug enforcement versus harm reduction; prisoners have regularly indicated that harm reduction options are inconsistent and unavailable to them within the prison (Watson, 2014, p.918; van der Meulen et al., 2016, p.6). However, reviewing standard harm reduction programs

that Canada utilizes within the prison is essential to reveal if PNEPs are valuable to CSC's continuum of programming. The most popular harm reduction tools used within Canadian prisons are:

1. Opioid agonist therapy/Opioid substitute therapy
2. Educational programming
3. Bleach
4. Naloxone
5. Safer snorting supplies
6. Safer tattooing programs
7. Overdose Prevention Site(s)
8. Needle Exchange Programs (as of 2019)
9. Condoms, lubricants, dental dams, safer sex supplies, etc.

(van der Meulen et al., 2018, p.300; Kerr et al., 2004, p.348; Sander et al., 2019, p.107)

Despite bleach's ineffectiveness at eradicating HIV and HCV within intravenous drug paraphernalia, bleach is one of the most significant, early-onset, and widely utilized harm-reduction tactics for mitigating disease. At the origin of conceptualizing providing bleach to prisoners, it was historically opposed for similar reasons to PNEPs, as people saw the introduction of bleach as condoning injection drug use and behaviour and worried bleach would be used against staff or increase drug usage as it would be viewed as safer (Kerr et al., 2004, p.349-350). For Canada, CSC's Commissioner's Directive 800-6 states how bleach must be distributed as a harm reduction measure to prisoners, where each federal prison must have three locations for prisoners to refill their one-ounce bottles of bleach carriers to minimize contact with correctional officers (van der Meulen et al., 2018, p.307; Jeon, 2020, p.15).

Although CSC is mandated to provide bleach, there are many issues with delivery and effectiveness. As early as 2004, the World Health Organization published that bleach is

ineffective under prison conditions (Thomas, 2005, p.5,7). At the same time, studies also noted this, delineating how bleach can not be the sole intervention to solve intravenous drug usage problems, but PNEPs should be instated to help (Lines et al., 2004, p.62). Bleach is no longer recommended or endorsed by public health experts or the international community as it is ineffective in reducing HCV transmission, despite success in decreasing HIV transmission (Lines et al., 2004, p.62). Further studies have noted how it may be ineffective at eliminating HIV and solely reduces the risk (Thomas, 2005, p.7). It also fails to fix concurring issues like abscesses, scarring, bruising and other vein problems due to dull needles and can not help prevent or decrease overdoses (Lines et al., 2004, p.62; Small et al., 2005, p.838). Bleach is only recommended if there is *no* possibility for another option, where because bleach can not rectify the inactivation of HCV or HIV inside an already-used syringe, it is insufficient to mitigate primary concerns for intravenous drug users in prison (van der Meulen et al., 2016, p.6; Chu & Peddle, 2010, p.29). In addition, the frequent use of makeshift needles found within prisons increases the likelihood of blood clots within the actual equipment, raising the possibility of HCV and HIV infection staying stagnant within needles which bleach can not rectify; therefore, bleach must be a second-line strategy in comparison to other techniques (Jeon, 2020, p.13).

Another issue with bleach is how the majority of prisoners fail to effectively use this harm reduction tool as intravenous drug users often have difficulties remembering the procedures to disinfect correctly as well as fail to practice this consistently each time the needle is used (Lines et al., 2004, p.62; Thomas, 2005, p.7; Kerr et al., 2004, p.349-350). Although bleach is often given alongside educational programming, there is limited effectiveness in this (Iafrate, 2015, p.33). As the prison environment sets a context where prisoners must rush to clean in a discreet location to avoid persecution, disinfection often does not occur effectively (van der

Meulen et al., 2016, p.6). And this usually means prisoners avoid using bleach at all, which is found dominant within Australian studies that have noted prisoners are reluctant to engage in behaviours risking their sentence as well as anything that would reveal their drug usage to prison staff (Lines et al., 2004, p.62).

Furthermore, although bleach should be readily available within prisons, specifically Canadian prisons, as Commissioner's Directive 800-6 mandates this, prisoners often struggle to access this care (Small et al., 2005, p.838). In many Canadian prisons, there are prisoners denoted "bleach reps" who are given the task of offering bleach to other prisoners, an attempt by CSC to utilize peers to decrease concerns of correctional officers knowing about drug usage (van der Meulen et al., 2016, p.6). Yet, these individuals often note how they do not have enough bleach for the needs of the prisoners they are tasked with caring for and describe how it is a massive issue that there are penalties for carrying more than one ounce of bleach at a time (van der Meulen et al., 2016, p.6). If prisoners are not a "bleach rep" and are found with more than one ounce, they are potentially sanctioned under section 2 of the *Corrections and Conditional Release Act* to face disciplinary action (van der Meulen et al., 2016, p.6). This often appears unnecessary, where although there must be a mandated maximum amount of bleach a prisoner can carry, prisoners could use more bleach than one ounce to mitigate disease concerns further without other adverse effects. Prisoners have even described times that bleach has been withdrawn from institutions without notice, or they have faced difficulties accessing bleach due to the refill stations being empty or broken, prompting the necessity to talk to correctional officers who then inquire why they need the bleach (Watson, 2014, p.918; van der Meulen et al., 2018, p.307). CSC has attempted to appear responsive to push through this harm reduction

policy. Yet, it is essentially ineffective in doing what it was set out to do – mitigating disease issues.

In conjunction with bleach, educational programming is given on bleach and other harm-reduction tools. Research denotes how educating injection users on proper usage procedures can best prevent overdoses, where when education happens, an increased acceptance of harm reduction techniques in prison occurs (Thomas, 2005, p.7). In the prison environment, educational programming is often most effective if peers deliver these programs, showcasing again how peers – like bleach reps – are necessary for best service delivery (Kerr et al., 2004, p.349). Education alone can not solely stop the issues affecting intravenous drug users. Still, as knowledge increases of safe practices, positive behavioural changes surrounding usage result from proper education (Kerr et al., 2004, p.349). It is important to remember that even if someone has utilized intravenous drugs for years, they may still be unaware of best-practice, especially regarding overdosing and disease concerns.

Bleach may be the longest-standing utilized harm reduction tool for intravenous drug use concerns within prisons, but opioid agonist therapy is the most popular regarding what prisoners want. Beginning with the World Health Organization pushing this in 1993, as of 2019, opioid agonist therapy is available in prisons in over fifty countries across the globe and is available in all forty-three federal prisons across Canada (Thomas, 2005, p.7; Sander et al., 2019, p.110). In 2002, CSC expanded access to opioid agonist therapy based on evaluations undertaken by CSC that found opioid agonist therapy positively affected institutional behaviour and release outcomes (Lines et al., 2004, p.62). Since then, many Canadian prisoners have utilized opioid agonist therapy or put themselves on waitlists to access this harm reduction tool.

Opioid agonist therapy "uses fixed, regular dosing of a long-acting opioid agonist medication to reduce symptoms of opioid withdrawal and craving[s]" (Leonard, 2020, p.23). Important here is how this is the gold standard for treating intravenous drug users' dependency on opiates and opioids specifically. Decreasing withdrawal symptoms and cravings often mean these users stop entirely using opiates or use less alongside opioid agonist therapy. Methadone and suboxone are primarily prescribed and produce reduced harms, costs, and risks with opioid usage that leads to other effects like reducing needle sharing (Kerr et al., 2004, p.350). In addition, prisoner participation in opioid agonist therapy has often meant these individuals further participate in educational programs, and can positively impact institutional behaviour, rates of usage, and release outcomes (Deveaux et al., 2017, p.71; Kerr et al., 2004, p.352).

Yet, there are limitations surrounding the effectiveness and success of opioid agonist therapy within the prison environment. To begin, interest in opioid agonist therapy is exceptionally high at all Canadian federal prisons, where wait times are egregiously long, often leading to prisoners seeking out other drugs as well as strong-arming prisoners who can access opioid agonist therapy, creating issues as suboxone and methadone cause erratic behaviour and effects when the dosage is inaccurate for someone (Leonard, 2020, p.23). There are often problems surrounding the adoption of opioid agonist therapy within the prison environment compared to the general community, as there are inconsistencies of aftercare and retention due the physical structure of the prison that cannot allow access to all prisoners access due to large numbers of prisoners requesting this help that is too burdensome for prisons, as well as overcrowding of this population (Kerr et al., 2004, p.352; Sander et al., 2019, p.110). For Canadian prisoners specifically, opioid agonist therapy is insufficient to solely decrease harms associated with drugs as only specific people who meet strict diagnostic classifications for opioid

use can use this service, leaving out many Canadian prisoners who would benefit from opioid agonist therapy (Iafrate, 2015, p.35). The strict diagnostic classifications include that patients must meet the Diagnostic and Statistical Manual of Mental Disorders-5 for opioid use disorder, which does not apply to many prisoners who need help managing their opioid use. Effectively, there is exceptionally high demand and limited supply of opioid agonist therapy for prisoners, and the application for opioid agonist therapy is lengthy. As there are long wait times, many prisoners continue injecting drugs to avoid withdrawal, illustrating how opioid agonist therapy can not counter the disease concerns and other issues associated with injection drug users as CSC limits the number of prisoners who can access opioid agonist therapy (Jeon, 2020, p.13-14; Iafrate, 2015, p.35). Ultimately, CSC's eligibility criteria for opioid agonist therapy leaves many prisoners to continue intravenously using drugs.

In addition to opioid agonist therapy, providing naloxone within prisons is commonly used as a harm reduction program to decrease opioid overdoses. For intravenous drug users, the universal principle is never to use drugs alone; however, within the prison context, most intravenous drug users end up using alone (Leonard, 2020, p.24). Because of this reality, international organizations like the UN have pushed to give prisoners access to naloxone to decrease overdose deaths, primarily based on the rise of fentanyl found within society and the drugs in prison. In addition, prisoners often note how correctional officers take significant time to respond to overdoses and often do not carry naloxone, further producing a need to increase naloxone access for prisoners (Leonard, 2020, p.24). Prison health and nursing staff at Canadian federal prisons state how they do not understand why all staff are not equipped with naloxone and continue to push to have naloxone a part of the kits provided at PNEPs for participants (Leonard, 2020, p.24).

Prisoners explain that safer snorting supplies and tattooing programs are imperative harm reduction tools to mitigate intravenous drug issues. To begin, prisoners describe how not only opioids are used as drugs within the prison, and snorting is the most common method of usage overall (Leonard, 2020, p.23). Prisoners explain participation rates for PNEPs would increase if safer snorting supplies were provided. Moreover, prisoners describe how they believe the majority of disease is distributed through tattooing within prisons, where a lot more tattooing occurs compared to intravenous usage (Leonard, 2020, p.25). When prisoners are tattooed, they often must provide drugs to the individual tattooing them, exhibiting how tattooing and drugs are connected alongside adding further infected needles into circulation.

Lastly, two critical components of progressive harm reduction exist in prisons that this thesis focuses on: needle exchange programs and overdose prevention sites. Needle exchange programs began in the 1980s within communities to decrease the HIV epidemic, yet it is arguably the most difficult harm reduction technique to integrate within prisons (Fernandes et al., 2017, p.2; Sander et al., 2019, p.109). Despite evidence of needle and syringe programs and overdose prevention sites' success, difficulties are encountered when transitioning these to prisons because of numerous factors such as the prison environment and zero-tolerance policies. Overdose prevention sites have been established in numerous Canadian communities, but only one overdose prevention site exists within a CSC prison (as Drumheller Institution). Harm reduction programs and policies must be idealized and pushed through a top-down approach from the highest levels of government, alongside acting as part of a continuum of programming that allows for the best-individualized care of prisoners (Fernandes et al., 2017, p.14; Lines et al., 2004, p.47; Lines et al., 2005, p.56).

The specific legal challenges that occurred from 2012 to 2018 that led to Canada's introduction of PNEPs are discussed at length later in this thesis; however, by 2016, there was stagnancy in the introduction of PNEPs that did not change since the late 1990s. Just as in the 2005-2006 Annual Report, the Correctional Investigator of Canada noted in the 2015-2016 Annual Report that PNEPs must be implemented in Canadian prisons (Sapers, 2016, p.14). In 2016, 250 Canadian organizations, led by the Canadian HIV/AIDS legal network, petitioned the federal government by signing a declaration to introduce PNEPs (van der Meulen et al., 2018, p.219; Collier, 2016, p.1; Danroth, 2018, p.112). Yet, in effect, this petitioning was ignored by the Canadian government (Danroth, 2018, p.122).

Harm reduction services in prisons must become genuinely available and accessible to prisoners. There must be an effort to remove both the legal and operational barriers that restrict the provision of harm reduction in prisons (Sander & Murphy, 2017, p.188). At an operational level, there should be cooperative work amongst criminal justice organizations, health systems, and prisons to ensure released prisoners can still access harm reduction care (Sander & Murphy, 2017, p.188). Prison health must be integrated within broader community health systems as prisoners return to the community in most cases, meaning the community must then deal with disease and injection issues (Sander & Murphy, 2017, p.188). This means prisons must address barriers to access, like restrictive criteria, stigma, and long wait times, to ensure this continuity. Overall, harm reduction within prisons should be monitored and reported on frequently to evaluate how their uptake and effectiveness. Monitoring and reporting should be systematic, standardized, and be updated often for a country to meet international obligations on care for prisoners.

Chapter 4: Historical and Legislative Context of PNEPs

Introduction to Legislation

National

Canada, including CSC, is first informed by the *Constitution Act* of 1982, which is the supreme law in Canada. The *Constitution Act* (1982) delineates how Canada's government is run and is comprised of different codified acts, treaties, traditions, and conventions between the Crown and Indigenous Peoples. The *Constitution Act* divides the responsibilities of federal and provincial governments, including the responsibility for the administration of jails, prisons, and prisoner care (Constitution Act, 1982). In addition, CSC is foremost informed by the *Canadian Charter of Rights and Freedoms,* which protects the rights and freedoms of those convicted of a crime unless reasonably forfeited by imprisonment conditions outlined within Canada's *Criminal Code* (Cesaroni, 2021, p.217). The *Criminal Code* describes what constitutes a criminal offence in Canada, establishes the form and length of punishment that may be imposed if convicted, outlines the procedure for investigation and prosecution, as well as describes the defences an individual can raise if they are charged with a crime (Criminal Code, 1892). The *Constitution Act* allows the federal government to create criminal laws within section 91(27), where the provinces and territories primarily enforce the law through investigating and prosecuting crimes, as well as providing services and assistance for victims ("The Criminal Code," 2021).

The *Corrections and Conditional Release Act* is the governing legislation for federal corrections in Canada and gives CSC the power to manage the correctional system; this entered into force in 1992 to replace the Penitentiary and Parole Act as the *Corrections and Conditional Release Act* expanded this framework to include the importance of victims (Cesaroni, 2021,

p.235; Branch, 2019). In addition, the *Corrections and Conditional Release Regulations* exist, outlining the "operational matters specific to CSC and gives directions on how CSC must carry out the requirements of the *Corrections and Conditional Release Act*" (Branch, 2019, p.1). These directions are vocalized through Commissioner's Directives that outline day-to-day functioning for federal corrections in Canada. These policies apply to those who have a custodial sentence of two years or more in Canada, as this comprises the federal prison population in comparison to jails that hold prisoners with custodial sentences of less than two years (Cesaroni, 2021).

Insofar as drug policy, CSC states it "will not tolerate drug or alcohol use or trafficking of drugs in federal institutions… [as] a safe, drug-free institutional environment is a fundamental condition for the success of the reintegration of inmates into society as law-abiding citizens" (National Drug Strategy, 2007; 2019). CSC's National Drug Strategy is historically aligned with zero-tolerance and furthers ideas that users create demand for drugs and are the root problem in comparison to harm reduction that accepts drug usage will occur, so the law must target supply ("Zero Tolerance," 2018). Sections 17-18, 28-67, 76-78, and 96 of the *Corrections and Conditional Release Act* outline responsibilities for drug strategy and safety that each institution must execute, whereas Commissioner's Directive number 585 constructs the detailed requirements for Institutional Heads where they must balance treatment, deterrence, and detection (National Drug Strategy, 2007; 2019). The details of all this legislation are discussed further in this chapter.

International

In addition to Canadian federal policy, Canada is a signatory state to international laws and conventions on prisoner well-being and care. It is essential to investigate if Canada upholds these principles in an effort to see if the nation is incompatible with existing international

doctrines. There are two types of instruments within the international sphere: international law and international declarations (Thomas, 2005, p.11). Whereas international law includes charters and conventions that legally bind states to their provisions, international doctrines serve as non-binding guidelines on policy for signatory countries (Thomas, 2005, p.11). For the context of prisoner rights, international human rights law is binding for governments; however, the international rules and standards surrounding this are not law and are, therefore, non-binding for states. International regulations and standards often entail coinciding principles and are mainly formulated and drafted by UN bodies for two crucial reasons. Firstly, these documents are often the "manifestation of … moral and philosophical standards" (Lines et al., 2004, p.15) for states, where countries often feel bound to these documents on an ethical basis and to fit amongst other countries. In addition, these documents guide states on how to draft and fulfill their domestic commitments and law for citizens (Lines et al., 2004, p.15). Nevertheless, although there is functioning binding international law surrounding prisoner rights, it is widely noted there is a massive difference between what is said and signed at the international level compared to what is mobilized on the ground within states concerning care (Glauser, 2013).

International human rights law delineates the obligations of states to protect the rights of all people, including those most vulnerable, such as those imprisoned as well as people who use drugs. Within these obligations, states commit to actively decrease discrimination of vulnerable groups, as states have a "duty of care" obligation to these populations to protect their lives proactively (Pearhouse, 2006, p.1; Sander & Murphy, 2017, p.187). There is a variety of applicable legislation regarding prisoner rights with a specific focus on health and human rights, where most international human rights law comes from the United Nations Universal Declaration of Human Rights (1948) as well as the European Convention on Human Rights (1950) that

prohibited cruel, inhumane, and degrading treatment of peoples (Thomas, 2005, p.11; Kerr et al., 2004, p.347). In addition, the UN's Basic Principles for the Treatment of Prisoners, the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, and the Standard Minimum Rules for the Treatment of Prisoners (*Mandela Rules*) set the stage for what fundamental rights prisoners are afforded while imprisoned (Thomas, 2005, p.11). Lastly, the Bangkok Rules (2011) specified gender-specific needs for those who identify as women, as well as the children of these women, in an effort to address the gap between providing care for the majority (men) versus the minority (women and other genders). The Bangkok Rules focuses on gender-sensitive issues for the needs of women, including pregnancy while in custodial care, young female offender concerns, and the role of the mother-child relationship. Lastly, these rules cover non-custodial measures for women offenders (Bangkok Rules, 2011).

Furthermore, the International Covenant on Civil and Political Rights, specifically article 12, is critical, as it sets out the role of states caring for fatal health issues like HIV and HCV that are prevalent amongst this population and are essential to discuss within the context of harm reduction and PNEPs, as this covenant enshrined the right for prisoners with these issues to be treated with respect and dignity (Thomas, 2005, p.11; Chu & Elliott, 2009, p.9; Kerr et al., 2004, p.348). In addition, the World Health Organization's Guidelines on HIV Infection and AIDS in Prisons, the World Health Organization's Prisons and Health Framework, the Declaration of Commitment within the United Nations General Assembly's Special Session on HIV/AIDS, and Recommendation No R(98)7 of the Committee of Ministers to Member States concerning the Ethical and Organisational Aspects of Healthcare in Prison all outline policies and practices for essential healthcare delivery in prisons (Thomas, 2005). These overarching policies coincide with international legislation by the World Health Organization on Guidelines on HIV Infection

and AIDS in Prison, as well as developed international guidelines on HIV/AIDS concerning Human Rights, which is vital to discuss within the context of harm reduction in prison as this led to the introduction of PNEPs (Thomas, 2005, p.11).

In addition, the role of disease control and international legislation surrounding HIV and AIDS that correlates with the rise of harm reduction materials in prisons is vital to address. Due to the repressive and punitive approach the international community historically held on drug policy, there was a rise of mass imprisonment for intravenous drug users coupled with insufficient harm reduction services within prisons that spurred the crisis of disease running disproportionately rampant within prisons in the late 20th century (Sander et al., 2019, p.105). Because of this, international law, policy, and principles specifically interrogate the role of governments in providing HIV/AIDS care within prisons, where the International Guidelines on HIV/AIDS and Human Rights highlight how criminal law should not impede what a state is doing to decrease their HIV/AIDS epidemic (Pearhouse, 2006, p.6). In the context of health services, this includes providing prisoners with the ability to protect themselves from exposure to HIV and HCV. The push to mitigate disease in this regard is imperative as most prisoners worldwide return to their communities after serving their sentence and risk spreading disease to the broader community (Thomas, 2005, p.12). Prisoners do not relinquish their ability to be free from infection by committing a crime, and they should not be condemned to this fate due to improper healthcare delivery, where prisons create environments that place people at heightened risk for acquiring lifelong communicable diseases. The international community has worked together on this issue owing to the fact that domestic policy cannot solely mitigate these issues, since diseases transcend borders. Yet, laws and programs look incredibly different depending on which signatory nation one views (Pearhouse, 2006, p.2). Many states ignore the reality of

improper care that exists within their countries, which helps create disease epidemics. This is specifically seen with the AIDS epidemic, where intravenous drug usage was not discussed at the beginning of the epidemic but only after it was an evidence-proven reality that substance use spread the disease at abnormally high rates. In addition, countries cannot meet the right to life they must afford citizens if they do not implement effective measures to prevent fatal diseases (Chu & Elliott, 2009, p.13).

The Joint United Nations Programme on HIV/AIDS supports the right of people in prison to access sufficient HIV/AIDS prevention and care, where they have explicitly stated how prisoners have the right to access the standard of medical care for HIV/AIDS found within the community (Lines et al., 2004, p.17). The World Health Organization sees the application of providing equal care to prisoners as that received in communities surrounding HIV/AIDS, wherein 1991, the WHO defined how "all prisoners have the right to receive healthcare, including preventative measures, equivalent to that available in the community, without discrimination… with respect to their legal status" (Lines et al., 2004, p.107) and that the "general principles adopted by national AIDS programmes should apply equally to prisons and to the general community" (Lines et al., 2004, p.109). Sustainable development goals set by the UN have pledged to end HIV and HCV by 2030, where for this issue, the catchphrase "leaving no one behind" was popularized by politicians and bureaucrats; however, prisoners are still left behind and suffer from high rates of these illnesses (Sander & Murphy, 2017, p.185).

A further issue arises surrounding how, if harm reduction programming is insufficient, healthcare workers may violate the oaths they made. For example, the Oath of Athens for Prison Health Professionals, which was founded in 1979 by the International Council of Prison Medical Services, outlines how imprisoned people must receive the best possible healthcare, where the

needs of patients supersede other non-medical matters like imprisonment (Lines et al., 2004, p.17). Physicians and other healthcare professionals always seek to uphold their international codes of practice, where failing to provide the opportunity for these people to receive the best care directly violates their ability to maintain their commitments deemed necessary by the domestic nation they are a part of, as well as the international community. Although health outcomes are not the essential focus of this thesis, it was imperative to note legislation surrounding decreasing disease rates and mortality associated with substance use due to its impacts on other agreements and arrangements signed by Canada both nationally and internationally on prisoner care and harm reduction programming.

Lastly, the World Health Organization published a Prison and Health Framework in 2021 in an effort to meet 2030 sustainable development goals and ideas of "leaving no one behind." This framework needs special consideration as it is the most recent Framework internationally published on prisoner care. The framework was developed for countries and prison systems regarding mental health and substance use care for prisoners. The framework outlines how to evaluate healthcare delivery, specifically in the context of prisoners. The framework posits how "the health profile of people in prison is one of complex, co-occurring physical and mental health conditions, [where] the poor health status of this population is typically set against a backdrop of entrenched and intergenerational social disadvantage" (World Health Organization, 2021, p.2). Therefore, the framework argues to address social determinants of health as risk factors that overlap with imprisonment.

The framework has five priorities: strengthen prison information systems to enhance surveillance and response capacity, monitor health service provision in prison, track performance, obtain reliable and valid measures of the health status of people living in prison,

and conduct intersectional work for better performance and outcomes (World Health Organization, 2021, p.6). There are three building blocks to this framework: health system, health service delivery, and health outcomes, with cross-cutting principles of the influence of the prison environment, health behaviours, adherence to international standards of human rights and good prison health and reducing health inequalities and addressing the needs of special populations (World Health Organization, 2021, p.14-17).

The health system building block comprises the inputs versus outputs of a prison. This entails the importance of leadership and governance in building system designs for prisons, as well as the financing of prison projects (World Health Organization, 2021, p.10). Further included are the vision and strategic plans prisons must have in line with domestic policy, as well as the publication of health information about this population. Regarding Canada, this is why it is essential that prison healthcare surrounding PNEPs, and harm reduction programming come from the agency and ministry responsible, community input, as well as consistent inspection of PNEPs (p.20). Moreover, financing is essential surrounding the fact that harm reduction programs and PNEPs actually *decrease* costs for prisons.

Health service delivery relates to primary, secondary, and tertiary care prisoners must receive (World Health Organization, 2021, p.12). Critical here is how the framework outlines how continuity of care is vital for a sustainable prison health service, which does not happen in Canada due to the separation of care that exists within healthcare, as well as how prisons must care and control their population. Moreover, the framework argues for preventative services, which PNEPs effectively are if they are implemented correctly. Overall, the framework echoes other concerns on disease prevention and rehabilitation of prisoners, positing that availability, accessibility, and acceptability of services are imperative for a sound prisoner healthcare system

(World Health Organization, 2021, p.12-14). Arguably, Canada does not meet this standard as diseases are still rampant, prisoners can not access harm reduction options in many cases, and there is a general lack of availability and acceptability for PNEPs and their related materials. Health outcomes within the framework are comprised of the general health and well-being of prisoners, morbidity and mortality (World Health Organization, 2021, p.14). PNEPs effectively seek to mitigate morbidity and mortality concerns and interrogate specifically the need to deal with HIV and HCV spread due to intravenous usage within the framework, alongside other infectious diseases. Without sufficient PNEPs, Canada may fail to meet what the Framework poses as sufficient health outcomes for a prison healthcare system.

The Right to Healthcare

Various international laws allow everyone the right to the highest attainable mental and physical health possible. This is defined by the UN as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Jeon, 2020, p.14). Article 35 of the Charter of Fundamental Rights of the European Union outlines how "everyone has the right to access preventative healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices," which is further reflected for the prisoner population within the UN's Basic Principles for the Treatment of Prisoners (1990) (Lines et al., 2004, p.16-17). Health policy in custody must be integrated with community healthcare and also be compatible with national health policy (Lines et al., 2004, pp. 16-17). Principle 9 of the Basic Principles for the Treatment of Prisoners describes this by explaining how "prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (Lines et al., 2004, p.16). Many argue that it is arbitrary to distinguish between the right of health for those within general communities and prisoners as the majority

are released into communities, illustrating how the issues prisoners face are also public health issues (Jeon, 2020, p.15). For the context of this research project, most of the rights of this group, including healthcare, are based on the UN's Universal Declaration of Human Rights, which sets the overall status of customary international law.

Healthcare for Canadian prisoners entails shared jurisdiction between the federal government and provincial/territorial governments because of the two-tiered health system that exists in Canada ("Companion Document," 2017, p.2). CSC operates healthcare facilities within every prison in Canada, where each region also has its own regional hospital and treatment centre (Iftene & Manson, 2013, p.886). Within the institution, healthcare facilities primarily offer nursing care that is supported by weekly visits from physicians and specialists (Iftene & Manson, 2013, p.886). Regional care is intended more so for post-operative care or chronic or acute care depending on the prison's locations and resources, whereas prisoners are transferred to community hospitals in all significant situations (Iftene & Mason, 2013, p.886). Prisoners may also visit regional centres for inpatient mental health treatment, but most remain in prison.

The *Corrections and Conditional Release Act* governs corrections by outlining how the primary purpose of CSC is to reintegrate prisoners back into society through various programs to mitigate recidivism rates, as well as outlines specifics surrounding healthcare delivery (Weekes, 2004, p.1). The *Corrections and Conditional Release Act* states all federal prisoners must receive "essential healthcare" in conformity with "professionally accepted standards," and sections 85 and 88 of the *Corrections and Conditional Release Act* mandate how CSC must provide every prisoner with adequate healthcare and access to non-essential mental health care that improves the likelihood for reintegration (Iftene & Manson, 2013, p.886; Thomas, 2005, p.12). Through the *Corrections and Conditional Release Act*, CSC has a statutory obligation to provide prisoners

with equivalent healthcare to that which they could receive in the community, entrenching the principle of equivalence within domestic policy (Thomas, 2005, p.12). Regarding "professionally accepted standards," Commissioner's Directive 800 states healthcare services must be equal to the community (principle of equivalence) unless directly forfeited by imprisonment (Chu & Elliott, 2009, p.12). This is where arguments for PNEPs in Canada originate from, surrounding how intravenous drug users utilize needle exchange programs that have existed since 1989 in Canada when they are residing in the community in comparison to prison; therefore, CSC should attempt to provide care within prisons that echo needle exchange programs so prisoners receive sufficient care (Weekes, n.d., p.3; Thomas, 2005, p.12; Lines et al., 2004, p.18).

Principle of equivalence

The principle of equivalence is one of the critical overarching principles that inform this project. Across the globe, citizens are afforded internationally recognized human rights to protect themselves against harm from others and uphold their fundamental freedoms against states (Lines et al., 2004, p.14). States must effectively protect, respect, and fulfill obligations within binding international human rights legislation found within a multitude of various international bodies (Lines et al., 2004, p.14). Noteworthy within the discussion of prisoners' internationally afforded rights is how an individual's imprisonment does not forfeit their civil rights except those deemed by necessary implication of an individual's imprisonment (ex., freedom of movement) (Thomas, 2005, p.11). The principle of limited exceptionalism also referred to as the principle of retaining all rights, is what describes this, where the international community accepts that prisoners retain these civil rights, including that of the highest attainable standard of health (Thomas, 2005, p.11; Chu & Elliott, 2009, p.8; Chu & Peddle, 2010, p.36). The principle is

further found under the UN's International Bill of Human Rights, which affords prisoners the highest standard of care possible (Danroth, 2018, p.122).

One of the most crucial principles regarding prisoners' rights that the international community holds is the principle of equivalence. The WHO and Council of Europe recommended in the 1990s that harm reduction measures and healthcare must be equally afforded to people within prisons and the general community (Hughes, 2000, p.75). Historically, prisoner care was often shaped by the "discourse of less eligibility" that set the standard of care for prisoners as lower than the general population due to the emphasis on punishing and controlling prisoners (Hughes, 2000, p.83). In comparison, the principle of equivalence is a legal, ethical, and moral obligation for states on how prisoners must be afforded a standard of healthcare equivalent to that outside of the prison within the general community (Jeon, 2020, p.15). It guarantees that a state's duty of healthcare for a citizen does not end "at the prison gate" (Thomas, 2005, p.11). Effectively, within the context of Canada, this means all Canadian prisoners must be afforded healthcare that is found within Canadian communities. This principle is further seen in Rule 24 of the *Mandela Rules* as well as Principle 9 of the Basic Principles for the Treatment of Prisoners, which is further reflected by the United Nations General Assembly, the World Health Organization, the United Nations Office on Drugs and Crime and The Joint United Nations Programme on HIV/AIDS (Jeon, 2020, p.15; Chu & Elliott, 2009, p.9). The obligation for governments to provide equivalent healthcare is also applicable when discussing preventative health measures, as the principle of equivalence requires achieving equivalent objectives to those envisioned for the general community (Chu & Elliott, 2009, p.9). This is where discussions surrounding how prisoner health services should be better than healthcare received in communities, as there are disproportionate rates of health issues within this

population (e.g., drug-associated harms, HIV/AIDS, sexually transmitted infections) (Chu & Elliott, 2009, p.9).

The principle connects specifically to how harm reduction that community-dwelling citizens in Canada receive must also be available within CSC prisons. The question often is, when harm reduction services exist in prison, are they equivalent to what is received outside an institution or upon release? To begin, the principles of harm reduction aim to reduce the legal, social, health and economic harms felt by the prisoners who use drugs, which requires providing programs grounded in dignity and evidence (Watson, 2014, p.916). Often, minimal harm reduction options exist within prisons compared to a community, and weaknesses are shown as harm reduction services within CSC prisons change depending on finances or changes in government, echoing what happens for community harm reduction programs (Sander et al., 2019, p.114).

Regarding specific offerings, opioid agonist therapy and bleach cannot meet the principle of equivalence. In their "position statement on Access to Opioid Treatment in Detention, the College of Family Physicians of Canada Addictions Medicine and Prison Health Member Interest Groups consider that access to opioid agonist therapy in Canadian correctional facilities varies widely and is often worse than access to opioid agonist therapy in the community" (Leonard, 2020, p.23). Accessibility and quality are inferior to that received upon release or within the general community, where opioid agonist therapy is often only accessible to prisoners already using it before their imprisonment (Sander & Murphy, 2017, p.187). In addition, as mentioned previously, access to opioid agonist therapy is limited to people who meet strict diagnostic criteria which differs from access to opioid agonist therapy in many communities (Sander & Murphy, 2017, p.187). Regarding bleach, the principle of equivalence states how

bleach should be eradicated as a technique as it is not seen as proper practice and is not utilized within Canadian communities as best practice anymore (Jeon, 2020, p.15; Watson, 2014, p.918).

It must be acknowledged that the type of healthcare or harm reduction services that is available to an individual in Canada differs depending on the community that is viewed, and within Canada, citizens receive different healthcare depending on where they are located. This means some systems are more robust and comprehensive, whereas other areas (primarily rural and Indigenous communities) lack vital health services that city-areas have. However, CSC *does* provide standardized care and services across the entire service and does not change this depending on what region a prisoner is in; therefore, when they provide substance use treatment programs, everyone receives the same treatment. This is where the principle of equivalence becomes complex and convoluted, as it is not necessarily equivalent to the community an individual is released to or the community where the individual resided before imprisonment but is regarding the nationally established standard for healthcare that should be delivered regardless. Where there are some exceptions and some limited programming that is specific to individuals' needs (e.g., Indigenous substance use care, women-focused care), the general population of prisoners receives services that are standardized. Even in cases of special programming, many people are still not afforded access who need these programs (e.g., Indigenous substance use care found primarily in healing lodges). The principle of equivalence, as defined by the UN, means that CSC is required to provide standardized services and programs so that everyone across the country receives similar care that is equal to standardized services CSC outlines.

CSC Operations

CSC operates 43 federal prisons across five different administrative regions in Canada, as well as four Indigenous-specific facilities (van der Meulen et al., 2016, p.5). Unlike most

Western countries, Canada has a two-tiered system, where provinces and territories have their own independent correctional systems that are responsible for young offenders (those under age 18), people serving probation, those who are remanded, as well as all custodial sentences up to two years, whereas CSC operates the other tier of federal prisons that serve those imprisoned of two years to life (Iftene & Manson, 2013, p.886; Weekes, 2004, p.1). This two-tiered system often causes issues for prisoner care. Foremost, there are often issues with aftercare services for released prisoners, as well as how the short duration of imprisonment in provincial or territorial institutions makes it challenging to deliver programming to these people (Weekes, 2004, p.1). In addition, the sizeable geographical nature of Canada poses issues for the aftercare of treatment for prisoners depending on where they are released (Weekes, 2004, p.1). Thus, there is a decentralized "nature" of prisons and prison programming in Canada, where because each system has individual responsibility over all aspects of prison operations for those they care for, there are often difficulties in delivery that must be mitigated by cohesive national coordination (Weekes, 2004, p.1). However, as this thesis focuses on federal prisons in Canada, the focus of this thesis is on the role of federal correctional care.

CSC is mandated to both control and care for its prisoners. Often, issues arise between this contradiction of *providing* care while *maintaining* control. Frequently, correctional issues are viewed solely as public safety issues in comparison to public health issues, where prisons routinely put safety first instead of equitable healthcare; and this is where we see CSC arguments on resisting harm reduction regardless of health benefits, as it is argued this cannot be adopted within the context of the prison for safety reasons (Kerr et al., 2004, p.353). The dual mandate also poses issues for correctional officers, who are vital to the success of prisons, as they must contend with the paradox of control and care within contradicting job duties. Correctional

officers' primary duty is to maintain safety and security and have the power to use force in this regard (van der Meulen et al., 2018, p.302). This power often leads to negative consequences for prisoners as correctional officers are detached from health services, in addition to correctional officers often lacking an understanding or feeling of moral obligation that providing this form of care is a part of their workplace duties, in comparison to control (van der Meulen et al., 2018, p.303).

Concluding Thoughts

Introducing PNEPs brings states closer to upholding international doctrines to which they are signatories, as well as adhering to essential obligations like the principle of equivalence. As needle exchange programs are available within community centers in Canada, PNEPs are thus necessary to implement (Kerr et al., 2004, p.352). International standards are clear that countries providing access to harm-reduction materials –such as needle exchange programs and access to snorting equipment– means communities must extend this right to prisoners (Liens et al., 2004, p.17). As international covenants have affirmed this principle, affording the right to access a PNEP upholds prisoners' rights by specifically providing sterile materials that are widely available to people living in the community (Kerr et al., 2004, p.348).

Evidence shows that needles are effectively found within almost all prisons worldwide, regardless of their legality. Canada's introduction of PNEPs echoes its aims to progress through a timeline where harm reduction is present, alongside similar programming to counterparts in the international community. PNEPs, within this context, work to improve the health, safety and care of intravenous drug users. Lines et al. (2004) pose the question of which situation is preferable,

> "the status quo – where there are syringes in prisons, the number and location of which are unknown, but these syringes are most likely contaminated with diseases – or the situation

in institutions with well-managed needle exchange programs, in which the number of syringes in circulation is known, the prisoners who have them are known, and the needles are sterile, or at least used by only one person whose identity is known?" (Lines et al., 2004, p.45).

Chapter 5: PNEPs

Why PNEPs are needed

PNEPs are a public health response to a public health issue. They provide sterile injecting equipment to decrease the risk of harm to prisoners who inject drugs. As in the community, drugs are present in every prison as there is a market for them due to existing demand (Lines et al., 2004, p.8). Drug use may increase when someone who intravenously uses drugs enters prison, or individuals may even use drugs for the first time once imprisoned. Intravenous drug users often desire to use drugs to "escape reality," where once they are faced with the harsh prison environment and surrounded by overcrowding and violence, drug use may increase or start to avoid this new reality (Lines et al., 2004, p.9). This is seen in reports noting how up to 21% of intravenous drug users begin injection while in prison, often just to "fit in" with the prison crowd (Lines et al., 2005, p.56; Thomas, 2005, p.5). This exhibits how intravenous drug use is a method of adapting to prison conditions, echoing the concept of prisonization, where these people use drugs to connect to the subcultural values and reality of imprisonment.

In Canada, increasingly aggressive prohibition laws began at the beginning of the 20th century when illicit drugs were first defined in 1908 alongside a diversion in police resources to primarily deal with the spread of opium in Canada (Erickson et al., 2014, p.47). The moral-ideological panic surrounding drugs occurred with the diversion of resources, culminating with the 1961 Narcotic Control Act (Erickson et al., 2014, p.48). Within the past ten years, there has been an increased necessity for PNEPs due to the increase in drug usage seen amongst the Canadian prison population, where transcendent effects often prevent the introduction of PNEPs. For example, tough-on-crime legislation, fewer options for alternatives to imprisonment, parole, conditional release, harsh working conditions of those employed within the federal prison

system, and the increase in prison violence and use of force by correctional officers (van der Meulen et al., 2018, p.300-301). Yet, one of the greatest pushes comes from the international community and the perceived moral obligation of countries to mitigate these human rights abuses. As needle exchange programs exist within Canadian communities, they should also exist within prisons, especially given that prisoners utilize health services at disproportionately high rates compared to the general public (Iftene & Mason, 2013, p.887). People who are imprisoned suffer from disproportionate rates of mental illness and discrimination while they cannot access tools found within communities to protect them from disease (Chu & Peddle, 2010, p.36). Prisoners are a population in Canada exhibiting disproportionate rates of substance use concerns and addiction issues spurred by punitive drug policies, overcrowding, and ultimately political parties who influence policy for this population, seen with the Conservative Party of Canada (Lines et al., 2004, p.9).

Fundamentally, PNEPs are needed because substance use *does* occur in prison and at high rates, as "prisons house the highest per-capita proportion of persons with substance use problems in society" (Weekes, 2004, p.4). High rates of substance use within prisons have been presented since the 1990s, where roughly 70% of prisoners use drugs within federal correctional systems, with over 40% being dependent on these drugs (Thomas, 2005, p.3; Weekes, 2004, p.1). In 2018, it was cited that two-thirds of men used drugs when committing their index offence (the offence that led them to prison), and over 80% had substance use issues when entering specifically a Canadian prison (van der Meulen et al., 2018, p.300; Weekes, 2004, p.3). Regarding injection drug use, in Canada, around 20% of prisoners reported injection drug use before entering prison, with over 50% injecting within six months before their imprisonment (Weekes, 2004, p.5). Urinalysis testing further shows the usage of substances amongst this population but only offers

rates of over 10% of tests resulting in positives for illicit drug use, whereas self-reporting by prisoners on usage is much higher (Small et al., 2004, p.832; Thomas, 2005, p.3). The issue of substance use for this population is demonstrated by high rates of prisoner release suspensions, where 70% of the cases involve alcohol or other drugs (Weekes, 2004, p.2). Although the majority of the prison population is dependent on substances, around one-third do not have 'problematic' issues, exhibiting why treatment should not, and cannot be, a one-sized fits all approach (Weekes, 2004, p.2). Each prisoner is unique, with their own intersection of how they fit within society. Prisoners need various options for care, as one form does not work for everyone. This was traditionally seen in how abstinence works for some, but not all, users and prisoners. Allowing for accessible treatment that is culturally sensitive within prisons is essential within domestic policy and PNEP guidelines as well to ensure effective delivery that is sensitive to the individual needs of a prisoner.

There is a direct link between intravenously using drugs and encountering the justice system as well as acquiring deadly diseases. Over 75% of intravenous drug users have been involved in the prison system (Thomas, 2005, p.3; Kerr et al., 2004, p.346). And for this population, the prevalence of HIV once commencing intravenous usage increases to over 60% (Kerr et al., 2004, p.346). Even while self-reporting, over 40% of prisoners note how the equipment they were using to inject was not clean, and 80% of intravenous drug users reported that they used a previously used syringe while imprisoned (Thomas, 2005, p.3; Small et al., 2005, p.834). Sander et al. (2019) describe how major HIV outbreaks within prisons are seen in Lithuania, Thailand, Iran, Ukraine and the United Kingdom directly because of intravenous drug paraphernalia sharing (p.107). Sharing equipment and needles in Canadian prisons is common. Frequently, sharing happens among friends or members of the same "clique" or "gang" within

the prison or through trading goods and services for needle usage (Small et al., 2005, p.836). Prisoners note how obtaining drugs within a prison is easier than accessing a sterile needle, where sharing is a part of everyday life (Small et al., 2005, p.836). Small et al. (2005) note that one prisoner study participant stated they saw over 30 people using the same needle for injection. In addition, other study participants said that many prisoners who share needles would not disclose if they had HIV or HCV for fear of being unable to access this extremely scarce resource in the future, prompting an increase in the spread of disease (Small et al., 2005, p.836-838).

Many features of prisons contribute to the rapid spread of HIV and HCV such as the number of prisoners who enter prison as active intravenous users with long histories of drug use, prisoners who commence using drugs while imprisoned, the scarcity of needles, alongside the mass presence of drugs (Lines et al., 2004, p.11). PNEPs can mitigate many of these issues. With the introduction of needle exchange programs in 1989, disease rates have steadily declined for this population within the general community (Thomas, 2005, p.2). Yet, intravenous drug users in prison share equipment much more often than in the community, where disproportionate rates of substance use and disease exist amongst prison intravenous drug users (Thomas, 2005, p.5). HIV infection rates for this population are more than ten times higher than the general population, and HCV rates are more than 20 to 30 times higher (Weekes, 2004, p.5; Thomas, 2005, p.5). In Canada, the most critical risk factor for the spread of HCV is injection drug usage, where around 30% of all new cases of HIV and over 60% of new HCV cases are attributed to injection drug usage (“Needle Exchange,” 2015, p.8; Thomas, 2005, p.2). And the more vulnerable a person is, the more likely they are to contract infection. For example, with female Indigenous prisoners in Canada, infection rates sit at over 50% for HCV (Iafrate, 2015, p.32).

Treating someone with HIV or HCV in prison amounts to roughly $30,000 to $60,000 per year in Canada, whereas prevention of this through PNEPs is exceptionally less expensive (van der Meulen et al., 2016, p.8). Prisoners have a right to health that includes access to measures to protect themselves from infection by these diseases. Prison authorities and elected officials are responsible for the delivery of these programs, and when service delivery does not occur, the risk for the entire public increases (Lines et al., 2004, p.2).

The disproportionate rates of HCV and HIV alongside high transmission poses a public health threat because the majority of these individuals are returned to their communities; it is naïve to perceive prisoner drug usage as an individualistic instead of a public health issue as the majority of the population is released within their lifetime (Iafrate, 2015, pp.31-32). Health behaviours of this population are concealed by the closed nature of the prison environment; yet, attending to this issue is vitally important for protecting prisoner health and public health (Lines et al., 2004, p.2). Inevitably, the high degree of mobility between the general community and prison exhibits how disease issues within the prison become a community issue—*everyone* benefits by accepting prison health as a public health issue (Lines et al., 2004, p.2).

When introduced, PNEPs decrease the spread of disease at astonishingly high rates. This is because PNEPs reduce injection equipment sharing rates and mitigate other health-related issues, like abscesses, making the prison a safer environment for prisoners and staff (van der Meulen et al., 2016, p.8). They also can decrease non-fatal and fatal overdoses (Lines et al., 2004, p.49). Meta-analyses of PNEPs show a reduction in the seroconversion and prevalence of HIV and HCV and further improve hygiene for intravenous drug users ("Needle exchange," 2015, p.8). This is seen alongside no further uptake in drug use due to reduced stigma and discrimination through education provided concerning PNEPs (Sander & Murphy, 2017, p.186).

PNEPs are an evidence-based approach to reducing blood-borne fatal diseases, where ad-hoc needles are continually removed from circulation (Peternelj-Taylor, 2018, p.123; Kerr et al., 2004, p.346). PNEPs can work to decrease overcrowding concerns regarding the rise of transmission due to overcrowding, as over 20% of Canadian prisoners are double-bunked due to punitive policies from the 1960s to mid-2000s (van der Meulen et al., 2016, p.5).

Ignoring the reality of drugs within prisons harms prisoners needing or seeking care. PNEPs are a pragmatic response to the problem of injection drug usage felt disproportionately by the prison population, where the number one priority must be to uphold prisoners' health (Lines et al., 2004, p.47). PNEPs are necessary as imprisoned intravenous drug users pose a public health issue, as most prisoners return to their local communities within their lifetimes, where PNEPs assist in protecting the overall communities of Canada (van der Meulen et al., 2018, p.319; Peternelj-Taylor, 2018, p.123; Elliott, 2007, p.263; Leonard, 2020, p.10).

Rise of the PNEP internationally

In 1992, the first PNEP program began as an act of medical disobedience by a part-time employed physician of Oberchongrun's prison in Switzerland (Lines et al., 2004, p.1-2; Thomas, 2005, p.9; Lines et al., 2005, p.52). Dr. Franz Probst saw the wide use of injectable drugs by over 20% of male prisoners, who had no access to sterile needles and thus shared materials only by necessity (Lines et al., 2004, p.1; Lines et al., 2005, p.52). Physicians are held accountable to the oath of Athens established by the international community in 1979 (Iftene & Manson, 2013, p.888). The convention states how,

> "the health professionals who are working in prison settings, meeting in Athens on September 10, 1979, hereby pledge, in keeping with the spirit of the Oath of Hippocrates,

> that we shall endeavour to provide the best possible health care for those who are incarcerated in prisons for whatever reasons, without prejudice and within our respective professional ethics," (Iftene & Manson, 2013, p.888).

Therefore, Dr. Probst sought to uphold his commitments to the doctrine as he saw prisoners were not cared for based upon prejudice and stigma.

When the Warden discovered this act of disobedience, he listened to Dr. Probst's arguments on how providing needles would decrease HIV and HCV rates, as well as the high rates of abscesses found within their intravenous drug using population (Lines et al., 2004, p.1; Thomas, 2005, p.9). As such, the first pilot PNEP project was introduced in 1994 at the Swiss Hindelbank prison, where, because of its success, PNEPs were expanded to seven subsequent Swiss prisons (Lines et al., 2005, p.52). These PNEPs came in two forms: automated syringe dispensing machines or hand-to-hand exchange through prison staff (Lines et al., 2005, p.52). This was done so that prison staff could keep track of how prisoners stored their syringes, as the primary concern about expanding the program came from prison staff's worries about needle-sticking (Lines et al., 2005, p.52). Prisoners were thus first afforded the right to access proper healthcare for intravenous drug usage while maintaining concerns about staff safety (Lines et al., 2005, p.52).

PNEPs have expanded to over 60 prisons of all different security levels and sizes across Canada, Europe, the Middle East, and Central Asia (Thomas, 2005, p.90; Chu & Elliott, 2009, p.7; Lines et al., 2004, p.66). However, many of these areas only have a few prisons with PNEPs, but the success of these programs is widely demonstrated no matter the region (Thomas, 2005, p.9). These programs have realized success in operating within various contexts, including underfunded and civilian, well funded programs, civilian and military systems, and with different

physical housing arrangements for prisoners within both women's and men's prisons (Lines et al., 2004, p.66). The widespread success of this harm reduction program provides an important context for the concerns that have been raised about PNEPs. Moreover, examining the diverse ways that PNEPs are configured and operated in different settings helps with understanding how they have spread across the globe.

Methods of PNEP distribution

Four main distribution models for PNEPs stem from either hand-to-hand distribution or distribution through automatic dispensing that is either one-for-one or multiple distributions (Iafrate, 2015, p.36; "Needle exchange," 2015, p.13). The four main models are distribution by syringe-dispensing machines, distribution by trained peer-workers within the prison, distribution by prison health and staff services, and distribution by external personnel like non-governmental organizaitons and other community healthcare professionals (Danroth, 2018, p.125; Iafrate, 2015, p.36; Lines et al., 2005, p.57). These programs must include providing necessary materials for intravenous drug users, and other materials like swabs, spoons, bowls, first aid, tips for usage, etc., to keep prisoners safe (Pearhouse, 2006, p.13). It is important to note how *every* model has its own "advantages and disadvantages with regard to anonymity, confidentiality, accessibility, feasibility, ease of implementation, cost, and effects on interpersonal relationships" (Chu et al., 2022, p.4), where it is essential to consider which distribution model works best depending on which prison environment is present. Moreover, with each model, there are most definitely trade-offs. For example, hand-to-hand distribution models take away the anonymity of users yet show increased success in facilitating counselling and treatment for prisoners (Iafrate, 2015, p.36). Overall, a distribution program without limitations is preferable, to maintain confidentiality while allowing for increased access for prisoners (Pearhouse, 2006, p.15).

Dispensing machines

To begin, distribution by syringe-dispensing machines is popular. The automatic dispenser gives inmates a "dummy syringe" prisoners insert to obtain a new sterile needle, where they place their used syringe as well into a slot for exchange where the needles are disposed of (Iafrate, 2015, p.35; van der Meulen et al., 2016, p.10). Typically, and for sufficient effectiveness, multiple dispensing machines are installed in various locations within a prison; experts recommend placing these in an area with high accessibility with coinciding high confidentiality from prison staff (van der Meulen et al., 2016, p.10). Often this is difficult as the entirety of the prison is under surveillance, so strategizing the location for machines is of utmost importance for prisoners to use the service.

The method of automatic dispensing distribution has positives and negatives. Confidentiality and anonymity are of utmost importance for the success of harm reduction programs, which this method upholds. Furthermore, there is a high degree of potential accessibility as this service is used within and outside of traditional business hours (Thomas, 2005, p.9). There is also strict one-for-one exchange with these machines which means the number of needles circulating is easily calculable (Lines et al., 2005, p.58). Necessary as well is the high acceptance of this method by intravenous drug-using prisoners (Thomas, 2005, p.9; van der Meulen et al., 2016, p.17; Lines et al., 2005, p.58). Prisoners note how the anonymity of this program means prisoners are more likely to participate in the PNEP (van der Meulen et al., 2016, p.17).

However, there are downfalls to this method of distribution. To begin, these dispensing machines do not provide any opportunity for support, counselling, or treatment from staff (van der Meulen et al., 2016, p.10). This means these individuals' continuity of care is jeopardized;

however, the actual goal of the PNEP on providing safe injection materials is upheld. There is also the possibility of prison staff going back and watching surveillance footage of the prison to see who is accessing the machines, where increased searches of cells are a possibility, decreasing participation rates (van der Meulen et al., 2016, p.17). In addition, a flaw with this method is the possibility of "machine sabotage," often through damage and/or vandalism by prisoners –or staff– that dislike the program (Thomas, 2005, p.9; Lines et al., 2005, p.58). Moreover, prisoner confidence in the program often wavers when machines are broken or unstocked, which inevitably happens as these programs and machines are new, and some prisons have seen long durations of unavailability (Lines et al., 2005, p.58; Thomas, 2005, p.9). Additionally, some prisons are not architecturally equipped to be able to handle this type of machine or the confidentiality that comes with it, or they do not have the spatial capacity to, automatically rendering this version useless within some prison contexts (Lines et al., 2005, p.58; Thomas, 2005, p.9). Lastly, these machines must be individually designed, constructed, and implemented for one specific prison (Thomas, 2005, p.9; Lines et al., 2005, p.58). This expense may be too burdensome for many prison systems that are already highly underfunded (Thomas, 2005, p.9; Lines et al., 2005, p.58). Intriguingly, many drawbacks to this form of distribution echo prior concerns and issues with bleach dispensing machines that were, and still are, predominantly used in prisons (van der Meulen et al., 2016, p.17). Prisoner comments suggest how this version would work successfully if the machines were sufficiently restocked and implemented without surveillance, for example, in a washroom or medical room that is not under video surveillance (van der Meulen, 2016, p.17).

Peer distribution model

Another distribution method is the peer distribution model, where specific prisoners receive training on delivering intravenous drug use materials and distributing, collecting, and facilitating the disposal of PNEP goods (van der Meulen et al., 2016, p.10). These peer workers are frequently given other harm-reduction supplies and informational packets to pass to prisoners. The peer workers commonly collect and distribute the goods in bulk to uphold anonymity from correctional officers and other prison staff (van der Meulen et al., 2016, p.10).

Advantages of this model include how there is high availability to access materials as the peer workers are fellow prisoners who are available on weekends and outside of business hours, as well as high potentiality anonymity, upholds (van der Meulen et al., 2016, p.10; Thomas, 2005, p.9; Lines et al., 2005, p.58). In addition, prisoners describe how there is an increased level of trust and comfort based on this non-judgemental method, as peers are providing the goods; most often than not, these individuals have experience with drug use, where prisoners will listen attentively in an effort to learn proper injection processes (van der Meulen et al., 2016, p.18). Overall, prisoner response to this type of program is predominantly positive.

There are potential downfalls and existing ones for this type of program. Foremost, peer workers are not as sufficiently trained as working healthcare professionals, where data they obtain or information they pass on is permeable to inaccuracy in comparison to questions and information a healthcare professional would provide (Lines et al., 2006; van der Meulen et al., 2016, p.10). This also means there must be consistent training and retraining of these individuals, which is often burdensome for the already overpopulated prison healthcare system (Lines et al., 2006). There is also a high possibility of corruption in this type of program. For example, evidence indicates there is an increased likelihood of no one-for-one distribution occurring, where the probability of PNEP materials circulating the prison black market increases (van der

Meulen et al., 2016, p.18; Lines et al., 2005, p.58). In addition, prisoners note how interpersonal conflicts between peer workers and prisoners sometimes mean specific prisoners are not afforded access to the program because of what occurs prisoner-to-prisoner in comparison to if this individual was prison staff, especially when it comes to issues between prison cliques/gangs (van der Meulen et al., 2016, p.18; Lines et al., 2005, p.58). Lastly, there is also the potential for corruption by staff, as the lack of staff control over distribution leads to increased fears of workplace safety for staff, wherein prisoners fear staff will pressure peer workers into telling them who is involved in the program, decreasing trust of the entire PNEP process (Lines et al., 2005, p.58; van der Meulen et al., 2016, p.18). One of the potential ways to mitigate this is through the prisoner population electing which prisoners should be peer workers so they are more likely to be respected and trusted by the prison community (van der Meulen et al., 2016, p.19). This can lead to further uptake of the program as each unit could nominate who they see fit, with regular elections (van der Meulen et al., 2016, p.19).

Distribution by external personnel

Another method of distributing PNEP goods is through external agencies, nongovernmental organizations, and healthcare professionals that do not reside within the prison system and are, therefore, not employed by the correctional institution or organization (van der Meulen et al., 2016, p.11). The workers enter the prison, most commonly only during business hours, to distribute and care for those utilizing the PNEP in their prison. These individuals have specialized knowledge of the processes behind the program and the unique needs of this vulnerable population.

This distribution method has significant advantages for prisoners and their continuity of care. For example, confidentiality issues reduce as external organizations, nongovernmental

organizations, and health professionals can take over responsibility for program users (van der Meulen et al., 2016, p.11). This has meant prisoners highly support this distribution method as there are high levels of trust that participation is kept private from prison staff (van der Meulen et al., 2016, p.19). Prisons can select a one-for-one exchange or multiple distribution methods that external individuals can carry out, limiting their knowledge of participation (Lines et al., 2005, p.58). In addition, connecting with these external organizations and individuals facilitates an increased connection between prisoners and local Canadian communities to which they are eventually released (van der Meulen et al., 2016, p.11; Thomas, 2005, p.9). This means there is an increased likelihood of continuity of care as prisoners are familiar with these peoples and organizations, where the external individuals have increased connection and outreach with previously unknown drug users and those who began intravenous usage while imprisoned (Thomas, 2005, p.9; van der Meulen et al., 2016, p.11). The likelihood of prisoners participating in treatment programs and counselling also increases (Lines et al., 2005, p.58; Thomas, 2005, p.9). With this distribution method, there is an increase in the availability of harm reduction information alongside professional distribution that includes the likelihood of proper dissemination of information alongside non-judgemental service delivery (van der Meulen et al., 2016, p.19).

However, there are disadvantages to this form of delivery. Depending on a prison's geographical location and set-up, it can be complex or unclear how often external individuals could visit (van der Meulen et al., 2016, p.11; Thomas, 2005, p.9). It is imperative these individuals have access daily to clean syringes as addiction to injectable substances usually coincides with daily usage, where limited outreach is a significant disadvantage that is also permeable to lockdown concerns (van der Meulen et al., 2016, pp.11,19; Thomas, 2005, p.9).

There are sometimes issues in delivery as well when there is high resistance from prison staff to PNEP programs, revealing how external workers may experience increased barriers in dealing with prison bureaucracy compared to if they were internal staff (van der Meulen et al., 2016, p.19; Thomas, 2009, p.9; Lines et al., 2005, p.58). There are also issues of prisoners avoiding programs by community workers. One reason for this is that some prisoners do not want community organizations and professionals to know about their usage, as they hold the opinion that exiting the prison into the community is a "clean slate," posing an increased likelihood of avoiding these programs if the individual is imprisoned within the jurisdiction of a pre-existing relationship with particular communities or workers (van der Meulen et al., 2016, p.19). Another fear is the high turnover rates seen at social service organizations. This can result in a lack of consistency of contact between specific people and prisoners, threatening the program's viability (Thomas, 2009, p.9; Lines et al., 2005, p.58).

Overall, this form of distribution has positive reviews from prisoners, where suggestions for strengthening this form of distribution could be made by first mitigating lockdown concerns (van der Meulen et al., 2016, p.19). A hybrid model could exist where community workers leave injection equipment behind for last-case scenarios where prisons are closed, an issue at the forefront of post-COVID-19 lockdowns (van der Meulen et al., 2016, p.19). Moreover, prisoners note how it is vital that community workers distinguish themselves as separate from prison staff and actively liaise with prisoners on their differences so that trust increases (van der Meulen et al., 2016, p.19). Overall, community workers and services should have the ability to connect prisoners to those within their own cultural or religious group. This means prisoners can receive appropriate knowledge, supplies, and information they understand from someone they recognize

as similar to them, as well as keeping language concerns of utmost importance so access increases (van der Meulen et al., 2016, p.19).

Distribution by prisoner health services

The last distribution method is the possibility of prisoners receiving injection equipment from prisoner health staff, including nurses, doctors, or other employed health professionals (van der Meulen et al., 2016, p.11). This method connects prisoners with healthcare professionals who can help them receive treatment, counselling, and other services. Frequently, this happens in overcrowded prisons with PNEPs with a significant turnover rate of prisoners (van der Meulen et al., 2016, p.11). Overall, prisoners receive the goods by travelling to the prison health facility area, where they are noted as participants.

There are advantages to this model, such as the fact distribution via healthcare workers allows for the best regulation and control of the PNEP environment, program, and policies, where even prisoners believed this would be most likely adopted in areas without existing PNEPs as a starting point (van der Meulen et al., 2016, p.20; Thomas, 2005, p.9). In addition, prisoners note an advantage to this model is seen when nurses with specific PNEP training are given the task of providing information and equipment, as they are often the most non-judgemental and caring and are widely employed within prisons (van der Meulen et al., 2016, p.20). Lastly, integrating these individuals who may be previously unknown drug users yields benefits as prisoners are exposed to other possibilities for care and recovery (Thomas, 2005, p.9; Lines et al., 2005, p.57-58).

However, unlike the prior distribution model through external personnel, this model has the most resistance from prisoners (van der Meulen et al., 2016, p.20). Confidentiality is not possible

with this method, limiting prisoner participation, especially in cases where prisoners are uncomfortable with their healthcare providers (van der Meulen et al., 2016, p.11; Thomas, 2009, p.9). This includes anonymity concerns that tie into beliefs that healthcare staff will liaise information to prison security staff and/or administration, as they are employees of the same institution (van der Meulen et al., 2016, p.20). Furthermore, barriers to this method include how healthcare staff are typically employed solely during standard work hours, limiting access to PNEP goods outside of this time period (van der Meulen et al., 2016, p.11; Thomas, 2009, p.9; Lines et al., 2005, p.57-58). In addition, prisoners describe fears of giving further power and control to healthcare staff, which could lead to staff withholding access as a form of punishment, as this has historically occurred with programming and correctional officers (van der Meulen et al., 2016, p.20). Lastly, there are concerns for the prison surrounding the increased possibility of needles entering the prison through smuggling from prisoner health services, so prisoners who have distrust with the providers can still access care, negating the entire purpose of the PNEP (Thomas, 2005, p.9; Lines et al., 2005, p.57-58).

Apprehension to PNEPs

Longstanding arguments have surrounded the apprehension to introduce PNEPs to new areas. Lines et al. (2004) identify four critical objections to PNEPs:

1. PNEPs would lead to increased violence and the use of syringes as weapons against prisoners and staff (p.44)
2. The implementation of prison needle exchange would lead to an increased consumption of drugs and/or increased use of injection drugs among those who were previously not injecting (p.44)

3. Implementation of PNEP would undermine abstinence-based messages and programs by condoning drug use (p.44)
4. Successful implementation of PNEPs does not indicate that other jurisdictions will be able to implement successful programs because existing programs reflect specific and unique institutional environments (p.44)

Although from 2004, these objections are widely present almost twenty years later as governments still argue against implementation due to these concerns. Foremost, there are fears that violence within a prison will increase when a PNEP is introduced as prisoners now have access to needles that could be used as weapons against other prisoners and staff (Iafrate, 2015, p.37-38; Hughes, 2000, p.82; van der Meulen et al., 2018, p.305; Danroth, 2018, p.123; van der Meulen et al., 2016, p.26). Most often, this comes from evidence of previous stabbings of prison officers (accidental or on purpose) of disease-infected syringes, prompting concerns about how PNEP material would be properly disposed of (Hughes, 2000, p.82). These stabbings are in reference to mainly correctional officers coming into contact with syringes prisoners have tried to hide in the absence of a PNEP when conducting cell searches, and not in regards to stabbings that occur once a PNEP is instated (as evidence notes this does not happen). Ministers of Public Safety and the Union of Canadian correctional officer's president in Canada have argued against PNEPs in Canada based on this reasoning (van der Meulen et al., 2018, p.305).

In addition, a significant concern regarding PNEPs surrounds arguments that drug usage will increase with the provision of this program alongside fears that people will begin to intravenously use drugs with the introduction of the PNEP (Hughes, 2000, p.79; van der Meulen et al., 2016, p.26; Hughes, 2000, p.80; Lines et al., 2004). This concern is widespread in prisons that do not have high rates of overdoses, especially fatal ones, as many subsequently argue the

program is not necessary as the risk for people beginning intravenous usage outweighs the small number of those dying from intravenous drug usage. There are concerns about this uptake even though the drug and needle markets exist regardless of a PNEP (van der Meulen et al., 2016, p.26).

The idea that PNEPs send a symbolic message of condoning drug use plagues governments with the issue of adequately managing a prisoner population while still upholding other government policies (Hughes, 2000, p.78). Governments are often apprehensive about implementing PNEPs as they view this as undermining zero-tolerance aims that exist within the prison, as well as view this as condoning illicit drug use, which is illegal within general society as well (Iafrate, 2015, p.37; Hughes, 2000, p.78; Danroth, 2018, p.123-124; Peternelj-Taylor, 2018, p.124; van der Meulen et al., 2016, p.25). Furthermore, governments argue that public funding should not be allocated to something like this compared to other areas that still need more funding (Iafrate, 2015, p.37). In Canada, CSC has created this zero-tolerance prison environment through its anti-drug mandates, posing issues for PNEP adoption as their premise is not to eliminate drugs but instead provide care for those who are using (van der Meulen et al., 2016, p.25).

In conjunction with this, prison staff, specifically correctional officers and their corresponding union, have issues with the instatement of PNEPs due to their role. For example, correctional officers have questioned how they can be involved in drug interdiction while simultaneously promoting harm reduction and allowing prisoners to use the substances they are tasked with removing from the prison (Hughes, 2000, p.78). In addition, correctional officers are concerned about how PNEPs potentially promote criminal activity, which puts correctional

officers' safety at further risk as they will need to deal with this fallout (Peternelj-Taylor, 2018, p.124).

Lastly, concerns arise regarding how PNEPs may not be possible within all jurisdictions and environments. Issues mainly surround how successful implementation within one jurisdiction and context does not mean that these program-specific goals can be met within all settings (Lines et al., 2004, p.44). However, this will be discussed further in the next section, as this argument is no longer utilized based on evidence that has risen since the original 2004 study, as many different institutions and countries have adopted and modified PNEPs since then.

Canadian Apprehension

As this thesis focuses primarily on Canada, it is important to interrogate why Canada was specifically apprehensive about introducing PNEPs. CSC never publicly communicated about why it failed to provide clean needles for over 20 years, so there can only be assumptions drawn on why Canada failed to uphold international commitments for this long. Chu & Elliott (2009) note how the concerns described in the previous section were echoed by the Canadian government (p.20). It is highly probable that PNEPs were not instated because Canada remained prohibitionist in nature with zero-tolerance policies and strict drug laws, where PNEPs and increased harm reduction contradict these aims (Watson, 2014, pp.921-922). This thesis argues that Canada failed to adopt PNEPs for the length they did due to political party influence, the union of Canadian correctional officers' opposition, as well as fears derived from the stigma surrounding this population.

The Conservative Party affected the uptake of harm reduction programming within prisons. From 1990 to 2015, legal and medical experts widely recommended PNEPs as the best

method to manage intravenous drug use issues, but policymakers failed to facilitate this (Elliott, 2007, p.263). Despite over ten years of research, Prime Minister Steven Harper, who ran the Conservative Party from 2006 to 2015, failed to implement PNEPs (Jeon, 2020, p.29). Instead, it was stated during his tenure that they would "never consider putting weapons, such as needles, in the hands of potentially violent offenders" by Public Safety Minister Steven Blaney (Jeon, 2020, p.29). Instead of introducing PNEPs, this era of Canadian governance saw widespread right-wing drug policy (like the National Anti-Drug Strategy) that focused on expanding law enforcement, attempting to reduce the demand for drugs, and growing punitive consequences through "locking up" drug-using citizens (Watson, 2014, p.921; Pearhouse, 2006, p.3).

The Conservative Government stated that sterile needles are *not* needed to control disease issues within Canadian prisons despite concrete evidence from many international studies that outline that PNEPs are imperative (Kondro, 2010). Issues for PNEP adoption based on the government that was in power were seen elsewhere. In Germany, effective PNEPs were shut down due to a newly elected conservative right-leaning government that took them away despite their success (Watson, 2014). Conservative governments hold tough on crime policies, where the piloted tattooing program Prime Minister Steven Harper rolled out was even cancelled based on fabricated government data that aimed to abandon the project as it was progressive (Watson, 2014, p.919). Watson (2014) argues that political decisions effectively override evidence where external stakeholders create "back-door" deals that further political aims instead of relying on empirical evidence (p.919). This can be seen with needle exchange programs in Canada that began operations without a traditional legal framework and were started by citizens wanting change; however, PNEPs within the prison environment need a concrete policy to exist, which poses a barrier for their adoption (Pearhouse, 2006, p.7).

Implementing PNEPs in Canada was challenging based on the union of Canadian correctional officers' opposition (Danroth, 2018, p.125). The union argued that sterile injection equipment is a massive risk to staff, and the union of Canadian correctional officer's President discussed that those pushing for PNEP introduction are out of touch with the actual reality of how prison operations work and how risky it is to work within this environment without introducing further "weapons" into it (van der Meulen et al., 2018, p.205). Moreover, the union of Canadian correctional officers argued there is no space for additional training for the safety of correctional Officers, and correctional officers are extremely apprehensive (Peternelj-Taylor, 2018, p.124; Watson, 2014, p.920-921). Correctional officers often view harm reduction programs as enabling drug use and contradicting their job duties, and they are often correctional officers due to their own conservative ideologies on prison management and control (Watson, 2014, p.920). Even if some correctional officers are in favour, if everyone is not on board, service delivery issues will happen. As the union of Canadian correctional officers is a union, individual correctional officers also feel pressure to conform to the dominant ideology and discourse of the union, leaving little room for actual interpretation of how many correctional officers would be on board (van der Meulen et al., 2018, p.305). Efforts occurred to bring the union of Canadian correctional officers on board by increasing collaboration with the union, as well as through pushing international evidence on the effectiveness of PNEPs; yet when PNEPs were instated in Canada, the union of Canadian correctional officers were still against the policy. A potential solution to mitigate the union of Canadian correctional officers' concerns could be to bring staff from prisons with existing PNEPs to discuss how correctional officers can work within the framework of harm reduction (van der Meulen et al., 2018, p.306).

Lastly, regardless of evidence that Canada should have implemented a PNEP for over 20 years, fears and stigma surrounding this population plagued reasoning on why this would be impossible. Ideas surrounding if PNEPs "condone" drug use behaviour negate the fact that drugs enter prisons regardless of how punitive policies are; therefore, managing other concerns is vital. The Canadian government and the union of Canadian correctional officers' view prisoners as prone to engage in violence towards themselves, others, and staff, as well as highly untrustworthy, which fueled claims that PNEPs put staff at risk (van der Meulen et al., 2018, p.304). Objective evidence comes secondary to fears felt based upon differing political or ideological reasons, as well as how the public is generally apathetic towards issues faced by prisoners. However, it is shown how the negatives or concerns with PNEPs are important to acknowledge, even if evidence contradicts these claims.

Positives of PNEPs

Many arguments have been advanced by governments, individuals, and other stakeholders on why PNEPs should *not* be implemented within prisons. However, evidence of existing PNEPs challenges many of these concerns. To begin, PNEPs do not lead to increased drug usage, are not cost-burdensome, and do not result in needles being used as weapons against other prisoners or staff, as many arguments against PNEPs suggest. In addition, PNEPs yield positive effects such as reducing the share of non-sterile injection equipment and, therefore, communicable infection rates, reducing drug overdoses, reducing abscesses and other injection-related infections, increasing referrals of prisoners to drug addiction treatment programmes, and are seen as effective within a wide range of institutional environments with different distribution methods.

One of the longstanding arguments against PNEPs is that it condones drug usage, and, therefore, rates of intravenous use will increase when PNEPs are introduced, or individuals will be more likely to try or switch to intravenous usage with PNEPs present. Studies show that prison drug-use rates decrease when PNEPs are introduced, and the number of intravenous drug users within a prison does not relatively increase with the addition of a PNEP (Thomas, 2005, p.10; Lines et al., 2005; Danroth, 2018, p.123). Lines et al. (2005) noted an exception to this with a prison in Hamburg wherein the presence of an anonymous syringe dispensing machine was pointed out as a temptation for prisoners that increased relapse rates; yet, with new evidence since 2005, this evidence is considered an outlier (pp.55-56). It is important to remember that if injection drug rates and disease rates were low within prisons, PNEPs would not even be discussed, but data suggests otherwise (Hughes, 2000, p.80). When there is a limited supply of clean equipment, many prisoners feel pressured to increase their drug use out of fear of not being able to use again, which PNEPs mitigate as they remove this fear as prisoners can access sterile equipment (Jeon, 2020, p.27). PNEPs can positively change the informal prison drug market, and PNEPs do not increase the number of drugs seized within a prison (Hughes, 2000, p.79; van der Meulen et al., 2016, p.26). Although one of the longest-standing arguments against PNEPs, evidence indicates that PNEPs do not increase drug usage and, in fact, can make the prison a safer environment for both staff and prisoners (Chu & Elliott, 2009, p.7-8; Lines et al., 2004; Chu & Peddle, 2010, p.3; Peternelj-Taylor, 2017, p.124; Jeon, 2020, p.27).

Fundamentally, "argument[s] that a needle exchange program would lead to prisoners begin[ning] using injection drugs is…undermined by the fact that this behaviour is already the norm in many countries without prison needle exchange programs" (Lines et al., 2004, p.47). PNEPs do not undermine abstinence-based programs either, as they are added as a part of a

continuum of programming. In addition, positing this argument ignores the reality of prisons across the globe, as drugs enter the prison regardless of what policy states should happen, and this has continued despite previous efforts to increase drug interdiction (van der Meulen et al., 2016, p.25). The provision of sterile equipment does not equate to condoning drugs or eradicating zero tolerance, but instead turns society towards harm reduction theory to deal with the problems that persist with abstinence ideology (Iafrate, 2015, p.37; van der Meulen et al., 2016, p.25). In addition, within the example of Canada, the government "admitting failure" in preventing drug usage would have actually been the origin of developing bleach programs that occurred before any PNEPs were instated globally, as this was a harm reduction technique that validated how needles are actively used for drug usage in CSC facilities (Danroth, 2018, p.124).

Many governments argue it is not within budgetary constraints to introduce PNEPs, and these programs are cost-burdensome to an already underfunded policy area. Yet, this argument is historically discussed surrounding *all* progressive harm reduction policies. And PNEPs are actually cost-effective for prisons compared to the responsibility of caring for those with life-long illnesses (Danroth, 2017, p.121; Elliott, 2007, p.263). Even when there was little evidence about the cost-effectiveness of PNEPs, economic analyses taken from needle exchange programs within general society were often used (Lines et al., 2004, p.64). Essential to this discussion is how expensive the costs of caring for individuals with HIV and HCV infections are (Lines et al., 2004, p.64). The cost of caring for a prisoner with this type of disease is egregiously higher than implementing PNEPs that decrease the total rate of these illnesses. Specifically, the price to finance a distribution system, staff for PNEPs, and needles are lesser than the costs spent on medical treatment for those with HIV or HCV in prison (Iafrate, 2015, p.38). In addition, when these peoples leave the prison, the cost of services falls to the community; therefore, it is

essential to consider the overall savings in government expenditures within and outside prison walls (Lines et al., 2004, p.64).

Arguably the most considerable apprehension to instating PNEPs comes from the idea that prisoners will use the sterile equipment they are given as weapons against themselves, other inmates, or prison staff. Yet, PNEPs have not resulted in needles, syringes, or other PNEP equipment being used as weapons, and fears of violence have not been seen in the case of any PNEP instated (Iafrate, 2015, p.38; van der Meulen et al., 2018, p.305). Instead, the prison environment becomes safer for prison staff and prisoners (Chu & Elliott, 2009, p.7-8; Lines et al., 2005, p.49; Chu & Peddle, 2010, p.3; Thomas, 2005). Governments who push back against PNEPs in fears about the weaponization of needles effectively go against what evidence has shown about PNEPs. Correctional officer unions, including the union of Canadian correctional officers, often use this as a reason for reconsidering implementation, but in reality, PNEPs virtually eliminate all accidental needle-stick injuries for correctional officers based on how PNEP equipment is stored compared to prisoners hiding needles (van der Meulen et al., 2018, p.319). With PNEPs, there are punitive measures incurred if storage is not proper or if ad-hoc or unclean needles are found within a prison that has a PNEP; thus, prisoners who use drugs intravenously often participate and stop concealing syringes in fear of having added time to their sentence, or incurring other punishments (Lines et al., 2005, p.55; Danroth, 2018, p.123). Governments often paint a PNEP as a trade-off to the institution's security, but this is not seen when examining their existence in various countries in different areas of the world (Lines et al., 2005, p.55). Prisoners have access to many other things that could, and are, used as weapons, like pens, pencils, cutlery, books, and toothbrushes, which are expected within the majority of prison settings and are infrequently used as weapons (van der Meulen et al., 2016, p.26). Even

with needles, prisoners with illnesses, such as diabetes, that need access to needles, where weaponization is not shown (Jeon, 2020, p.29; van der Meulen et al., 2016, p.27). In over 25 years of PNEP operations across the globe, there has not been *one* reported incident of PNEP equipment used as a weapon, where the basis of this argument is more so founded on the stigma surrounding prisoners in comparison to fact or evidence (Jeon, 2020, p.28). Governments must remember that prisoners also want the prison to be a safer environment for themselves, free from violence and disease when possible.

In addition to empirical evidence contradicting some of the opposing arguments against PNEPs, studies have shown that PNEPs bring other positive effects when introduced. Needle exchange programs in the community reduce rates of disease by more than 5% per year for intravenous drug users, so it is likely that similar effects can be observed in prisons (Kerr et al., 2004, p.352). At the crux, PNEPs were foremost introduced to deal with rampant HIV and HCV spread within prisons, and they effectively *do* reduce the usage of non-sterile injecting equipment, which reduces rates of blood-borne infections (Chu & Elliott, 2009, p.7-8; Lines et al., 2004, p.57; Fernandes et al., 2017, p.6-12; Chu & Peddle, 2010, p.3; Peternelj-Taylor, 2017, p.124). In addition, PNEPs often remove old syringes in circulation and replace these with sterile ones (Kondro, 1999, p.1887). An early example of the effectiveness of PNEPs in reducing disease and unsafe usage rates was demonstrated by the Spanish Ministry of the Interior and Ministry of Health and Consumer Affairs in 2004 (Lines et al., 2004, p.45-46). Essentially, PNEPs in Spain fixed the issues of concealed illicit syringes, decreased accidents during injection usage, and decreased the sharing of needles which reduced disease rates within Spanish prisons and proved how prisons could become a healthier *and* less risky environment (Lines et al., 2004, p.45-46). Since 2004, there is consistent evidence demonstrating the positive effects of

PNEPs across the globe. As prisons are often overcrowded environments that lead to the spread of illness, PNEPs can exist within these congested environments to reduce the infectious spread at the bare minimum while overcrowding concerns are worked out.

There is a reduction of both non-fatal and fatal drug overdoses when PNEPs are introduced (Chu & Elliott, 2009, p.7-8; Peternelj-Taylor, 2017, p.124; Lines et al., 2004, p.57). This coincides with how injection-related infections and abscesses decrease when PNEPs are introduced (Chu & Elliott, 2009, p.7-8; Lines et al., 2005, p.49; Peternelj-Taylor, 2017, p.124). Moreover, prisoners who participate in PNEPs are more likely to be referred to other drug addiction treatment programmes, as PNEPs are part of a continuum of drug-related programming within a prison (Chu & Peddle, 2010, p.3; Chu & Elliott, 2009, p.7-8; Peternelj-Taylor, 2017, p.125; Lines et al., 2005, p.56). One of the reasons why PNEPs are successful in bringing these positives is because they are proven effective in a wide range of institutions with various PNEP distribution methods (Chu & Peddle, 2010, p.3; Chu & Elliott, 2009, p.7-8). At its origins, individuals often argued against PNEPs and dismissed them as governments piloted PNEPs in smaller areas only; however, PNEPs are now seen within different contexts worldwide. In addition, PNEPs have employed various methods of needle distribution previously discussed, creating an adaptable environment for governments to implement PNEPs into (Chu & Elliott, 2009, p.7-8; Lines et al., 2004).

To conclude, PNEPs are proven effective at decreasing drug usage, improving costs for prisons, eliminating the issue of accidental needle-stick injuries, reducing disease rates and injection-related infections, increasing referrals of prisoners to other treatment programs, and are utilized as a part of a continuum of programming for prisoners gripped with addiction issues while imprisoned. These programs are adopted in various contexts, institutions, environments,

and areas across the globe and are effective through multiple distribution options to keep in mind the site the PNEP is introduced into. Allowing prisoners access to clean injection equipment is not equated to condoning using illicit substances. Because of this evidence, Canada transitioned towards introducing PNEPs within federal facilities.

Rise of the PNEP in Canada

Vulnerability of the Canadian Prisoner Population

Canadian prisoners suffer extreme inequities in healthcare and health status and hold significantly worse health than those within broader society (van der Meulen et al., 2016, p.3; Kouyoumdjian et al., 2016). Mortality, substance use, disease infection, chronic disease issues, and mental health concerns are significantly higher for Canadian prisoners, where all social determinants of health suffer for this group (Kouyoumdjian et al., 2016). Many prisoners suffered from lengthy abuse and early exposure to drugs and alcohol and disproportionately come from "low-income backgrounds, [who] have less formal education than the general population and [often have complex] mental health care needs" (Chu & Peddle, 2010, p.9-10; van der Meulen et al., 2016, p.3; Iftene & Manson, 2013, p.886). These people may have already neglected, or faced discrimination, from community healthcare before their imprisonment.

Depending on where a prisoner sits within an intersectional framework of oppression, their struggles may be different than other prisoners around them. Those with mental illness concerns often cite substance usage at heightened rates (Chu & Elliott, 2009, p.28). Within Canadian federal prisons, women suffer disproportionately compared to men surrounding addiction issues and mental health concerns, and Indigenous women in Canada suffer the most (Chu & Peddle, 2010, p.23; Glauser, 2013). Denying access to sterile equipment

disproportionately impacts these specific groups of prisoners, where overrepresentation is seen based on historical trauma; Indigenous peoples in Canada make up 4% of the overall population, yet over 25% of the prisoner population (Kerr et al., 2004, p.346; van der Meulen et al., 2016, p.5). Prisoners suffer *so* disproportionately that the average biological age of a Canadian prisoner is at least 10 to 15 years older than their chronological age (Iftene & Mason, 2013, p.887).

The health of a prisoner can be negatively impacted by entering the prison. There are unique factors like anxiety about what the future holds, fears of violence in prison, the stress of imprisonment and forfeiting rights, as well as isolation, cultural shock, and rampant drug use that can affect many prisoners, especially those in "recovery" (Iftene & Mason, 2014, p.887). Intravenous drug users are disproportionately imprisoned, with over 90% of intravenous drug users will enter prison at some point within their lifetime (Sander et al., 2019, p.106). Traditional strict drug law policy supported by zero-tolerance ideology means one in five prisoners are held on low-level drug offences (Sander et al., 2019, p.106; "Companion Document," 2017, p.4; Leonard, 2020, p.10; Danroth, 2018, p.121). In addition, over 70% of Canadian prisoners have a mental health diagnosis, with depression along being 50 times higher in prisons compared to Canadian communities (Chu & Peddle, 2010, p.23; Iftene & Mason, 2013, p.887). Many believe prisoners engage in denial behaviour when asked about mental health or substance use issues, yet this is *not* true; although this may not directly translate into motivation to deal with their problems, prisoners regularly report accurate rates of usage and mental health concerns (Weekes, 2004, p.6). Due to the high rates of both substance use and mental health concerns for Canada's prisoner population, tangible action began on how to push PNEPs into policy.

Court Challenges

Those pushing for PNEPs began to face legal and structural issues that prevent prisoners' usage of needles in federal prisons for non-medical purposes (Iafrate, 2015, p.27). The possession of needles in federal prison is illegal as it is labelled as "contraband" in the *Corrections and Conditional Release Act* and *Corrections and Conditional Release Regulations* (Iafrate, 2015, p.40-42). Thus, although needle exchange programs in Canadian communities were not an offence under S.462.2 of the Criminal Code, as they could distribute needles based on disease control instead of labelling this as drug paraphernalia, the policy framework of the prison system has caused issues in adoption (Weekes, n.d., p.3). In Canada, PNEPs became a legal issue that activists began to challenge surrounding how implementation could occur regardless of Canadian legislation (Weekes, n.d., p.3; "Companion Document," 2017, p.6; Chu & Elliott, 2009, p.6; Iafrate, 2015, p.40-42).

In September 2012, Steven Simons, a former Canadian prisoner, alongside the Canadian HIV/AIDS Legal Network, Prisoners with HIV/AIDS Support Action Network, Canadian Aboriginal AIDS Network, and CATIE, began a constitutional court challenge in Canada to compel CSC to provide prisoners with sterile injection equipment. They claimed that refusal to do so was a violation of the *Canadian Charter of Rights and Freedoms* under section 7 and 15, as well as under Section 86(1)(a) of the *Corrections and Conditional Release Act* (van der Meulen et al., 2016, p.4; Danroth, 2018, p.123; Chu et al., 2022, p.4; Jeon, 2020, p.31). Simons was imprisoned at Warkworth Institution in Ontario and utilized intravenous substances –and was reliant on them– to manage issues caused by a previous work accident (Jeon, 2020, p.30). When imprisoned, a fellow prisoner used his needle without his knowledge, and the individual had HCV, which Simons then contracted (Jeon, 2020, p.30). To prevent this from happening to other prisoners, Simons worked with these organizations to launch a *Charter* challenge against

CSC (Iafrate, 2015, p.41; Glauser, 2013). This was the first time the Canadian government and CSC were vulnerable to legal challenges in relation to denying prisoners access to sterile syringes, as Simons could prove he contracted HCV as a direct result of the prison environment.

The lawsuit argued that failure to introduce PNEPs goes against the right to healthcare prisoners are afforded under Section 86(1)(a) of the *Corrections and Conditional Release Act*, as well as the *Charter* under Section 7 that protects a prisoner's right to life, liberty and security; section 12 that protects against cruel and unusual punishment; and section 15 that protects discrimination of peoples (Jeon, 2020, p.31). To justify infringement of the *Charter* by policy, law, or action, the government must prove the following:

1. The objective of the government measure is of sufficient importance to warrant overriding a constitutional right, meaning that, at a minimum, it must relate to pressing and substantial concerns.
2. That the government measure is rationally connected to achieving this objective, meaning it is not arbitrary, unfair or based on irrational considerations.
3. That the government measure impairs as little as possible the constitutional right(s) in question.
4. That the harm done by limiting the right does not outweigh either the importance of the measure's objectives or the benefits of the measure – which is argued not to be proven in the case of PNEPs.

(Lines et al., 2004, p.18-36).

The *Corrections and Conditional Release Act* affords prisoners with a standard of healthcare equivalent to that found in Canadian communities, with Section 86 stating that the

government must “provide every inmate with essential healthcare and reasonable access to non-essential healthcare that conforms to professionally accepted standards” (pp.14-15). This is important as professionally accepted standards in Canada argue for PNEPs. Section 7 of the *Charter* states that “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.” For prisoners, their life, liberty and security depend upon CSC and prison authorities, wherein CSC must act as the means to mitigate risks to these three aspects (Chu & Elliott, 2009, p.13). Section 7, alongside Section 3 of the *Charter,* establishes the purpose of the *Corrections and Conditional Release Act*, which is to maintain prisoner and public safety; therefore, CSC argued to prohibit needles as a means to maintain safety within the prison (Iafrate, 2015, p.48). Yet, this prohibition directly affects prisoners’ lives, liberty and security based upon needle sharing.

For Section 7 to be infringed upon, it must be demonstrated there is:

1. An interest protected by the person's right to life, liberty and security.
2. A “deprivation” by Canada concerning that interest.
3. That this deprivation is contrary to the principles of fundamental justice.
4. That all prisoners would benefit equally from the protection.

If Section 7 is breached, the burden shifts onto the government to prove that the negative impacts of whatever law or policy is “proportionate to the pressing and substantial goal of the law in furthering the public interest under Section 1 that empowers the government to limit *Charter* rights if limits can be justified within a democratic and free society” (Iafrate, 2015, p.50). In this case, the proportionality of the law would most likely be upheld if the government could rationally connect the government's goals to the policy, illustrate how the law minimally affects

prisoners' section 7 rights, as well as if they could present the proportionality of the adverse effects to the law (Iafrate, 2015, p.51). Often, it is imperative to have proof that legislation is overbroad and to illustrate how individuals are not just minimally affected (Iafrate, 2015, p.54). As such, it is necessary to reveal if prisoners' life, liberties, and security are at risk without the PNEP, as was argued during this court challenge.

In sum, these three fundamental rights of life, liberty and security were argued to be infringed upon. It was argued that the right to life was endangered through lethal consequences of sharing a dirty needle and contracting a blood-borne illness. The right to liberty was argued to be infringed by the punitive consequences associated with possessing a clean needle that is "contraband". And, the right to security was argued to be endangered by the increased likelihood of a prisoner contracting an infectious disease (Iafrate, 2015, p.43).

A pivotal case –but not in a prison context– from British Columbia was referenced for the right to life. In *Canada (Attorney General) v PHS Community Services Society*, the government argued that the threat to life regarding intravenous usage results from an individual choice instead of a state action, but this was rejected by the British Columbia Supreme Court, which noted that addiction is an illness; therefore, the Supreme Court of Canada upheld this decision where it was pointed out that closing safe injection sites infringes section 7 of the *Charter* (Iafrate, 2015, p.42; Chu & Elliott, 2009, p.18). The Court upheld that a law that prevents access to healthcare services preventing death infringes the right to life, and because of the precedent set in *Canada (Attorney General) v Bedford,* section 7 of the *Charter* can be challenged with causal connection (Chu & Elliott, 2009, p.18; Iafrate, 2015, p.42). Due to the principle of equivalence, CSC's failure to provide access to sterile needles in federal prisons has a causative link to this case, wherein legal scholars argue this threatens the right to life and therefore violates section 7.

The right to liberty is "afforded [to] individuals in respect of matters that can be properly characterized as fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and independence" (Chu & Elliott, 2009, p.14). As drug usage rates are high regardless of access to sterile needles, denying prisoners access to this knowing it will not increase rates of using drugs and therefore "crime rates" puts prisoners liberty at risk by limiting access to necessary health services, but are labelled as "contraband" where possession brings punitive consequences (Chu & Elliott, 2009, p.15).

The right to security for a Canadian prisoner is found within the *Corrections and Conditional Release Act* regarding the obligation CSC has surrounding providing essential healthcare that will help with the reintegration of the individual into the community post-release (Chu & Elliott, 2009, p.16). Chu & Elliott describe how "imminent deprivation" of security of the person applies for PNEPs, which means a violation of section 7 can be established on something that may not have occurred but *could* occur in the future (p.16). As evidence outlines how the absence of sterile needles directly increases the risk of HIV and HCV because of outbreaks, "imminent deprivation" is argued in the case of PNEPs (Chu & Elliott, 2009, p.17).

Section 12 delineates how Canada must protect against cruel and unusual punishment of citizens (Lines et al., 2004, p.18; Chu & Elliott, 2009, p.12). To breach this right, refusal to instate PNEPs must be shown to be "grossly disproportionate for the offender; so excessive as to outrage standards of decency; and having regard to all contextual factors" (Chu & Elliott, 2009, p.33). Effectively, denying people in prison the right to protect themselves against HCV and HIV while community members can through needle exchange programs illustrates treatment that is contrary to minimum standards of decency and care, where CSC's failure to launch PNEPs is

"grossly proportionate to any of its purported aims" due to the risk of deadly illness (Chu & Elliott, 2009, p.34).

Lastly, section 15 of the *Charter* defines that every individual is equal under the law and has the right to equal protection without discrimination (Lines et al., 2004, p.18; Chu & Elliott, 2009, p.21). For there to be a violation of section 15, there must be "differential treatment or failure to take into account prior disadvantage; this must be based on a ground that is either enumerated explicitly in s.15 of the *Charter* or is analogous to the listed grounds; and this must constitute discrimination" (Chu & Elliott, 2009, p.23). As prisoners are a marginalized population that often faces discrimination, failure to provide equal protection to this population is an issue as legal scholars argue section 15 is breached as other populations in Canada can access sterile needles.

Canada instates PNEPs

The government failed to regard these claims until the change in government from the Conservative Party to the Liberal Party, where in January of 2017, the government offered to participate in mediation discussions surrounding the topic of PNEPs; yet, a week before the mediations were set to begin, the government withdrew (Jeon, 2020, p.32). Four months before the next hearing date in May of 2018, the government announced its plans to implement PNEPs at all federal prisons – a complete shock to the plaintiffs (Jeon, 2020, p.34). On May 14th, 2018, Ralph Goodale, the Minister of Public Safety and Emergency Preparedness, officially announced the national rollout (Webster, 2018, p.2095; Leonard, 2020, p.3). The first PNEPs were planned to open at Grand Valley in Kitchener, Ontario, and at Atlantic Institution in Renous, New Brunswick (Peternelj-Taylor, 2018, p.122; Leonard, 2020, p.3). The government only announced

implementation for federal prisons in Canada that are operated by CSC without any indication surrounding territorial or provincial facilities (Peternelj-Taylor, 2018). Although a complete national rollout was announced, stagnancy occurred; by 2022, only nine institutions had PNEPs (Chu et al., 2022, p.6). Yet, this announcement was significant, as adopting a PNEP in Canada marked the first program of its kind in North America (Peternelj-Taylor, 2018, p.123).

The government argued that PNEPs would be adopted because of evidence that PNEPs increase safety for prison staff, improve prisoner access to drug treatment, decrease needle sharing, reduce transmissions of blood-borne infections, reduce the occurrence of skin infections, and increase opportunities for health promotion and opioid agonist therapy access (Webster, 2018, p.2095). In addition, it was argued they bring Canada closer to upholding national standards like the Canadian Drug and Substance Strategy, as well as international obligations from the United Nations Office on Drugs and Crime on instating PNEPs as a part of a comprehensive harm reduction prison plan (Webster, 2018, p.2095; Leonard, 2020, p.3). However, when details emerged about how the government would instate PNEPs, the groups involved in arguing for PNEPs began to criticize the government's decision because of deficiencies seen in their rollout plan that the plaintiffs argued would cause Canada to still be inconsistent with professionally accepted standards for PNEP programs as well as essential public health principles (Chu et al., 2022, p.7). The announcement was made without any consultation with those involved in the legal proceedings or with prison staff, where the plaintiffs continued with the case to claim instead now that the existing program the government implemented is unconstitutional under section 86(2) of the *Corrections and Conditional Release Act* (Jeon, 2020). The plaintiffs argued the program is not in accordance with professionally accepted standards which "require that access be provided by means designed and implemented

as a health service under the direction of CSC health services instead of the protocols that involve security staff" (Jeon, 2020, p.34-36). Chu et al. (2022) explains that one of the most significant issues with the announcement of the rollout of PNEPs concerned the confidentiality of prisoners, which would be violated through subjecting prisoners to assessments for the PNEPs based on security instead of clinical need. Additionally, Canada implemented daily visual inspections for PNEP participants that contrasts accepted practice elsewhere.

However, in April 2020, Justice Belobaba of the Ontario Superior Court ruled against the applicants and for the government, as he argued overturning the program is premature because the rollout is incomplete (Jeon, 2020, p.36). Justice Belobaba also said the constitutional argument is rendered moot as the strict separation between health and security staff is not required under this law. He noted that although it may be important, it is not *necessary* (Jeon, 2020, p.36). Thus, as the program was new and not fully introduced, it was argued the rollout must continue as the plaintiffs failed to provide enough evidence on how separation between health and security staff is *required* under law.

How Canadian PNEPs are run in Canada

In Canada, prisoners' participation in PNEPs is voluntary. Prisoners are required to complete a four-step application and assessment process before participating. The process begins with a prisoner submitting a request to visit health services, where a nurse meets with the prisoner to assess if they will complete an application on the prisoner's behalf to the assistant warden of operations (Chu et al., 2022, p.7; Leonard, 2020, p.6). Next, the assistant warden of operations conducts the Threat Risk Assessment process, determining if the prisoner's participation in the PNEP is of appropriate security risk for the prison (Leonard, 2020, p.6; Chu

et al., 2022, p.7). After this, the deputy warden or warden of the prison must provide a decision and return the threat risk assessment to health services within ten days of the initial prisoner request (Leonard, 2020, p.6; Chu et al., 2022, p.7). During this time, the prisoner remains in contact with health services to work on accessing other harm-reduction tools in the meantime (Leonard, 2020, p.6). Important to note is there are no clear guidelines to determine when someone is ineligible or eligible for the PNEP (Jeon, 2020, p.35). If approved, those who participate must sign the PNEP Information and Contract form outlining behavioural expectations, and if this is breached, they face expulsion from the program (Leonard, 2020, p.6; Chu et al., 2022, p.7). If a prisoner is removed, they may still reapply (Leonard, 2020, p.6). Those who are approved receive a kit that contains "a 1-ml 27-gauge 0.5-inch sterile needle, sterile cup, sterile blister pack of 5 dense cotton filters, a sachet of sterile ascorbic acid (vitamin C) and 3-ml plastic ampoules of injection grade sterile water," (Leonard, 2020, p.7). The kit becomes a part of the prisoner's personal effects, where all items remain visible within the prisoner's cell when not in use, as the equipment is subject to daily checks by correctional officers (Chu et al., 2022, p.7; Jeon, 2020, p.35).

CSC has made improvements surrounding critiques by scholars on PNEP programming. In 2021, CSC updated promotional material on PNEPs and now provides vein finders and safer snorting supplies at this service (Zinger, 2022). In addition, naloxone is now accessible at each Canadian prison and is given to prisoners when released (Zinger, 2022). The overdose prevention site that exists at Drumheller Institution extended its hours to decrease the opioid substitution therapy waitlist, and CSC promised to improve the safe return of used needles in general (Zinger, 2022). The entity further noted how external evaluations and reports would continue to be

utilized by CSC but that many changes will not be seen for a while due to the impacts of COVID-19 (Zinger, 2022).

Chapter 6: Findings to the Reality of PNEP Delivery: Canadian Focus

What successful PNEPs need

The reality of PNEP delivery frequently differs from what is written in policy. However, there are a few definitive characteristics of successful PNEPs. These characteristics are drawn from the final data set of literature that echoed similar arguments on how PNEPs are best implemented. These include strong leadership and correctional officer involvement, high confidentiality and trust in the tool by prisoners where no further discipline is enacted, sufficient access to the number of needles necessary, and the value of prisoner involvement, all while maintaining the PNEP as part of a continuum of programming within a prison. These characteristics are noted as important within successful PNEPs surrounding decreases in overdose rates, and anecdotal commentary from stakeholders, where individual prison systems may have their own goals surrounding targets for the PNEP, yet all encapsulate emphasizing these characteristics.

Strong leadership and correctional officers backing of the program leads to an increase in prisoner involvement in PNEPs (Lines et al., 2004). As PNEPs are controversial, as well as regularly seen as unorthodox based on their juxtaposition to traditional abstinence programming, there must be strong leadership backing of the program for prisoners to feel safe to participate (Lines et al., 2005, p.59). Regarding correctional officers, as mentioned earlier within the thesis, many have fears that PNEPs increase injection rates and encourage drug use, which is viewed as inconsistent with their primary job duties of drug interdiction (van der Meulen et al., 2018, p.304). In effect, many of the negative opinions correctional officers have towards PNEPs change once correctional officers receive education on the positives of harm reduction and their

role in this type of programming (van der Meulen et al., 2018, p.304). It is crucial that educational training occurs before instating a PNEP and not just afterwards. Bottom-up processes for PNEPs wherein staff members are involved at the base instead of a top-down process of leaving it up to the direction of the government prove increasingly successful in changing staff opinions and preconceived ideas of PNEPs and harm reduction (Lines et al., 2004, p.54).

Prisoners often believe correctional officers are out of touch with harm reduction information as well as the realities of being a drug user. Prisoners note how without CSC broadly mandating this change and pushing for a progressive approach, stagnancy will occur (van der Meulen et al., 2018, p.304). Thus, original endorsement from high-up leadership is imperative for a successful PNEP. Lines et al. (2004) note that strong leadership demonstrates an understanding of the legal obligations of prison systems and the role of healthcare for prisoners while imprisoned, knowledge about the realities of existing PNEPs, and a commitment to make PNEPs responsive to the wide range of needs among the drug using prisoner population (p.67). This is why it is vital to include both prisoners and prison staff in the development of these programs. Endorsement at the highest levels can occur by senior officials responsible for overseeing prisoner healthcare endorsing PNEPs, prison staff pushing for prisoners to visit PNEPs, support from the head of the prison in the rollout of the program, support from outside physicians that work in/on prisons, and a constant revisiting of the positives and benefits for staff of these programs that may be initially unclear to them (Lines et al., 2005, p.59).

In addition to the importance of correctional officers and overall staff endorsement of PNEPs, confidentiality and trust are imperative to the success of programming. The number one concern for prisoners is the adverse effects the program could potentially have for them. This concern is primarily derived from confidentiality and trust issues prisoners have with prison

staff, where many concerns further surround any discipline or punishment they may incur. These concerns come from the difficulty of upholding the confidentiality of prisoners that needle exchange programs in communities uphold, but that the prison environment makes impossible to sustain. As absolute confidentiality is virtually impossible, preserving the confidentiality of prisoners who use the PNEP to the greatest extent possible is essential (Lines et al., 2005, pp.59-60). This can be done by dispensing machines implemented in areas prisoners are housed, as this is the closest and most private area for them. If person-to-person methods are used, these must be instated in confidential areas (Lines et al., 2004, p.54). Uptake for the PNEP is seen when the distribution method becomes increasingly secretive and private (Lines et al., 2004, p.54).

Sufficient access to needles is also necessary for a successful PNEP. Without materials, the PNEP is ineffective for achieving its goals. Many PNEPs in Canada and abroad face issues with supplying the right number of materials. In several contexts, this is improved by increasing the number of dispensing machines within an institution if this is the method. Where a hand-to-hand/person-to-person method is chosen, there must be an increase in selecting additional discreet locations to give out materials which is often tricky (Lines et al., 2005, p.60). This is primarily difficult as the majority of prisons are fully surveyed with cameras, where discreet locations fundamentally do not exist within the structure of the prison. This problem is best mitigated by peer-based structures as the workers live in the same units where the needles are distributed, so they can access extra when needed. In addition, peer-based structures aid in this issue as they have the potential to allow prisoners 24-hour access to materials, decreasing the burden in the case of a PNEP having structured hours (Lines et al., 2004, p.55).

It is also necessary for PNEPs to be a part of a service continuum. PNEPs can not exist alone, where they exist as a part of harm reduction programming within prisons, and not in

isolation. It is necessary to have other harm reduction tools and techniques available to prisoners, where PNEPs can assist with decreasing burdens, but not on their own. This is primarily because the service continuum that PNEPs are part of must be responsive to individual prisoners needs, where care is looked at intersectionally regarding where a prisoner sits with their identity in relation to also intravenously using drugs.

In sum, PNEPs must be part of a continuum of harm reduction programming within a prison. The involvement of both staff and prisoners is imperative for their success. The actual method of distribution becomes less important than whether or not the PNEP is effective in meeting the needs of the prisoner population it serves. It is also necessary for PNEPs to exist as part of a continuum, where in effect, this can best address individual needs of prisoners to provide sufficient care.

Leonard's Study

CSC commissioned Dr. Lynne Leonard in 2020 to evaluate Canada's PNEPs, the structure of PNEP programming, rates of participation, and to provide recommendations for improvement, barriers to access, and assess the status of harm reduction services in Canadian federal prisons (Chu et al., 2022, p.6). This was done to evaluate existing PNEPs in Canada so as to support the best rollout of PNEPs to *all* CSC institutions– something unique to Canada's implementation (Leonard, 2020, p.3). For the evaluation, Leonard looked at the sustainability and feasibility for both implementation and operationalization of the PNEP as well as the degree to which prisoners accepted the program. Leonard analyzed data in relation to security and safety concerns such as needle stick injuries and assaults on staff or prisoners, as well as staff and prisoner opinions on PNEPs (Leonard, 2020, p.10). This was done through semi-structured

confidential, anonymous qualitative interviews with a range of stakeholders such as correctional officers, health services staff, as well as prisoners including those who participated in the program, were asked to or chose to leave the program, or were awaiting approval to join the program (Leonard, 2020, pp.10-11).

Leonard (2020) derived a few conclusions from the evaluation:

1. Low rates of prisoner participation were observed across the PNEPs instated.
2. Access or barriers to access other harm reduction services like opioid agonist therapy, safer snorting supplies, Naloxone, and safer tattooing coincide with PNEP issues.
3. There are barriers to the PNEPs in place: lack of adequate preparation for implementation, difficulties in exchanging used needles for sterile needles, difficulties with PNEP eligibility criteria as well as kit storage and removal, the Parole Board of Canada and the worry of needle stick injuries.

These conclusions are important as they echo similar issues noted within international evidence on the effectiveness of PNEPs. However, Leonard (2020) also provided further information, by noting how Canada's individual approach to PNEP programming is important, further reflected by the example of the involvement of the Parole Board of Canada.

The prison environment in Canada directly affects the success and ability of PNEPs to serve their needed population, where PNEPs are one of the most controversial harm reduction initiatives within prisons. Often, they are framed as incompatible with the prison environment, since "security *always* trumps other concerns" (Iftene & Manson, 2013, p.886). As prisons are designed to protect against the illegality of drugs, opponents to PNEPs argue that the program is

indicative of the organization's failure of being unable to stop drugs from entering the prison as well as CSC's inability to "rehabilitate" drug-dependent prisoners (Lines et al., 2005, p.50; Small et al., 2005, p.839). This echoes discourse about harm reduction within the broader Canadian community, particularly in conservative areas (such as Alberta) and when the conservative governments are in power. Since the ability for prisoners to access needles 24 hours a day conflicts with the many aspects of the prison environment, modifications to community-based needle exchange programs are necessary to increase the likelihood of PNEP success (Kerr et al., 2004, p.353).

A recent report by the Correctional Investigator Ivan Zinger argued that CSC must revisit its PNEPs by consulting prisoners and staff to increase confidence and trust in the program, as well as to revisit international examples of PNEPs that are successful. At the time of Leonard's evaluation, only 56% of institutions with a PNEP had active participants, and it became apparent why participation rates are low (Leonard, 2020, p.16). Through the interviews, Leonard discovered that the prisoners she interviewed were often unaware that PNEPs even existed at their institution, even if they intravenously used drugs (Leonard, 2020, p.16). Interviews with staff revealed that they believed the reason for low participation rates in PNEPs were from the existence of other programs, such as opioid agonist therapy, that support intravenous drug users, which was somewhat supported by the fact that institutions that had high rates of participation in opioid agonist therapy had lower rates of participation in PNEPs (Leonard, 2020, p.17).

The study also revealed that some prisoners did not want PNEPs instated and, therefore, would not use them. Many participants explained that prison is a place where people should "get clean" and that a PNEP would upset the existing environment of the prison (Leonard, 2020, p.17). Some prisoners with substance use issues working to remain abstinent from drugs

described that PNEPs introduced temptations for them and further explained being triggered by needles or fearful that they would be placed in a cell with someone accessing the PNEP (Leonard, 2020, p.17). This was especially demonstrated in interviews with prisoners from institutions with mother and child units, who were opposed to the idea as drug usage would be open around the children (Leonard, 2020, p.18). Leonard (2020) argued that, within Canada, CSC must distribute PNEP promotional materials that are accurate depending on which institution they are displayed at, as well as be proactive in explaining the program before it is introduced to decrease inaccurate beliefs from misinformation (Leonard, 2020, p.26). Lack of knowledge was discussed at length in the report and within other academic literature that highlights how sufficient information for prisoners and staff is necessary to increase confidence and trust in the program, which might increase participation (Leonard, 2020; Chu et al., 2022, p.13).

Leonard (2020) noted a lack of adequate preparation for the rollout of PNEPs alongside the inconsistency of implementation for the program within Canada. During stakeholder interviews, all levels of institutional staff explained their discontent with the PNEP implementation process within their institution (Leonard, 2020, p.19). Staff often felt that optimal implementation did not occur as they did not have a real opportunity to absorb and comprehend essential information about the program and felt the program was rushed to get implemented (Leonard, 2020, p.19). This became a barrier as staff could not "embrace the health protection underpinnings of the program" which often led to resentment or lack of interest in the program/endorsing the program (Leonard, 2020, p.19). Prisoners also explained that they were unable to comprehend even the basics of the programs, especially in relation to their own individual objectives and casefiles (Leonard, 2020, p.19). And, once the PNEPs were instated,

there were inconsistencies in their implementation and operation. This affected PNEP participation rates and revealed a barrier to access through "the inconsistency in access to the program dependent on living arrangements, requirements for kit storage and display, and circumstances under which a PNEP kit can justifiably be removed" (Leonard, 2020, p.26). In effect, it is necessary to disseminate or create "one generic, standardized Standing Order Document to ensure consistency of process in PNEP implementation and operation and consistency of care across all federal institutions" (Leonard, 2020, p.26).

The confusion surrounding the involvement of the Parole Board of Canada was a significant concern raised by prisoners during the interviews. Prisoners questioned if their involvement in PNEPs would be reported to the Parole Board of Canada, and if this was the case, how this would be viewed, positively or negatively, by the parole board (Leonard, 2020, p.22). Prisoners were unclear if their involvement would appear as them working towards recovery and benefit their file or if they would be viewed as using illegal drugs and directly violating their conditions. The interviews showcased how the general belief held by prisoners is that involvement in PNEPs is seen as unfavourable by the parole board; therefore, prisoners were less likely to participate because of this perceived belief (Leonard, 2020, p.22-23).

Parole officers were consulted during the planning and development of Canadian PNEPs and were directed by the government to view their client's participation in a PNEP in the context of the prisoner's "personal values and judgement" (Leonard, 2020, p.23). However, there was no binding directive set by CSC or the government on what this looks like in execution (Leonard, 2020, p.23). This led to confusion among staff, parole officers, and prisoners about what their role should be in relation to reporting people's participation in PNEPs. Since the Parole Board of Canada decides whether a prisoner receives parole based on programs they complete, how

participation in PNEPs is viewed and handled are critical issues. Parole officer's views about their clients' participation in PNEPs, as well as their resulting parole recommendations, could be shaped by their beliefs about harm reduction services, including whether they support or oppose PNEPs. Furthermore, the Parole Board of Canada's interpretation of PNEP participation will have significant impacts on parole decisions, including whether a person is released and the nature of the conditions of their release. Such variability and discretion leaves PNEP programming in Canada permeable to different interpretations, posing a challenge for increasing trust and confidence amongst prisoners in PNEPs.

The COVID-19 pandemic impacted PNEP rollout and participation. During COVID, prisoners could not access PNEPs, and overall drug usage increased. One prisoner noted how "…there were more drugs in once the onset of COVID than [they] had seen in that prison in [their] entire 12 years" (Chu et al., 2022, p.14). As healthcare visits were also limited, and all healthcare procedures changed due to the unprecedented nature of the pandemic, these restrictions revealed flaws in PNEP programming as the ability to access sterile needles were taken away, as well as the availability of healthcare and overall staff. Prisoners noted how, during this time, injection equipment was increasingly shared, including the actual PNEP needle kits (Chu et al., 2022, p.14). In addition, urinalysis tests came back increasingly positive for illicit drugs after 2019 because of the surge in demand for drugs to deal with the severe isolation (Zinger, 2022). This was seen alongside CSC's inability to maintain its rollout schedule of PNEPs. PNEPs were planned to be established in all 43 federal prisons by August 2020, yet they were not expanded and remain only established in the institutions that piloted the program (Jeon, 2020, p.41).

Leonard's 2020 report is the first example of literature describing how PNEPs operate within Canada. Although concerns about needle-stick injuries and concerns were still of utmost concern, Leonard's study refuted this as there were no reports of needle-stick injuries in relation to Canadian PNEPs (echoing what is found internationally) (Leonard, 2020, p.22). Overall, the study found that "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" were of primary concern (Chu et al., 2022, p.7). COVID-19 exposed how PNEPs are permeable to broader issues that may threaten their viability and continuance.

Developments since Leonard's study

Since Leonard's study in 2020, the landscape of PNEPs looks slightly different in Canada. As of 2022, the number of participants at PNEPs has risen from 42 to 53 (Chu et al., 2022, p.7). CSC considered Leonard's report in the 2021 Annual Report of the Correctional Investigator, where CSC updated promotional information on PNEPs and increased the availability of harm reduction tools by implementing safer snorting supplies and vein finders (Zinger, 2022). Moreover, CSC communicated that it would increase staff training about PNEPs so that they could develop opinions on harm reduction programming based on evidence and fact instead of stigma (Zinger, 2022). CSC also expanded health resources to increase the recruitment of psychiatrists, nurses, and other health professionals (Zinger, 2022). In addition, the Annual Report by the Office of the Correctional Investigator in 2021 noted how CSC now provides naloxone at each prison site and is also working with the national opioid agonist therapy Medical Advisor to decrease waitlist times (Zinger, 2022). CSC lastly noted that they would revisit

Commissioner's Directive 585 to best align with the Canadian Drugs and Substances Strategy, but no details were specified (Zinger, 2022).

As a result of Leonard's report, CSC stated that external experts would be continually consulted on PNEPs. However, the organization noted how that it would be impossible to meet the standards set out in the 2021 Annual Report. The Annual Report addressed stagnancy in the rollout of PNEPs and argued for a total expansion of PNEPs and overdose prevention sites within 12 months; however, CSC stated that because of ongoing impacts from COVID-19 and the lack of consultation –in their opinion– with stakeholders on where to begin rollout, meeting this goal would be improbable (Zinger, 2022). COVID-19 had a massive impact on this program, as it suspended the national rollout as well as increased drug usage within prisons (Zinger, 2022). As Leonard failed to address the shortcomings of PNEPs in relation to confidentiality, as well as the difficulties in the eligibility criteria regarding the specific security-orientated Threat Risk Assessment, Chu et al. (2022) published a more recent piece on the gaps in Leonard's report (Chu et al., 2022, p.7).

Chu et al. (2022) conducted a study examining prisoners' experiences with PNEPs after Leonard's study (p.8). Participants included those who were released post-program implementation, and from one of the federal prisons listed on CSC's website as having a PNEP (as of September 2021) (Chu et al., 2022, p.8). The former prisoners were questioned on the frequency and type of drug use that occurred in federal prison, their own knowledge and/or experience of the PNEP at their institution, their perspectives on different syringe distribution models, and their own recommendations for improving the PNEP.

Of the 21 participants, 11 injected drugs while imprisoned (Chu et al., 2022, p.8). Most participants estimated that between 60% to 80% of people in prison used drugs, with the majority selecting the method of snorting substances (Chu et al., 2022, p.10). Participants reported common themes about PNEPs, such as how the absence of such a program promoted regularly sharing of injection equipment as well as contributed to the using of injection practices to conceal drug use in prison (Chu et al., 2022, p.10). The study echoed similar findings from an early study (Chu & Peddle, 2010). Participants in both studies –although twelve years apart– noted that providing sterile needles would decrease disease and stop sickness. They also described that drugs inevitably enter the prison and usage rates are high, so distributing sterile needles would protect everyone, but that anonymity would be of utmost concern (Chu & Peddle, 2010, p.35; Chu et al., 2022). In the 2022 study, prisoners elaborated that needle stick injuries were caused not from the PNEP, but instead during random cell searches in attempts to hide these from staff (Chu et al., 2022, p.10). The prisoners offered the perspective on how prisoners who inject drugs would much prefer to keep sterile needles for their own usage instead of a weapon and noted how needles exist anyways and could pose this threat, so they questioned why this threat is only discussed in relation to drug usage and the role stigma has in this (Chu et al., 2022). Prisoners from the study shared how they were sometimes unable to access the PNEP and were deterred from applying for fear of punishment, which were the primary reasons for homemade injection materials were chosen instead (Chu et al., 2022, p.10).

Recommendations

Evidently, needle exchange programs in communities have to be adapted to respond to the prison context. For needle exchange programs to work in prisons, there must be strong leadership and correctional officer involvement, high confidentiality and trust in the program by

prisoners, sufficient access to materials, as well as have PNEPs as part of a continuum of programming. However, issues arise due to the construct of the prison. For example, total and complete confidentiality for prisoners in PNEPs is improbable as the prison still must control its population and the safety of this population as they have forfeited this right entering the prison. Thus, although this is one of the largest issues, there may be concerns that are simply insurmountable in a prison context for implementing harm reduction principles in comparison to the community. However, there are specific recommendations to improve PNEPs in Canada. Utilizing the constant comparative method, nine primary recommendations were seen during data collection from the final data set. This thesis argues PNEPs in Canada can be strengthened through standardizing how the PNEP rollout process works in light of COVID-19, reviewing how PNEPs can be hybrid or multi-modelled and adapted based upon which Canadian prison they reside in, and fixing the anonymity and confidentiality concerns prisoners have to increase the trust of the program; moreover, Canada must mitigate the administrative barriers to accessing a PNEP, continue to rollout other harm reduction supplies through the PNEP, decrease wait times for opioid agonist therapy, as well as recognize the imperative role of staff and leadership for PNEPs. Furthermore, there must be an increase of education on the program for both staff and prisoners, while addressing broader concerns like stakeholder considerations and how we view drug use as a society. Lastly, data collection on this subject must continue, and research must be updated as the program is new, which this thesis foremost does.

As mentioned earlier, the COVID-19 pandemic stagnated progress in the rollout of PNEPs in Canada. Although van der Meulen et al. (2016) stated in 2016 that PNEP access should not be restricted or blocked in light of a prison lockdown, inevitably, prisons were unprepared for the effects of COVID-19 on the PNEP program (p.29). Currently, there is no longer a concrete

plan or date on when PNEPs would be nationally rolled out because of the pandemic. Therefore, there must be a revisit to the original timeline in light of the pandemic to evaluate when the rollout can actually occur. Standardizing the rollout process at the beginning can assist with increasing the likelihood of a timely rollout. Standardization occurs through delineating specific policies all Canadian prisons must uphold with PNEPs, while also considering the different models and how to standardize delivery based on different prison structures. As there is feedback on current PNEPs in Canada, these evaluations can be reviewed in order to standardize a rollout. However, alongside standardizing a timeline for PNEPs, it is imperative to investigate how PNEPs should be hybrid or multi-modelled and adaptable based on the prison context it resides. As prisoners have vastly different needs, at least two PNEP models should be available at each prison, with one model focusing on anonymity concerns (such as dispensing machines) and one increasing face-to-face interaction (van der Meulen et al., 2016, p.31). The greatest success is seen at institutions with more than one model of a PNEP.

For prisoners, recommendations come in the form of fixing confidentiality concerns and improving access to the PNEP by decreasing administrative barriers while increasing their access to opioid agonist therapy and other harm-reduction supplies. Anecdotal evidence from prisoners suggests that removing administrative barriers to PNEP enrollment is necessary, as prisoners regularly view the application as confusing as well as burdensome (Chu et al., 2022, p.14). This includes the recommendation to remove the Threat Risk Assessment, as this is the primary barrier prisoners face (Chu et al., 2022, p.7,17). In addition, this coincides with how the administration must improve the turnaround for prisoners to be able to access a PNEP, as many prisoners have waited weeks for a response on their application, wherein provisions delineate how this is an unsuitable amount of time (Chu et al., 2022, p.15).

The confidentiality of PNEP participants is regularly labelled of utmost importance, which can be challenging for a prison context trick. In prisoner voice studies, anonymity and confidentiality were noted as the number one concern with the PNEP rollout (Chu et al., 2022, p.14). Therefore, enhancing trust can be done by ceasing daily visual inspections of PNEP kits, providing a more discreet method of presenting the kit as well as disposing of needles, as well as limiting access points to areas least likely or not on camera(s) (Leonard, 2020; Chu et al., 2022, p.17). Prisoners further note that correctional officers have methods of identifying PNEP participants even if they are not privy to the information, which they believe is done through communications of medical staff to the security staff. This affects trust in the PNEP program and participation rates since prisoners may choose to intravenously use outside of the PNEP in order to avoid this identification (Chu et al., 2022). Participants also noted how they believed increased surveillance and room checks occurred once they joined the program. It is imperative that staff uphold, and prisoners are aware of, regulations confirming that PNEP participants are not to be subject to any discipline or surveillance because of their program participation (Chu et al., 2022, p.5,19). In addition, prisoners who apply to participate in PNEPs should also not be subjected to increased urinalysis, which was the experience of one study participant (Chu et al., 2022). The role of community-based harm reduction workers providing care is one solution to mitigate these concerns. When these workers are tasked with PNEP care, trust improves as they are more likely to preserve confidentiality and not share personal information about prisoners between themselves (Chu et al., 2022, p.16). In addition, trust can be improved through the potential of a proxy person collecting PNEP kits for participants (Chu et al., 2022, p.12). Prisoners fear that accessing a program that directly contravenes CSC's zero-tolerance strategy CSC upholds, where

CSC must inform prisoners it is aligned with harm reduction policy to improve the trust and transparency of the program.

Jeon (2020) summarizes these concerns in light of other PNEP programs found worldwide. To begin, PNEPs in Canada lack confidentiality, accessibility, and separation from disciplinary measures based on CSC's justification of their threat-risk model, lacking critical elements found in successful PNEPs elsewhere (Jeon, 2020, pp.37-38). For accessibility concerns, the security-orientated program should be turned away from security-staff involvement and towards medical-staff involvement, where if a participant is rejected, there is clear criteria and explanation for why, as this does not currently exist in Canada (Jeon, 2020, p.38). This means Canada should shift PNEP program philosophy and practices away from a security-orientation towards a health-orientation, echoing arguments on how prisoner health is a public health concern. Trust is increased if staff delivering the program are health staff compared to correctional staff, where the need for clearer admission and discharge criteria for PNEPs is necessary as many prisoners are unsure why they are limited in accessing the program. Moreover, as prisoners in Canada are verified visually, this decreases participation rates, whereas international models of PNEPs have shown the least likelihood of success if intrusive inspections take place (Jeon, 2020, p.38). As PNEPs are supposed to be a healthcare measure, unless a specific security concern is not met by a prisoner, they should be able to participate and have no fears of further discipline when they access materials.

PNEPs would be increasingly successful in Canada if they continue to roll out other harm-reduction supplies, specifically through improving access to snorting materials and naloxone. These materials are increasingly accessible across Canadian prisons since 2019, yet PNEPs can be a venue to diversify the opportunities for accessing harm reduction materials and

allow prisoners to access them even if they do not use a needle (Leonard, 2020, p.27; Chu et al., 2022, p.15). Foremost, due to the opioid crisis, naloxone has become an important tool in assisting with overdoses as it rapidly reverses overdoses, decreasing the likelihood of death (Leonard, 2020, p.28). In addition to the further rollout of naloxone, Canada must improve the availability of opioid agonist therapy in prisons, which directly affects PNEP participation. In the majority of Canadian institutions, there are significant waiting lists for prisoners to access opioid agonist therapy who meet all of the criteria necessary, which often prompts prisoners to continue using drugs throughout this wait time, posing health threats to other prisoners (Leonard, 2020, p.27). The College of Family Physicians of Canada states that opioid agonist therapy within prisons is one concrete, effective intervention at decreasing the transmission of blood-borne infections and recommend access to this evidence-based program without delay (Leonard, 2020, p.27-28). Increasing access and decreasing wait times for opioid agonist therapy could decrease the demand for PNEPs as opioid agonist therapy offers support for people who would like to stop or reduce their use of unregulated illicit drugs.

Leadership and staff play an essential role in PNEP success. Correctional officers are imperative for program success and significantly impact if a prisoner receives further discipline, warranted or not. Leadership from influential Ministers and government individuals has also been necessary for the rollout of PNEPs, as this is where change and progress were seen surrounding the transition from the Conservative Party to the Liberal Party (Watson, 2014, p.920). The role of policy, training, and supervision of staff surrounding PNEPs is necessary to ensure staff attitudes have a minimal impact on the implementation of this essential service. Attitudes of staff regularly shift from resentment, fear, or anger toward the importance of the program in upholding the health of both prisoners and staff (Peternelj-Taylor, 2017, p.124; Lines

et al., 2004, p.63). In addition, when PNEPs are rolled out, the institution adopts a harm reduction philosophy that often changes the way prison staff engage with prisoners, where staff become more open on how they can assist prisoners in the reality of the prison, instead of the ideal "drug-free" prison environment (Lines et al., 2004, p.50).

In effect, the need to increase the education of both staff and prisoners on PNEPs is necessary in Canada. It is routinely noted that many prisoners are unaware of the existence of a PNEP at their institution or the requirements due to the lack of information distributed, and staff in these contexts also feel unprepared. Stigma often prevails in environments like this, as traditional ideas come to the forefront based on assumption versus evidence-based fact. By ensuring staff are prepared at the onset of PNEP introduction alongside increasing education and training for staff on harm reduction through different educational workshops, the likelihood of prisoners accessing the program is increased through providing care instead of control (Chu et al., 2022, p.5,14,17). Moreover, prisoners must have access to information on PNEPs, which could be done through peer engagement, external organizations, pamphlets, and medical staff (Chu et al., 2022, p.14; van der Meulen et al., 2016, p.30). In addition, it is also imperative to ensure participants in PNEP programs are protected from being flagged by the Parole Board of Canada, or from having any release or correctional decisions influenced by their participation.

Extensive and broader issues plague the inability of a PNEP to thrive. Primarily, Canada must revisit how stakeholder concerns are interrogated, how the nation views drug use, and how the rights of prisoners are threatened without PNEPs. To begin, prisoners *must* be consulted on how PNEPs are implemented. The phrase "nothing about us without us" is routinely used by community drug users pushing back against policies implemented by the government that affect their health when users are not consulted, and the same applies within a prison context. The

essential stakeholder of the prisoner must be considered alongside other factions that are viewed as "more important," like government and Ministers. The ongoing rollout and delivery of the program must include further consultation with prisoners on PNEP programming and structures, which also increases the probability PNEPs are culturally sensitive and appeal to the diverse needs of the prisoner population, increasing the trust prisoners have in this voluntary program (van der Meulen et al., 2016, p.32-33; Jeon, 2020, p.40).

Canada must also review the broader issue of stigma and how drug use is viewed within society as a security and legal issue instead of a social and public health issue. Drug use is seen as non-compliant behaviour in communities, where stigma and inaccurate information surrounding addiction are pervasive. This neglects the ability to view the root cause of individualistic substance use concerns, and instead groups large masses together under one umbrella (van der Meulen et al., 2016, p.34). The stigma associated with mental health issues aligned with concurrent drug use impacts the success of instating PNEPs and similar programs as therapeutic environments are seen as less favourable to security ideology (van der Meulen et al., 2016, p.34). It must be recognized that drug use is a transcendent public health issue that is complex and multi-varied, where if punitive means are favourable, the risk to general society increases once these individuals are released. The current process of punitive consequences applied to prisoners based upon drug use isolates and further punishes marginalized individuals within the prison system, where these anti-drug policies actually further complicate the prison environment context as drugs are *inevitable* within a prison (van der Meulen et al., 2016, p.34).

There is also the argument for reconsidering the criminalization of people who use drugs overall. Evidence shows how drug use is rampant regardless of punitive consequences, where prisons tend to harm drug users more than help them. There are much broader considerations to

this issue, such as the history of imprisoning drug users, the overrepresentation of minority groups within prisons, as well as how we view substance use and crime as a society. As Canadian prisons are overcrowded, suggestions of de-incarcerating prisons and viewing substance users as a health concern instead of a security threat are possible options, although mass changes would have to occur. The general Canadian society, and the international community as a whole, should work towards addressing different structural inequalities that cause these individuals to end up in prison, as well as become overrepresented. Reducing the supply of people entering prisons also decreases the demand for drugs and associated harm-reduction programming. Overall, the question is asked of how the Canadian landscape would look if drugs were regulated and/or legalized.

Evidently, there is a multitude of recommendations for Canada to improve its PNEPs to align itself closer to the internationally set ideas on proper PNEP programming. Data collection must continue on PNEPs in Canada in an effort to increase the breadth of knowledge on the subject through different pilot project evaluations (Lines et al., 2005, p.60). It is further necessary for the government to collect data and conduct qualitative and quantitative reports on how many people applied to PNEPs, how long these people have waited, how many were accepted and rejected or left, how the implementation process works, and difficulties faced, in addition to considering prison staff and prisoner opinions (Jeon, 2020, p.39). A program that does not meet necessities for accessibility and effectiveness has the threat of having a worse effect than having no program at all, as in this context, it can provide a false impression that prisoners are not accessing the program because they do not need it when in effect it is due to other concerns (Jeon, 2020, p.36). However, harm reduction strategies are only effective if there is an uptake from users, and PNEP access in Canada inherently restricts enrollment (OCI, 2019, p.15). The

principle of equivalence was even reaffirmed domestically in *Milton Cardinal v. The Director of the Edmonton Remand Centre and the Director of the Fort Saskatchewan Correctional Centre,* where it was ordered that prisoners who received opioid agonist therapy treatment prior to imprisonment should be provided with it during imprisonment (Chu & Elliott, 2009, p.12). Without the existence of PNEPs, the Canadian government is not aligned with the *Charter of Rights and Freedoms*, national strategies that recognize the importance of harm reduction services, as well as international law (van der Meulen et al., 2018, p.307). Therefore, the PNEP program "remains a program largely in name only" (Zinger, 2022), wherein it appears for PNEP success in Canada, there must be a "metaphorical aligning of planets between the needs of the incarcerated, public opinion, political powers and an army of change-makers and leaders inside the system and outside the gates" (Danroth, 2018, p.125). Overall, it appears necessary for Canada to consider these recommendations to best meet the needs of their prisoner population.

Chapter 7: Conclusion

Sander et al. (2019) argues that "there is broad consfensus seen through evidence of the past hundred years that illustrate[s] how in our pursuit of a drug-free world, we have created far more harm than the drugs themselves" (p.105). Canada's current PNEP program breaches the principle of equivalence by failing to provide for prisoners what is afforded to people in the community, which has been affirmed by the Office of the Correctional Investigator ("Annual Report," 2021). Increasing trust in the program and pushing for a full rollout can increase participation rates and allow for further program evaluation.

The primary response from the majority of the world throughout history regarding problems associated with drug use has been to intensify law enforcement efforts and surge drug interdiction efforts within prisons. Yet, despite drug use and possession being illegal, there has been consistent growth in the prison population facing increasingly complex problems because of this (Lines et al., 2004, p.2). The mass imprisonment of this population has meant an increase in sharing materials alongside the persistence of drug use, where PNEPs are crucial in upholding the rights of prisoners who inject drugs (Lines et al., 2004, p.65). Leadership is required in the case of PNEPs, from Ministers, CSC, and prison staff. CSC must afford prisoners access to sufficient materials surrounding intravenous drug usage to mitigate health concerns. Although the introduction of harm reduction measures has faced scrutiny, PNEPs must exist to afford Canadian prisoners equivalent care to what is received in the general Canadian communities (Lines et al., 2004, p.65). General public apathy faced by prisoners, alongside other political and ideological considerations, has dramatically impacted the provision and success of Canadian PNEPs, wherein "a harm-reduction strategy that does not include sterile needle exchange is not

only a suboptimal public health measure; it is a contravention of international norms related to prison health and fails to meet best practice" (Lines et al., 2004, p.66-67).

The information of this thesis is understood through a critical social lens regarding the difference between needle exchange adoption in Canadian communities compared to PNEP programming, where recommendations and conclusions are grounded in this critical social lens to reveal how there is not necessarily a concrete solution to fix PNEP programming in Canada, but underlying tensions are seen that impact the issue at hand. This thesis revealed that prisoners continue to suffer in the realm of care they should be afforded despite historical pushes for social reform seen through the push for harm reduction policies and techniques, culminating with PNEPs. Yet, stagnancy exists, where Canadian federal prisons still do not have equal access to this program. The tensions discussed reveal how the inherent structure of the prison sometimes makes adoption of community programs difficult or improbable within the realm of the prison. Ultimately, the lens allowed for further interrogation of why some prisoners suffer even more in this regard, depending on their identity.

One contradiction that exists is the various legislation discussed in the thesis that Canada holds to support the criminalized approach to drug use, which sits alongside all of the other evidence that showcases how harm reduction programming is more effective at preventing deaths and the spread of disease amongst intravenous drug using prisoners. This contradiction is exacerbated within the prison context where harm reduction services are undermined by zero-tolerance policy and staff biases, and the overcrowding of prisons. Legislation is also inconsistent with international policies on prisoner care that position harm reduction as a critical factor in upholding fundamental human rights. Contradictions between harm reduction and zero tolerance are another major tension within legislation. Examples of this in Canada include "a)

Discipline and charges continue to be implemented if the prisoner is found to be in possession of illicit drugs or drug paraphernalia (except for the PNEP kit and supplies provided); b) PNEP kits can be seized if the syringe or needle is altered, missing or observed outside the kit; and, c) Drugs and drug paraphernalia (except official CSC-issued PNEP kit and supplies) are considered contraband items, subject to disciplinary measures" (Zinger, 2022).

Furthermore, there is the concern that staff involved in PNEP execution do not operate from the same theoretical foundation surrounding harm reduction programming. All staff may have the same goal of upholding public safety, but different staff do not necessarily align on how to achieve this. Health professionals addressing mandates on health issues for prisoners work from a different foundation and values than those grounded in security and control of the prison. Various groups of employees within the prison system aim for institutional safety but from different perspectives, where both of these perspectives are supported by Canadian law on providing control and care for prisoners, posing an issue of who is "right."

Canadian nurses' responsibility for harm reduction care does not differ depending on the setting, meaning they must – and push to – provide judgement-free care within the prison environment ("Companion Document," 2017, p.1). The Code of Ethics for Registered Nurses guides ethical practice for nurses and aligns harm reduction with the core values nurses must have ("Companion Document," 2017, p.7). Nurses have "an ethical responsibility to provide non-judgmental care to individuals experiencing (or at risk of) harm from substance abuse," where the role of a nurse in the context of a PNEP is essential for success ("Companion Document," 2017, p.1). In comparison, correctional officers and their unions traditionally do not push or wish for harm reduction. However, correctional officers are primarily detached from health services, which has negative consequences for prisoners as correctional officers often lack

an understanding of these tools yet are tasked with harm reduction service delivery instead of health professionals (van der Meulen et al., 2018, p.303). The tension of pursuing control while maintaining care makes it difficult for staff to see eye to eye on issues depending on their mandates. Moreover, as seen in discussions of the Parole Board of Canada, tensions arise surrounding individual opinions of staff members where staff react and respond the way they do based on biases.

In addition, tension rises where both prison authorities and policymakers have been highly reluctant to introduce increasingly progressive harm reduction for two main reasons: political opposition and lack of funding (Sander & Murphy, 2017, p.185-186). There is often a lack of political leadership on harm reduction, prompting a lack of funding as this field has little public interest. The lack of financing alongside political opposition has meant a stall in increasing harm reduction services for the world's most vulnerable populations. We must effectively look at the origin of problems for PNEP programming that is seen amongst all of these tensions, where these issues can be addressed in a reflective manner.

Future research on this topic is needed to examine how to mitigate these tensions. In addition, further investigation must be looked at how the COVID-19 pandemic changed the landscape for PNEP rollout. As differences exist between the introduction of community and prison needle exchanges, revisiting the need for sensitive and individualized programming for prisoners along a continuum is imperative. Overall, research and scholarship must continue to examine why the issue of instating PNEPs has existed for over two decades, yet this programming continues to have limited access due to deeper social issues and considerations on drug usage and drug interdiction.

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Appendix

Appendix 1

Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8	Step 9
Records from: Novanet advanced search N = 558	Records through PsycINFO N = 88	Records through CINAHL N = 114	Records through Canadian Research Index N = 1	Records through PAIS Index N = 261	Records through Canada Commons Database N = 280	Records through Public Affairs Index N = 30	Records within Social Services Abstracts N = 278	Records in Google Scholar N = 50
Duplicate records removed from the individual search N = 81 duplicates; total articles N = 477 Duplicates removed once seen in word document N = 4; total articles N = 473	Records then compared to Novanet bibliography for duplicates Duplicates: N = 66; new articles = 22 N = 495	Then compared to advanced reference list for duplicates Duplicates: N = 71; new articles = 43 N = 495 + 43 N = 538	Then compared to advanced reference list for duplicates Duplicates: N = 0; new articles = 1 N = 538 + 1 N = 539	Then compared to advanced reference list for duplicates: Duplicates: N = 15; new articles = 246 N = 539 + 246 N = 785	Then compared to advanced reference list for duplicates: Duplicates: N = 5; new articles = 275 N = 275 + 785 N = 1060	Then compared to advanced reference list for duplicates: Duplicates: N = 20; new articles = 10 N = 10 + 1060 N = 1070	Then compared to advanced reference list for duplicates: Duplicates: N = 24; new articles = 254 N = 1070 + 254 N = 1324	Compared to advanced reference list: Duplicates = 24; new articles = 26 N = 1324 + 26 N = 1350

Table 1.

Appendix 2

Authors	Title	Country from which data was obtained	Aim of study	Study design	Population of Focus / Data Source
Gerald Thomas (2005)	Assessing the Need for Prison-Based Needle Exchange Programs in Canada: A	Canada	Present a situational analysis of current trends in prison drug use, the prevalence of HIV/AIDS and HCV in prisoner populations other	Review of peer-reviewed and gray literatures in English on topics directly related to assessing the need for	Canadian prisoner populations; key word searches of the World Wide Web (online sources) and library databases (including

	Situational Analysis		information relevant to assessing the need for prison-based needle exchange programs in Canada.	implementing prison needle exchanges with a focus on Canada	comprehensive worldwide databases such as WorldCat, MEDLINE and SCIENCEDIRECT)
Emily van der Meulen, Rai Reece, Sandra Ka Hon Chu (2018)	Building Dialogue on Prison Health: Improving Access to Harm Reduction in Federal Prisons	Canada	Reveal research participants thoughts on issues and challenges related to the implementing of PNEPs as well as the importance of correctional officers and the union that represents them in the success or barriers of these programs	Drawing on a qualitative study with former federal prisoners in Ontario and key medical and community professionals across Canada, the authors built a commentary to build dialogue with CSC on prison needle exchanges being essential harm reduction measure in prison	Former federal prisoners in Ontario and key medical and community professionals from across the country
Paul Webster (2018)	Canada reveals needle exchange programme in prisons	Canada	Reveal what has happened since Canadian government conceded to activists on prisoners accessing clean needles	Not stated (this is a report by Paul Webster in Toronto that is 1 page)	Prisoners, key citizens involved in pioneering PNEPs and contacting government
Adrien Iafrate (2015)	Canadian Prison Needle Exchange Programs: Can the Health Benefits Overcome the Current Legal Barriers?	Canada	This article assesses the ability to challenge the legislative prohibition on sterile needles through a claim under the Canadian Charter of Rights and Freedoms.	Combines social science and legal research; analysis of various govt, scholarly and nongovernmental data to develop view of public health risk present within federal penitentiaries without PNEPs; focused on sources	Canadian federal prisoners;

				published in past 10 years and then conducted analysis of possible remedies to issues found within Canadian federal prisons; then, analysis of *Charter* jurisprudence to determine whether a *Charter* challenge could force govt to implement PNEPs	
Sandra Ka Hon Chu and Richard Elliott (2009)	Clean Switch: The Case for Prison Needle and Syringe Programs in Canada	Canada	Reveal the necessity of PNEPs through looking at the reality of HIV, HCV and injection drug use in prison, the well-established legal principles of retaining all human rights and of equivalence in healthcare standards, the availability and general acceptance of NSPs in the community as harm reduction, and CSCs obligations to take effective measures to prevent the spread of infectious diseases amongst prisoners. Analyzes this in light of Canada failing to meet commitments to international and	Not listed; basically a large overview of previously existing data	Canadian federal prisoners; federal documents; intl documents governing Canadas commitment to intl entities and agreements

			health and human rights standards, its mandate under Canadian correctional legislation, and/or its obligations under the *Charter*		
Richard Elliott (2007)	Deadly disregard: government refusal to implement evidence-based measures to prevent HIV and hepatitis C virus infections in prisons	Canada	Concisely summarize/provide commentary on the overview of research on government failure to citizens re disregarding evidence-based measures like PNEPs to prevent disease	Not stated – short article that is more editorial in nature. Richard Elliott is deputy director of Canadian HIV/AIDS network.	Canadian federal prisoners; other prisoners throughout the world from other studies information
Ricardo Fernandes, Maria Cary, Goncalo Duarte, Goncalo Jesus, Joana Alarcao, Carla Torre, Suzete Costa, Joao Costa, Antonio Vaz Carneiro (2017)	Effectiveness of needle and syringe Programmes in people who inject drugs – An overview of systematic reviews	International – various	conducted an overview of systematic reviews that included PWID (excluding prisons and consumption rooms), addressed community-based NSP, and provided estimates of the effect regarding incidence/prevalence of various diseases.	Systematic literature searches were undertaken on relevant databases, including EMBASE, MEDLINE, and Psych INFO (up to May 2015). For each review, it was identified what the relevant studies and extracted data on methods were, and findings, including risk of bias and quality of evidence assessed by review authors. They also evaluated the risk of bias of each systematic	Various prison populations worldwide

				review using the ROBIS tool. Then, they categorized reviews by reported outcomes and use of meta-analysis; no additional statistical analysis was performed. Included thirteen systematic reviews with 133 relevant unique studies published between 1989 and 2012. Reported outcomes related to HIV (n = 9), HCV (n = 8) and IRB (n = 6). Methods used varied at all levels of design and conduct, with four reviews performing meta-analysis.	
Patricia Erickson, Diane Riley, Yuet Cheung, Pat O'Hare (2014)	Harm Reduction: A New Direction for Drug Policies and Programs	Various	Third collection of papers drawn from 7 international conferences on harm reduction; most detailed to date in exploring number of specific policy options and outlining several practical innovations. Aims to overview harm reduction, what it means in different	Compiled different papers from different conferences; Applying harm reduction thinking to a number of areas broadly associated with current drug policies like prisons and incarceration, international	Very broad – different populations as it is a collection of papers.

			contexts, and its application in general within international law and prisons.	security and order, development policies, and human rights. Also assembled number of clinical and laboratory studies.	
Thomas Kerr, Evan Wood, Glenn Betteridge, Rick Lines and Ralf Jurgens (2010)	Harm reduction in prisons: a 'rights-based analysis'	Canada	Utilize a rights-based approach to evaluate current responses to drug-related harm in prisons and to consider obligations of govts to respond to these harms through looking at human rights violations and instruments within this context. Analyzing various harm reduction programs: Education, Provision of bleach, Methadone maintenance treatment, Needle exchange or distribution	Not stated; rights-based analysis? Emphasizing how harm reduction programs can be implemented within prisons without compromising security or increasing illicit drug use with a move away from current emphasis on security and abstinence from drugs that is normal within prisons.	Mainly prisoners but also extraction from intl documents and program information
Will Small, S. Kain, Nancy Laliberte, Martin T Schechter, Michael O'Shaughnessey, Patricia Spittal (2005)	Incarceration, Addiction and Harm Reduction: Inmates Experience Injecting Drugs in Prison	Canada	goal of this research was to qualitatively examine HIV risk associated with injecting inside British Columbia prisons. Explored how harms normally associated with drug addiction and injection drug use are exacerbated in	A sample of 26 former male inmates who had recently used drugs within prisons were recruited from an ongoing cohort study of injection drug users in Vancouver, Canada. Data for	26 former male prisoners who recently used drugs within Canadian prisons

			prison. Interpersonal relationships and possession of exchangeable resources determine access to scarce syringes. Thus, sharing often happens – poses health hazards and bleach is inadequate. Therefore there's a need for effective harm reduction programs	this study were collected through in-depth interviews conducted in 2001/2002. Analysis of these data involved identifying emergent themes and then exploring these central concepts in further interviews to confirm the accuracy of interpretation	
Richard Pearshouse (2006)	Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS	Not intended for any one country or set of countries; takes from multiple	This model law resource is designed to inform and assist policy-makers and advocates approaching reforming or creating new laws to meet legal challenges posed by HIV epidemic amongst those who inject drugs. Supposed to be a resource useful for those countries where injection drug use is significant factor driving HIV epidemic.	Model Law Resource; Detailed framework of legal provisions and accompanying commentary; refers to examples of law from jurisdictions that have attempted to establish a clear legal framework for addressing HIV/AIDS. Also includes human rights principles and state obligations. Aim to present different legislative options for implementing states human rights	Various prison populations; also intl documents and domestic legislation depending on country

				obligations. Constructed through eight modules that are laid out in stand alone document.	
Rhidian Hughes (2000)	Lost Opportunities? Prison Needle and Syringe Exchange Schemes	UK (focused) but also draws on other intl sources: Germany, Switzerland, Canada,	Represent and discuss range of considerations that surround PNEPs. Concludes with a call for a much fuller and all-encompassing debate on issue of PNSES.	Not stated; article seeks to answer six questions: are PNSES unrealistic and unpopular? Do PNSES conflict with the duties and principles of the prison service and its staff? Do PNSES affect levels of drug use and drug injection in prison? Would PNSES affect levels of infections? Will drug injectors use PNSES? Will PNSES affect safety and security?	International sources; Focus on UK prisoners; utilizing different pre-existing articles on issues that have already conducted their own studies.
Wayne Kondro (1999)	Needle exchange advocated for Canada's prisons	Canada	Discusses emerging ideas about first PNEPs in Canada	One page report in Lancet by reporter	Canadian prisoners
Canadian Agency for Drugs and Technologies in Health (2015)	Needle Exchange Programs in a Correctional Setting: A Review of the Clinical and Cost-Effectiveness	Canada, Germany, Spain, Switzerland	aim of this report is to summarize available evidence on the effectiveness and cost effectiveness of needle exchange programs to reduce harm associated with injection drug use in prisons, to	HTA/Systematic Reviews/Meta-Analyses, Randomized Controlled Trials, Non-Randomized Studies, Economic Evaluations. Literature search conducted on key	Adults in a correctional setting in Germany, Spain and Switzerland

			facilitate the evaluation of the benefits of the program in correctional settings.	resources as well as focused internet search; retrieval limited to human population and limited to English documents published between Jan 1, 1995 – Aug 6, 2015; all included studies had non-randomized design with one described as cross-sectional with all others before-after studies	
Ryan Danroth (2018)	On pins and needles: More support for prison needle exchanges	Canada and intl documents	Provides arguments for and against PNEPs and what the response to concerns are that are common; Describe different PNEP models	Not specified	Intl documents; Canadian prisoners
Rich Lines, Ralf Jurgens, Glenn Betteridge, Heino Stover, Dumitru Laticevschi, Joachim Nelles (2004)	Prison needle exchange: Lessons from a Comprehensive Review of International Evidence and Experience	Moldova, Switzerland, Spain, Germany, Canada, Kyrgyzstan and Belarus	This report examines the issue of prison needle exchange based upon the international experience and evidence current to 31 March 2004. The authors undertook a literature review, visited prisons in four countries, and corresponded with people responsible for administering	Evidence for report was gathered over 18-month period beginning Oct 2002. This is when review of existing intl literature was undertaken; then, original research conducted during site visits to PNEPs in Moldova, Switzerland,	Moldova, Switzerland, Spain, Germany → primary research Kyrgyzstan and Belarus → personal communications Canada → intl documents and published Canadian domestic govt documents

			prison needle exchange programs. The report provides a comprehensive review of the evidentiary and legal basis for prison needle exchange programs. The goal of this report is to encourage prison systems with HIV and HCV epidemics driven by injection drug use to implement needle exchange programs.	Germany and Spain. Kyrgyzstan and Belarus added programs during research time, so unable to do site visit but instead personal communications were used.	
Emily van der Meulen, Rai Reece, Sandra Ka Hon Chu	Rebuttal to the Correctional Service of Canada's response	Canada	Responding to Jonathan Smith and Henry de Souza who wrote on behalf of CSC	Smith and de Souza neglect to explain why the federal prison service has yet to implement PNEPs contrary to over 2 decades of evidence that this is safe and emphasize how this is an essential program seen in UNODC 15 interventions: thus, CSC not consistent with UNODC recommendations	Canadian prisoners
Adelina Iftene and Allan Manson (2013)	Recent crime legislation and the challenge for prison health care	Canada	This article provides an overview of the current health status of the Canadian prison population, recent legislation and the impact of overcrowding, with a predominant focus	Not specified	Bill C-10; Canadian prisoners

			on the federal system.		
Jonathan Smith and Henry de Souza (2018)	Response to Building Dialogue on Prison Health: Improving Access to Harm Reduction in Federal Prisons	Canada	Responding to other article; basically explaining how CSC policies and programs support 14 of 15 initiatives identified by UNODC and overview of harm reduction available within CSC	Not specified	Referencing other article (Building Dialogue on Prison Health); Canadian prisoners
Rick Lines, Ralf Jurgens, Glenn Betteridge, Heino Stover (2005)	Taking action to reduce injecting drug-related harms in prisons: The evidence of effectiveness of prison needle exchange in six countries		Reviewing the appropriateness of PNEPs as seen through six other countries successes	This specifically interrogates overview of the PNEP initiated and commentary on outcomes. A review of existing literature was undertaken together with original research comprising site visits to prison needle-exchange programmes in four countries operating such initiatives in October 2002.	
Gen Sander and Fionnuala Murphy (2017)	The furthest left behind: the urgent need to scale up harm reduction in prisons	Various	Raise awareness about the disproportionate impact of HIV and hepatitis C (HCV) on prisoners worldwide and the need for key harm reduction services such as needle and syringe programmes and opioid substitution therapy in prisons offer	This study is a desk review of existing data and evidence on HIV, HCV and harm reduction in prisons, analysis of political barriers and formulation of key policy recommendations	Prisoner populations; Intl documents

			practical recommendations to assist policy makers in implementing or scaling up these services. Provides recommendations		
Gen Sander, Sam Shirley-Beavan, Katie Stone (2019)	The Global State of Harm Reduction in Prisons	Switzerland, UK, Australia, Canada, USA, intl documents, Moldova, WHO, UNODC, UNAIDS, Germany, various	begins with a review of drug-related incarceration, drug use in prisons, and HIV and hepatitis C (HCV) prevalence among prisoners globally. provides a global overview of the availability, accessibility, and quality of harm reduction services in prisons—specifically needle and syringe programs; opioid substitution therapy; provision of the opioid agonist naloxone; and diagnosis, treatment, and care for HIV, HCV, and tuberculosis.	It presents the scientific evidence, alongside legal and economic arguments supporting the provision of harm reduction to people who use drugs, both inside and outside of prisons. Most data derived from research undertaken for Harm Reduction International's *2018 Global State of Harm Reduction* report. For that report, data were gathered using existing sources including research papers and reports from multilateral agencies, international nongovernmental organizations, civil society organizations networks, organizations of people who use	Various prisoner populations across the globe

				drugs, and expert and academic opinion. Regional harm reduction networks and researchers also provided support in gathering qualitative data on key developments	
Cindy Peternelj-Taylor (2018) - Nurse	The introduction of prison needle and syringe programs in Canadian federal prisons	Canada	Providing nursing perspective on introduction of PNEPs and if this is best approach, etc.	Not specified	Canadian prisoners; looking at provinces specifically too
Tara Watson (2014)	The politics of harm reduction in federal prisons	Canada	Examines the situation in the Correctional Service of Canada (CSC), a federal prison agency with a zero-tolerance drug policy and general opposition to prison needle and syringe programs (PNSPs) and safer tattooing initiatives. (contradictory basically is what is stated)	This study draws on 16 interviews with former CSC senior officials, former frontline staff, and external stakeholders; CSC policy and practice documents; and testimony from a House of Commons Standing Committee public study. Thematic coding and comparison of texts were used to examine emergent themes of interest	Important individuals involved policy-wise in creation of PNEPs
Sandra Ka Hon Chu and Katrina Peddle (2010)	Under the Skin: A People's Case for Prison	Canada	Looking to answer: What do people in prison have to say about the Canadian	Between 2008 and 2009, interviews were conducted in	N = 50 Canadian prisoners

	Needle and Syringe Programs		government's unwillingness to address the problem? How has this policy, that denies the realities of injection drug use in prison, affected individuals who are struggling with drug addiction? And what does this mean for the community as a whole?	person and over the phone in British Columbia, Alberta, Manitoba, Ontario, Quebec, New Brunswick and Nova Scotia, resulting in sworn affidavits or testimonials from 50 individuals who either were currently incarcerated or had previously served time in a federal prison. nine interviews were conducted in British Columbia, five in Alberta, six in Manitoba, 13 in Ontario, five in Quebec, two in New Brunswick and 10 in Nova Scotia. Eight interviews were conducted with people currently in prison. Despite initial challenges identifying women for interviews, 12 women were ultimately interviewed, from four of the five regions in which interviews were conducted.	Previously incarcerated Canadians Canadian lawmakers/important individuals governing this/these decisions

				Aboriginal and African Canadians were also represented among the individuals interviewed, including 12 individuals who self identified as Aboriginal or Métis, and five individuals who self-identified as African Canadian. Among the people who provided us with their age, ages ranged from 24 to 58.	
Sandra Chu (2020)	Correctional Service of Canada must do better	Canada	Discussion from Chu's perspective on why CSC must do better to prevent disease spread	News article/opinion piece by head of HIV/AIDS network	Canadian prisoners

Table 2. Summary of final inclusion articles.

Authors	Title	Country from which data was obtained	Aim of study	Study design	Population of Focus / Data Source
Lynne Leonard (2020)	Evaluation of the Overdose Prevention Service at Drumheller Institution	Canada (specifically Drumheller Institution in Alberta)	Providing summary and overview of overdose prevention site at Drumheller Institution – was launched in 2019 and first inmate participated on 10th of July. As a unique initiative not only in Canada, but also internationally,	The evaluation framework comprised two components – an Outcome Evaluation and a Process Evaluation. The Outcome Evaluation will be undertaken using the quantitative methodological approaches of a structured	Drumheller Institution prisoners

			CSC required an in-depth evaluation of the overdose prevention site in order to inform the optimal roll out of an overdose prevention site in other CSC institutions. Dr Lynne Leonard from the School of Epidemiology and Public Health at the University of Ottawa was engaged by CSC to conduct the evaluation. Wanting to look at feasibility and sustainability of program and also review staff opinions	questionnaire among inmates and associated descriptive statistical analyses, and a current examination of service utilisation and health services data. The Process Evaluation employed qualitative methodologies and analysis techniques permitting detailed rich descriptions of how the service was operationalised by staff and experienced by inmates. This mixed methods design facilitates triangulation of the data thus strengthening the evaluation outcomes with the objective of developing actionable recommendations for program and policy re-development.	
Lynne Leonard (2020)	Evaluation of the Prison Needle Exchange Program Interim Report	Canada	As a unique initiative in Canada and with limited international implementation, CSC required an in-depth evaluation of the	The evaluation framework comprised two components – an Outcome Evaluation and a Process Evaluation. The Outcome	Canadian prisoners

			PNEP in order to inform the optimal roll out of PNEPs in other CSC Institutions. Dr Lynne Leonard from the School of Epidemiology and Public Health at the University of Ottawa was engaged by CSC to conduct the evaluation. Touches on how UNODC recommends PNEPs and looking at introduction of PNEPs post 2018 on May 14th when it was officially announced.	Evaluation will be undertaken using the quantitative methodological approaches of a structured questionnaire among inmates with subsequent descriptive statistical analyses, and a current examination of service utilisation and health services data. The Process Evaluation employed qualitative methodologies and analysis techniques permitting detailed rich descriptions of how the service was operationalised by staff and experienced by inmates. This mixed methods design will facilitate triangulation of the data thus strengthening the evaluation outcomes with the objective of developing actionable recommendations for program and policy re-development.	

Correctional Service Investigator in 2005	Annual Report	Canada	The beginning of mentioning prison needle exchange programs to move forward from 1990s.	Annual Government Report	Canadian federal prisoners
Correctional Service Investigator in 2015	Annual Report	Canada	Discusses their recommendations STILL to input needle exchange. Highlights no change in 10 years from investigator suggestions.	Annual Government Report	Canadian federal Prisoners
CMAJ 2016	Optimism for prison syringe programs	Canada	Discusses optimism with CSC and push from activists for PNEPs	News Article	Canadian prisoners
Canadian Nurses Association	FOCUS ON HARM REDUCTION FOR INJECTION DRUG USE IN CANADIAN PRISONS: A SUPPLEMENT TO CNA'S HARM REDUCTION DISCUSSION PAPER	Canada	From perspective of nurses association. Looks at prison health overall as well as in Canada, and provision of needle exchange and harm reduction	Not stated	Prisoners in general
Statement by 70 organizations in Canada (2019)	CORRECTIONAL SERVICE OF CANADA MUST FIX FUNDAMENTAL FLAWS WITH PRISON NEEDLE EXCHANGE PROGRAM	Canada	70 orgs come together to state they are in support of PNEPs, their importance, and that CSC must fix fundamental problems	Not specified	Organizations
CSC's Health Services (2017)	Evaluation Report File #394-2-96	Canada	The evaluation focuses on the relevance and performance of	The evaluation of CSC's health services used a mixed-method	Canadian prisoners

Don Head = Commissioner Brigitte de Blois = Director of Evaluation Division Authors: Kendra Delveaux, Colleen MacDonald, Ashley McConnell, Sheena Bradley, Adam Crawford, Felicia Tse,			CSC's mental, clinical, and public health services. Evaluation questions examine the following areas: relevancy of CSC's health services, effectiveness and efficiency of the intake assessment process, offender access to care and services throughout incarceration, public health education and harm reduction, institutional mental health services, pre-release and community health services and the management and coordination of health services. Given the breadth and complexity of health services within CSC, the evaluation is organized into seven findings in focus for evaluation. Lists recommendations they argue are important as well.	research design, incorporating both quantitative and qualitative methodologies. Several lines of evidence were used to address the evaluation issues and questions, including literature and document review, interviews with offenders, electronic questionnaires with staff, automated data	
Canadian Medical Association (2013)	Prison needle exchange programs rare despite evidence	International	Emphasizes questioning why PNEPs rarely exist although	News article	Prisoners worldwide

			there is evidence they prevent disease		
Harm Reduction International (2022) Gideon Lascoo Wangari Kimemia Anya Dovbakh Maria Plotko Carolina Ahumada Jorgelina Di Iorio Elie Aaraj Sandra Hajal Hanna Michala Kowalski Derek Frasure Sam Shirley-Beavan Kunal Naik Robert Csak	The Global State of Harm Reduction	International	The Global State of Harm Reduction 2022 shows the positive changes that communities and civil society are making among people who use drugs through evidence- and rights-based harm reduction services. Provides worldwide overview of harm reduction. Is leading organization internationally on this topic and publishes annual reports. In this year's report, dedicated chapters pay special attention to viral hepatitis and the ongoing impact of the COVID-19 pandemic. In addition, we now report on Eastern and Southern Africa and West and Central Africa separately, reflecting the growth of harm reduction across Africa. We have also expanded our attention to	Firstly, Harm Reduction International – in collaboration with regional partners – disseminated an extensive survey to community and civil society organisations and other national and regional experts. This survey sought quantitative and qualitative information on the harm reduction services available in each country, region or territory. In 2022, this effort led to contributions from 192 people in 87 countries. Secondly, researchers undertook an extensive review of research papers and reports from intergovernmental organisations, multilateral agencies, international non-governmental organisations, academics, civil society, harm reduction organisations and networks of people	Drug users

			include harm reduction for non-injected drugs and stimulants.	who use drugs. Epidemiological data in many of the regional chapters has been sourced from two global systematic reviews, supplemented by national or regional published data and experts.	
CMAJ (2010)	Inmates urge needle-exchange programs	Canada	Discusses how Canadian prisoners are pushing for PNEPs to be introduced.	News article that discusses primarily one person's perspective on their need for PNEPs	Canadian Prisoners
CMAJ (2010)	Prison needle exchange	Canada	Discusses how groups within Canada are calling on CSC to stop disease through PNEPs	News article	Canadian prisoners
John Weekes and Karen Cumberland (2006) Prepared by the Canadian Centre on Substance Abuse	Needle Exchange Programs (NEPs) FAQs	Canada	Provides empirically based information to guide discussion on use of NEPs. Goes through bullet points to summarize FAQ on PNEPs.	Just prepared with questions as headings and then answers as bullet points with footnotes	Canadian prisoners and Canadian public/corrections officials/law enforcement
Sandra Ka Hon Chu Ann De Shalit Rhiannon Thomas Emily van der Meulen (2022)	Points of Perspective: Research Report on the federal prison needle exchange program in Canada	Canada	Interrogating the process of PNEPs being introduced in Canada, barriers of using PNEPs, Covid-19 impacts, and recommendations and improvements for PNEPs	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	Canadian prisoners

				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. We collected socio-demographic information about each participant at the start of the interview. 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.	
Office of the Correctional Investigator Ivan Zinger (2022)	Annual Report 2021-2022	Canada	Entire overview of annual report of all Canadian corrections the OCI is tasked with completing annually. Specific section "Correctional Service of Canada's Drug Strategy" is of importance due to discussions of PNEP	Annual government report	Canadian prisoners
Emily van der Meulen Stephanie Claivaz-Loranger Seth Clarke Annika Ollner Tara Marie Watson (2016)	On Point: Recommendations for Prison-Based Needle and Syringe Programs in Canada	Canada	This somewhat precedes points of perspective. Details need for PNEPs in Canada, PNEPs around the world, lessons from Switzerland, addresses arguments against PNEPs, proves recommendations for PNEPs in Canada	Stakeholder Meeting, Prison Site Visits in Switzerland, Community Based Research (focus groups and interviews with former federal prisoners; interviews with community and medical professionals)	Prisoners worldwide with emphasis on Canada
John Weekes Gerald Thomas Canadian Centre on Substance Abuse (2004)	Substance Abuse in Corrections FAQs	Canada	Goes over in general how corrections Canada operates, why this is a pressing issue within prisons regarding drugs, how extensive this issue is, and	Like other FAQ article: set up with questions and bullet point answers from variety of sources. Not specifically specified.	Those in contact with CSC

			what substance abuse programming is available. Ends with needle exchange		
Alice Jeon (2020)	The Long Road towards a Prison Needle Exchange Program in Canada	Canada	"In this paper, Z explain why prison needle programs are necessary to uphold prisoner's rights; and provide a comparison of needle exchange programs in other countries to demonstrate the limitations of the Canadian program. Then, Z will provide a narrative of the long road, both in and outside of the legal system, that has been taken to establish a prison needle exchange program that meets professional standards. Finally, Z will explain the changes that must be made in the Canadian program and the specific ways in which we must ensure government accountability"	Not specified. Is a report/summary for centre for human rights and legal pluralism in efforts to publish on human rights and legal pluralism.	Prisoners

Table 2(A). Summary of included gray literature.