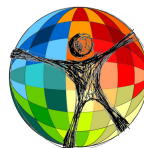


VOL. 9 | NO. 1 | SUMMER 2020

The Long Road towards a Prison Needle Exchange Program in Canada

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Human Rights
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ABSTRACT

In June of 2018, the government of Canada announced its plan to implement needle exchange programs in all federal prisons across the country. This program acknowledges the widespread drug use among prisoners and aims to prevent the sharing of injecting equipment as well as the spread of blood-borne diseases such as HIV and HCV, by providing prisoners with sterile needles. At first glance, this appears to be a good-faith effort by the government to take a harm reduction approach to drug use: an approach that aims to reduce drug-related harm rather than eliminate drug use, to recenter the focus on healthcare rather than criminalization. With this goal in mind, however, it becomes clear that the current needle exchange program implemented in Canada is, at best, an acceptable first step. At worst, it creates the false impression that prisoners are provided with a program that they cannot access de facto. In this paper, I 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, I 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, I will explain the changes that must be made in the Canadian program and the specific ways in which we must ensure government accountability.

ACKNOWLEDGEMENTS

To Sandra, thank you for being an amazing supervisor and for your invaluable help editing this paper.

To Professor Ramanujam, thank you for providing me with the wonderful experience of being a part of the IHRIP and the CEHR class this year, and for your steady guidance throughout the semester.

To all the incredible staff at the HIV/AIDS Legal Network, and others who have dedicated so much to fight for the rights of those who are marginalized, thank you.

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LIST OF ABBREVIATIONS

CSC: Correctional Service of Canada

HCV: Hepatitis C Virus

HIV: Human Immunodeficiency Virus

NADS: National-Anti-Drug Strategy

NGO: Non-Governmental Organization

OAT: Opioid Agonist Therapy

PASAN: Prisoners with HIV/AIDS Support Action Network

PHAC: Public Health Agency of Canada

PNEP: Prison Needle Exchange Programs

UCCO: Union of Canadian Correctional Officers

Preface

During my time as an intern for the HIV/AIDS Legal Network (“the Legal Network”), I was asked to write a short article about prison needle exchange programs. Only then did I even learn what this program was, that they had already been implemented in Canada, and that the Legal Network had been an organization at the forefront of its implementation. As I read through the extensive studies conducted by the organization, I wished that there was a way to bring all these documents together, to provide a snapshot of all this information from a bird’s eye view. This was the start of my paper. Although supplemented by various other sources, the foundation of this paper is guided by the studies published by the Legal Network. It is also shaped by the conversations I have had and the advice that I have received from the Legal Network staff. I have learned so much during this process and I write in hopes of sharing as much as I can.

Introduction

In June of 2018, the government of Canada announced its plan to implement prison needle exchange programs (PNEPs) in all federal prisons across the country.¹ This program would allow for the distribution of unused, sterile injection equipment within prisons, often alongside other harm reduction mechanisms such as condoms, educational pamphlets, and counselling.² In this paper, I document the long and arduous road that has been taken in order to implement this program in Canada—the process has involved long-term advocacy by numerous stakeholders who have had to overcome political, legal and social obstacles. At the same time, this paper also demonstrates that the work is far from over. As they are implemented now, Canadian PNEPs have severe limitations, and ongoing reform will be required.

The first section of this paper serves to explain why Canada needs a PNEP. I do so by explaining the medical and health-oriented justifications, as well as the legal, ethical, and rights-

¹ See Correctional Service Canada, “Prison Needle Exchange Program” (28 August 2019), online: *Government of Canada* <<https://www.csc-scc.gc.ca/health/002006-2005-en.shtml>>.

² See *Ibid*; Emily van der Meulen et al “On Point: Recommendations for Prison-Based Needle and Syringe Programs in Canada” (Toronto, 2016) at 7.

based obligations. The second section then provides an overview of different PNEP models that have been established around the world. Through a horizontal and vertical examination of these models, I abstract the important lessons to consider and to apply in the Canadian context. In the third section, I shift the focus back to Canada. Documenting the implementation of the Canadian PNEP from a legal, political and social lens, I capture the multi-faceted efforts and obstacles in this process. In the fourth and final section of this paper, I provide recommendations for future reform: the journey towards a truly accessible and effective Canadian PNEP is to be continued.

An Overview of Drug Use and Health in Canadian Prisons

Drugs and HIV in Prison

"I would say about one third of the prison population would inject. Drugs were easy to get. Once drugs got in, guards didn't really care, because we were already in the worst place we could possibly be in our life."³

Each year, the Correctional Services of Canada (CSC) spends millions of dollars enforcing security measures to prevent illegal drugs from entering prisons including increased use of ion body scanners, frisk searches, dog searches, random urinalysis testing, and threat of harsh punishment.⁴ Despite these efforts, it is an open secret that illegal drugs remain widely available and used behind closed doors, leading to numerous reported overdoses (see Figure 1).⁵ Drugs enter through various means. Prisoners have been caught smuggling drugs in creative ways through mail, by inserting drugs so far in their body cavities so that it is no longer visible during body searches, using the help

³ See Sandra Chu & Katrina Peddle, "Under the Skin: A People's Case for Prison Needle and Syringe Programs" (Toronto: Canadian HIV/AIDS Legal Network, 2010) at 15. This quote was taken from an interview of "Pete," a 51-year-old prisoner in Nova Scotia who spoke about the reality of drug use in prison.

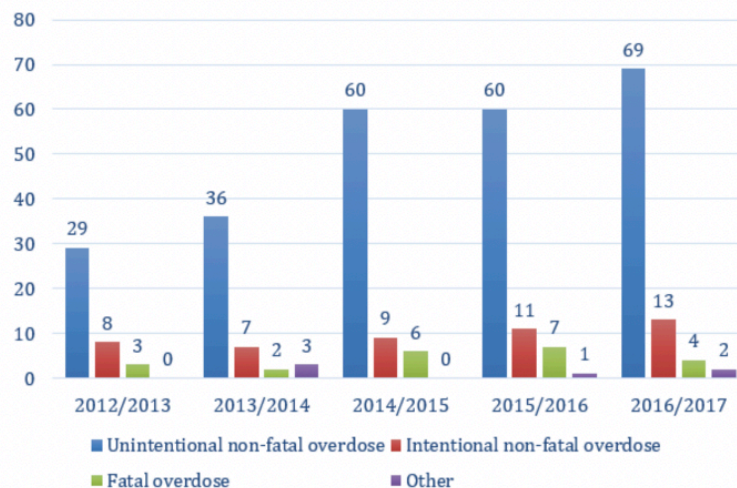
⁴ See Correctional Service Canada, "Overdose Incidents in Federal Custody, 2012/2013-2016/2017" (January 2019), online: *Government of Canada* <<https://www.csc-scc.gc.ca/research/sr-18-02-en.shtml#n2>>.

⁵ *Ibid.*

of visitors, and more.⁶ There are also often guards and other prison staff who are complicit—they receive money or sexual favours in exchange for providing drugs to prisoners.⁷

Figure 1. Graph showing the number of overdose incidents 2012/2013-2016/2017 (top) and graph showing the substances involved in these incidents (bottom).⁸

Overdose Incidents in Federal Custody, 2012/2013 - 2016/2017

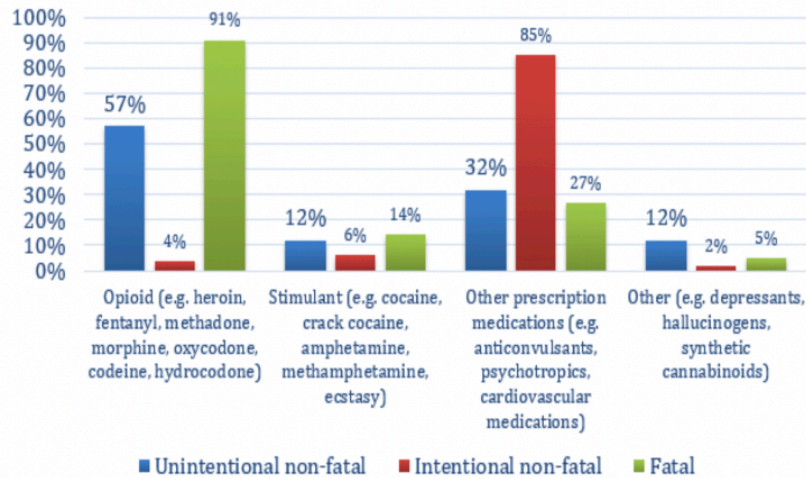


⁶ See Chu & Peddle, *supra* note 3 at 19. See e.g. Tracy McLaughlin, "Smuggling drugs into Ontario's jails" (9 January 2019), online: *Toronto Sun* <torontosun.com/news/provincial/smuggling-drugs-into-ontarios-jails>; Jonny Wakefield, "Contraband, overdoses, death: documents detail the flow of drugs into one of Canada's most advanced jails" (5 November 2018), online: *Edmonton Journal* <<https://edmontonjournal.com/news/local-news/hundreds-of-overdoses-dozens-of-seizures-how-are-drugs-still-flowing-into-canadas-most-advanced-jail>>; Misha Gajewski, "Quebec prison smuggling goes high-tech with drones" (6 February 2017), online: CTV News <<https://www.ctvnews.ca/canada/quebec-prison-smuggling-goes-high-tech-with-drones-1.3273586>>.

⁷ See Chu and Peddle, *supra* note 3 at 19. See e.g. Diana Weeks, "Hamilton police charge two correctional officers with drug offences," (19 June 2020) online: *Global News* <<https://globalnews.ca/news/7085837/correctional-officers-drugs-hamilton/>>; Karen Edwards, "Correctional officer charged with drug trafficking, breach of trust released on \$7500 bail" (25 June 2020) online: *tbnewswatch.com* <<https://www.tbnewswatch.com/local-news/correctional-officer-charged-with-drug-trafficking-breach-of-trust-released-on-7500-bail-2518753>>.

⁸ See Correctional Service Canada, *supra* at note 3.

Substances Involved in Overdose Incidents*



Compared to drugs, however, it is markedly more difficult to smuggle in sterile needles, which has led prisoners to rely on sharing or even creating their own makeshift needles.⁹ A 2007 survey found that 17 per cent of men and 14 per cent of women in federal prisons admitted to injecting drugs within the six months preceding the survey, about half of whom shared their injection equipment with others.¹⁰ Some prisoners have disclosed that they create their own makeshift material when sharing is not an option, using whatever items they could find.¹¹ One prisoner from Alberta revealed his experience in an interview:

“...I injected using a makeshift rig made out a Q-tip, masking tape, Bic pen and a piece of gum. I used the Bic pen and masking tape to fashion the barrel and plunger; the gum was used to attach the ‘needle’ to the end of the barrel. The ‘needle’ was fashioned out of a Q-tip, which is hollow, but which makes quite a wound when being inserted into the vein. Sometimes I would need to make a cut in my arm to make it easier to insert the Q-tip ‘needle.’ It works to inject but is very painful. Other things I witnessed people using to make rigs for injecting included eye-

⁹ See Chu and Peddle, *supra* note 3 at 24.

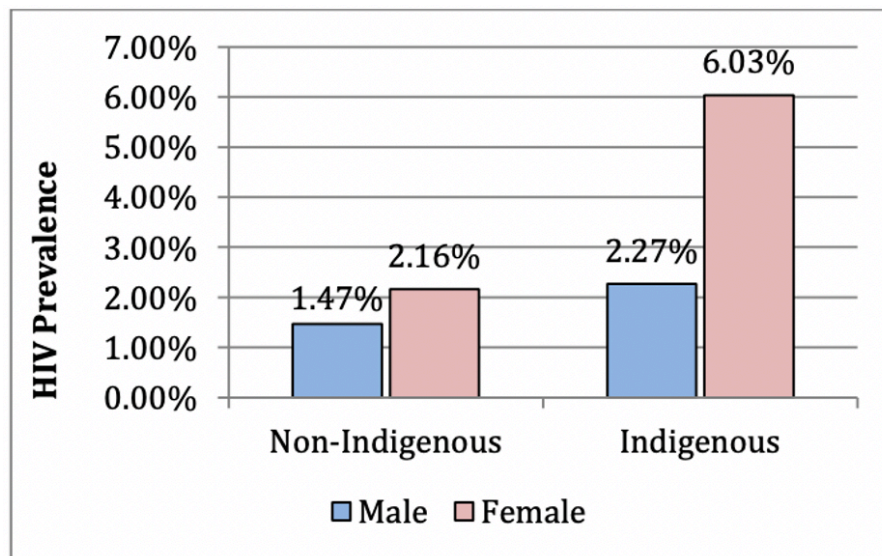
¹⁰ See Dianne Zakaria et al, “Summary of Emerging Findings from the 2007 National Inmate Infectious Diseases and Risk-Behaviours Survey” (March 2010), online: Government of Canada <<https://www.csc-scc.gc.ca/research/005008-0211-eng.shtml>>.

¹¹ See Chu & Peddle, *supra* note 3 at 25-26.

droppers, pieces of glass from light bulbs and plastic pens that had been melted and stretched...”¹²

These circumstances consisting of high drug use as well as high rates of sharing injection material in an enclosed area have led to increased susceptibility to blood-borne diseases.¹³ A 2016 study indicates that about 30% of people in federal prisons are living with HCV, and 1-2% of men and 1-9% of women in prison are living with HIV.¹⁴ Notably, the rates of infections are higher among certain marginalized groups: women and especially Indigenous women.¹⁵ Among Indigenous women in federal prisons, more than 1 in 10 is reported to be living with HIV and nearly 1 in 2 with HCV.¹⁶

Figure 2. HIV Prevalence in Canadian Prisons between 2005-2012 by Indigenous Ancestry and Gender.¹⁷



¹² See *ibid* at 24.

¹³ See Ralf Jurgens, Andrew Ball & Annette Verster, “Interventions to reduce HIV transmission related to injecting drug use in prison” (2009) 9 *Lancet Infect Dis* 57 at 58.

¹⁴ See Fiona Kouyoumdjian et al., “Health status of prisoners in Canada” (2016) 62:3 *Canadian Family Physician* 215 at 217.

¹⁵ See Correctional Service Canada, “Health Services Quick Facts: Human Immunodeficiency Virus (HIV) Age, Gender and Indigenous Ancestry” (September 2016), online (pdf): *Government of Canada* <<https://www.csc-scc.gc.ca/publications/092/005007-3034-eng.pdf>>.

¹⁶ See Zakaria, *supra* note 10.

¹⁷ See Correctional Service Canada, *supra* note 15.

Currently Existing Harm-Reduction Programs in Prisons

Recognizing the widespread drug use in prisons, CSC has implemented several harm-reduction programs over the years. There is no clear consensus on the meaning of harm reduction,¹⁸ although at its crux, it refers to “policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use.”¹⁹ Principles of harm reduction include respect for the rights of people who use drugs, a commitment to evidence, and avoidance of stigma.²⁰ Following these principles, harm reduction measures accept the reality of drug use, and focus on reducing its more immediate harms through a “pragmatic and low threshold” approach.²¹ In this section, I outline the harm reduction programs that currently exist in Canadian federal prisons.

Bleach (chlorine) distribution is one program that exists in many Canadian prisons, although it is not endorsed by public health experts.²² This program works by providing one-ounce bottles of bleach for the purpose of disinfecting injection equipment, and thus lowering the risk of blood-borne transmission of diseases.²³ The problem with bleach, however, often lies in the implementation of its use within the prison setting. Proper syringe-disinfecting protocol is a multi-step and

¹⁸ See James A. Inciardi & Lana D. Harrison, *Harm Reduction: National and International Perspectives*, (USA: Sage Publications, 2000) at introduction.

¹⁹ This is a widely adopted definition set out by a leading NGO in harm reduction. *Harm Reduction International*, “What is Harm Reduction?” (2020), online <<https://www.hri.global/what-is-harm-reduction>>.

²⁰ *Ibid.*

²¹ *British Columbia Ministry of Health*, “Harm Reduction: A British Columbia Community Guide” (no date) online (pdf): <<https://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf>> at 4.

²² See United Nations Office on Drugs and Crime (UNODC), “A handbook for starting and managing needle and syringe programmes in prisons and other closed settings” (July 2014), online <https://www.unodc.org/documents/hiv-aids/2017/ADV_PNSP_REV_FEB2015with_cover1.pdf> at 13. See also Camille Arkell & Scott Anderson, “Bleach: Should it be recommended to disinfect needles and syringes?” (2016), online: CATIE <<https://www.catie.ca/en/pif/fall-2016/should-bleach-be-recommended-disinfect-needles-and-syringes>>: “The World Health Organization, the Public Health Agency of Canada, and the *Best Practice Recommendations for Canadian Harm Reduction Programs* do not recommend the use of bleach as an HIV and hepatitis C prevention strategy.”

²³ See Arkell & Anderson, *ibid.*

time-consuming process;²⁴ the prison setting, where injection drug use takes place under rushed and clandestine circumstances, often leaves insufficient time to adhere to proper protocol.²⁵ Furthermore, the frequent use of makeshift needles leads to a greater likelihood of blood clots in the equipment, which makes it difficult to disinfect properly.²⁶ For these reasons, public health experts have argued that bleach can provide prisoners with a false sense of security and should only be regarded as a second-line strategy.²⁷

Opioid Agonist Therapy (OAT) is another harm reduction program implemented in Canadian institutions over 20 years ago.²⁸ OAT involves taking opioid agonist medications such as methadone, suboxone or sublocade, which act slowly in the body to prevent withdrawal and reduce cravings for opioid drugs.²⁹ Community organizations have long advocated for this program, for it has shown to reduce rates of drug use, as well as sporadic syringe-sharing and fatal overdoses.³⁰ However, there are several reasons why OAT is insufficient to alone counter the harm caused by drug addictions within prisons. First, only people who classify within a certain diagnostic criterion of opioid usage (DSM-5) are eligible,³¹ leaving out those who are addicted to classes of drugs cocaine or amphetamines or opioid-users who do not fall into this specific criterion. Furthermore, the high demand relative to the supply, means that there is often a waitlist (see **Figure 3**).³² Furthermore, the reality of OAT is that

²⁴ See *ibid.* "In a real world setting, using bleach to kill HIV or hepatitis C in used needles involves many steps...people should first rinse the needle twice with water, shaking the syringe to loosen any dried blood, followed by two rinses with full-strength bleach...and two final rinses with water."

²⁵ See *ibid.*; UNODC, *supra* note 22 at 13.

²⁶ See UNODC, *supra* note 22 at 13.

²⁷ See *ibid.*

²⁸ See Correctional Service Canada, "Opioid Agonist Treatment" (27 August 2020), online: Government of Canada <<https://www.csc-scc.gc.ca/health/002006-3000-en.shtml>>.

²⁹ *Ibid.*

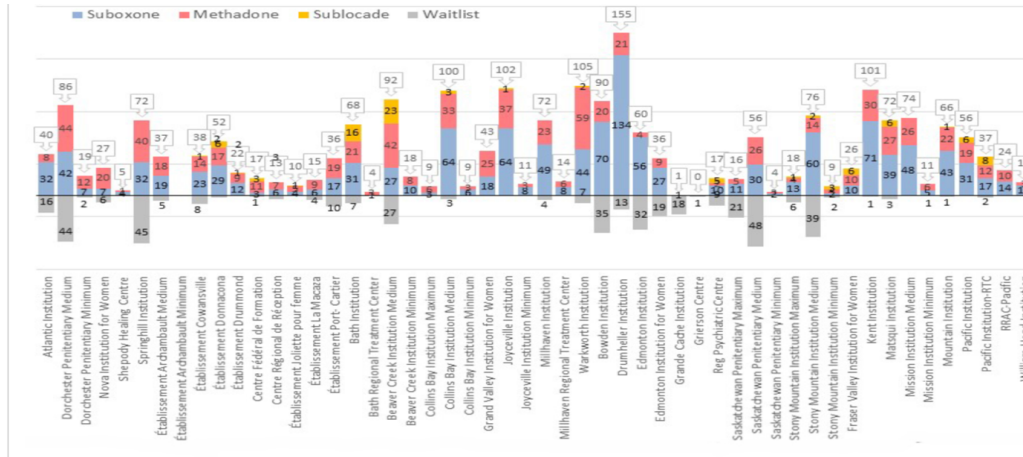
³⁰ See e.g. Thomas Kerr and Ralf Jurgens, "Opioid Substitution Therapy I Prisons: Reviewing the Evidence" (revised in 2008), online (pdf): <http://www.hivlegalnetwork.ca/site/wp-content/uploads/2013/04/OST_brief_08-EN.pdf>.

³¹ See Correctional Service Canada, "Guidance on Opioid Agonist Treatment (OAT): November 4, 2019" (4 November 2019), online: Government of Canada <<https://www.csc-scc.gc.ca/health/002006-3004-en.shtml#1>>.

³² See Correctional Service Canada, "Opioid Agonist Treatment: March 2020" (March 2020), online: Government of Canada <<https://www.csc-scc.gc.ca/health/002006-3003-en.shtml>>.

some people will continue to inject drugs and share injection equipment while they are on OAT, which means that they will continue to be vulnerable to HIV or HCV infection.

Figure 3. Opioid Agonist Treatment in Canadian Institutions in March 2020³³



The Rights of Prisoners

There is often a tendency to distinguish between the right to health of people in prisons and the right to health of people in general, but this distinction is problematic. Everyone, including prisoners, have the right to the right to enjoyment of the highest attainable standard of physical and mental health,³⁴ which is understood as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”³⁵ In Canada, this right is recognized under section 86 of the *Corrections and Conditional Release Act*, which states that the government must “provide every inmate with essential health

³³ *Ibid.*

³⁴ See *International Covenant on Economic, Social and Cultural Rights*, United Nations, Treaty Series, vol. 933, 1966, at art 12. This Covenant recognizes the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” See also *Universal Declaration of Human Rights*, United Nations General Assembly, 217 A(III), 1948, art 25. This declaration also recognizes the “right to a standard of living adequate for the health and well-being of himself...”

³⁵ *World Health Organization Constitution*, United Nations General Assembly, A/RES/131, 1947, at preamble.

care and reasonable access to non-essential health care” that “conform to professionally accepted standards.”³⁶

Moreover, not only is it problematic to distinguish between the right of health to people in and outside of prison, but it is also arbitrary, because most people who serve time in prisons are released, and once again integrated into society. Rising rates of blood-borne diseases within prisons will inevitably have an impact on populations outside of prisons once the prisoner is released. Prisoners’ health is public health.³⁷

As a matter of ethical and legal obligation under international human rights law, prisoners are entitled to a standard of healthcare that is equivalent to that available outside of prison and that conforms to professionally accepted standards. This principle, often called the principle of equivalence, is recognized in Rule 24 of the *Mandela Rules*, which states that “the provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community...”.³⁸ Principle 9 of the *Basic Principles for the Treatment of Prisoners* also states that “prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”³⁹ The principle of equivalence makes clear why the practice of using bleach should not be encouraged within prisons, since it is not seen as good practice within harm reduction programs in the broader community.⁴⁰ It also provides an argument as to why needle exchange programs should be available within prisons, since it is also widely available for people in Canadian communities, outside of prison.⁴¹

³⁶ *Corrections and Conditional Release Act*, SC 1992, c 20, s 86.

³⁷ See generally Rick Lines, “The Right to Health of Prisoners in International Human Rights Law” (2008) 4:1 *Int J Prison Health* 3.

³⁸ *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*, United Nations General Assembly, A/C.3/70/L/3, 2015 at rule 24.

³⁹ *Basic Principles for the Treatment of Prisoners*, United Nations General Assembly, A/RES/45/111, 1991, at principle 9.

⁴⁰ See Emily van der Meulen et al, *supra* note 2 at 7.

⁴¹ See e.g. Ontario harm reduction distribution program, “Programs” (2020) online: < <http://www.ohrdp.ca/about-us/needle-exchange/>>.

Learning from International Models of Prison Needle Exchange Programs

The world's first prison needle exchange program started as one doctor's act of medical disobedience. Dr. Franz Probst, who was a part-time physician in the Oberschöngrün prison for men in Switzerland, was aware of the disturbing reality that many prisoners resorted to using drugs by reusing and sharing needles.⁴² Probst felt that it was his ethical responsibility as a doctor to prevent the risk of transmitting blood-borne diseases. In 1992, he started to distribute clean syringes on his own initiative. More surprisingly, when this act was discovered by the authorities, they were also convinced that it was a good initiative for the public health of the prisoners, and the program soon became institutionalized.⁴³ And so, the first program of prison needle exchange was created.

Since this first program created in 1992, PNEPs have spread to over 86 countries, although the numbers continue to fluctuate because the programs are dependent on the political context in the countries (see **Figure 4**).⁴⁴ To start, I begin by presenting the case studies of Switzerland, Spain, and Moldova, three countries that have each used very different models of implementing PNEPs.⁴⁵ Following these case studies, I conduct a horizontal analysis, outlining the broader lessons that can be

⁴² See Joachim Nelles & Timothy Harding "Preventing HIV transmission in prison: a tale of medical disobedience and Swiss pragmatism" (1995) 346:8989 *The Lancet* 1507 at 1507; Rick Lines et al, "Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience", 2nd ed (Toronto: Canadian HIV/AIDS Legal Network, 2006) at 1.

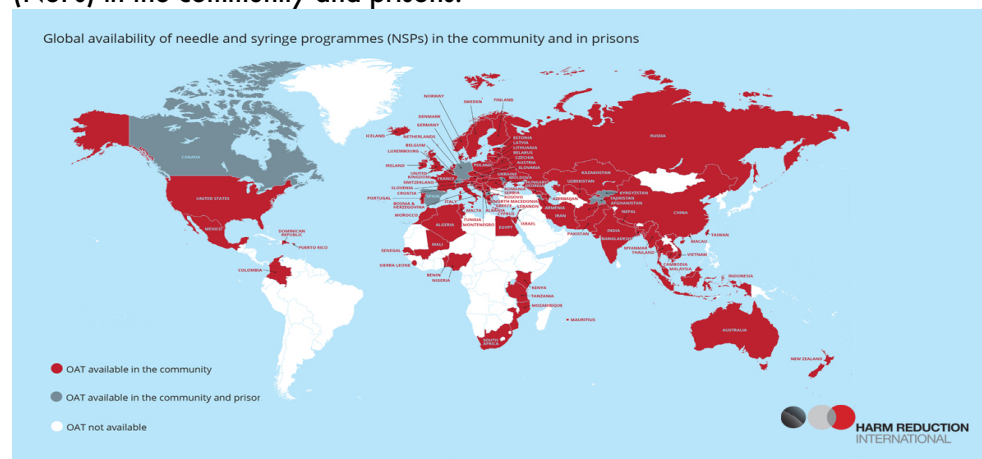
⁴³ *Ibid*; see also Kate Dolan, Scott Rutter & Alex D. Wodak, "Prison-based syringe exchange programmes: a review of international research and development" (2002) 98:2 *Addiction* 153 at 154.

⁴⁴ See Harm Reduction International, "The Global State of Harm Reduction 2020" (2020), online: <<https://www.hri.global/global-state-of-harm-reduction-2020>>.

⁴⁵ For case studies on other countries, see Lines, *supra* note 42; Thomas Wong et al, "Prison needle exchange: Review of the evidence" (April 2006), online (pdf): *Public Health Agency of Canada (PHAC)* <<http://www.hivlegalnetwork.ca/site/wp-content/uploads/2017/11/Tab-4-06Jun-PNEP-Report-to-CSC.pdf>>. This 2006 PHAC report was prepared at the request of Correctional Services Canada. As part of the research, over 200 documents were reviewed, field-visits were conducted to Germany and Spain, and a two-day expert consultation was convened.

abstracted from these international models and applied in the Canadian context.

Figure 4. Global availability of needle and syringe programmes (NSPs) in the community and prisons.⁴⁶



Switzerland

By December 2000, Switzerland had seven PNEP programs across the country.⁴⁷ Several of these prisons⁴⁸ distributed needles in the same manner as was established by Dr. Probst in Oberschöngrün: healthcare professionals who worked in the prisons distributed needles upon request. Other prisons in the cities of Hindelbank and Realta started to use automatic distribution machines (see Figure 5).⁴⁹ All prisoners were offered dummy syringes at the start of the program or during entry into the prison; these dummy syringes or used syringes were then able to be inserted into the machine to release a new syringe. In Hindelbank prison, six distribution machines were placed at various locations that were accessible and yet discrete, to allow a level of confidentiality for the prisoners (see Figure 6).⁵⁰ The high number of syringes exchanged serve as an indicator of the successful

⁴⁶ See Harm Reduction International, *supra* note 42, for more information about the various NSPs that exist around the world.

⁴⁷ See Lines, *supra* note 42 at 23.

⁴⁸ Champ Dollon prison in Geneva, and Witzwil and Thorberg prisons in Berne.

⁴⁹ See Joachim Nelles, A Dobler-Miklova, B Kaufmann, "Provision of syringes and prescription of heroin in prison. The Swiss experience in the prisons of Hindelbank and Obershongrun" in Joachim Nelles and A Fuhrer, ed, *Harm Reduction in Prison* (Bern: Peter Lang) 239.

⁵⁰ *Ibid.*

implementation of the machines: during the first year of the PNEP program in Hindelbank, 5335 syringes had been exchanged through the distribution machines.⁵¹ In Realta, 1389 syringes were exchanged over a 19-month period.⁵²

Figure 5. A photograph of the syringe distribution machine in Saxerriet Prison, Switzerland.⁵³



Figure 6. In Hindelbank Prison, Switzerland, syringe dispensers are freely available but hidden from general view.⁵⁴



⁵¹ *Ibid.*

⁵² See Joachim Nelles, A Fuhrer and I Vincenz, "Drug, HIV and Hepatitis Prevention in the Realta Contonal Men's Prison: Summary of the Evaluation" (1999) Bern: Swiss Federal Office of Public Health.

⁵³ See Lines, *supra* note 42 at 22.

⁵⁴ See Joachim Nelles et al, "Provision of syringes: the cutting edge of harm reduction in prison?" (1998) 317:7153 British Medical Journal 270 at 273.

Spain

The first PNEP in Spain was established in Basauri prison in the Basque region in 1997.⁵⁵ In 2001, following the positive results from the pilot programs, the Spanish government ordered that needle exchange programs be implemented in all 69 prisons under their jurisdiction.⁵⁶ The latest recorded data shows that, by the end of 2003, there were 30 PNEPs.⁵⁷

In Spain, all prison needle exchange is done through hand-to-hand methods, often through prison healthcare staff in collaboration with external non-governmental organizations.⁵⁸ For instance, in Bausari, where the first PNEP program in Spain was launched, non-governmental organizations would visit the prisons for five hours each day and meet with prisoners in discreet areas.⁵⁹ In addition to a sterile needle, prisoners would receive a comprehensive harm-reduction kit containing an alcohol swab, distilled water, a hard container for carrying the needle, and a condom. Needles needed to be kept in the plastic cases to minimize risk of accidental injuries, and these needles were marked so that they could be distinguished from contraband needles.⁶⁰

⁵⁵ See Lines, *supra* note 42 at 31; see also C Menoyo, D Zulaica, and F Parras, "Needle exchange programs in prisons in Spain" (2000) 5:4 Canadian HIV/AIDS Policy & Law Review 20 at 21.

⁵⁶ See Lines, *supra* note 42 at 32. In March 2002 the Ministry of the Interior and the Ministry of Health and Consumer Affairs jointly published the document *Needle Exchange in Prison: Framework Program*, which provides the prisons with guidelines, policies, and procedures, and training and evaluation materials for implementing needle exchange programs.

⁵⁷ *Ibid.*

⁵⁸ *Ibid.*

⁵⁹ In the rest of Spain, the availability of the NGO workers varied from two days per week to everyday, depending on the institution. Times of program operation also varied, although sterile needles were generally available during a two-to-four-hour period in either the morning or evening.

⁶⁰ See Lines, *supra* note 42 at 33. This is representative of most PNEPs in Spain. Prisoners participating in the program need to keep their needle inside the hard-plastic case at all times. In the case of search by staff, they must identify that they have the needle and its location.

Figure 7. The Harm reduction kit provided in Soto de Real Prison, Madrid.⁶¹



The needle exchange programs in Spain are notable for their clear and progressive governmental guidelines. For one, the program guidelines do not mandate strict adherence to the one-for-one exchange. They state that “a flexible attitude should be maintained towards [the one-for one rule’s] application keeping in mind that the primary objective of the program is to prevent shared use of syringes.”⁶² Furthermore, the only legitimate reasons why people can be excluded from the program are serious mental health issues or violence.⁶³ Instead of detailed rules and regulations, the Spanish guidelines follow the general principle that it is better to “ensure compliance with a minimum number of basic rules that have real impact on maintaining the safety of the program than to implement a program with many accessory rules [that] may cause effective preventative measures to be neglected,”⁶⁴ thus allowing for flexibility within institutions.

Moldova

The first pilot PNEP program in Moldova was established in 1999 in Prison Colony 18 in Branesti, as a joint initiative between the Department of Penitentiary Institutions and the

⁶¹ See *ibid*.

⁶² See *ibid*; Ministerio Del Interior /Ministerio De Sanidad y Consumo “Needle Exchange in Prison: Framework Program” (2002) at 4.

⁶³ See Lines, *supra* note 42 at 34. “Prisoners participating in methadone maintenance for example, are not disqualified from accessing the needle exchange program... In the case of violent prisoners, prison officials are encouraged to bear in mind that it is always preferable to adopt special security rules with these inmates than to deny access to sterile syringes.”

⁶⁴ See *ibid* at 33.

NGO, Medical Reforms in Penitentiary Institutions.⁶⁵ This prison was chosen because it housed the largest number of prisoners known to be HIV-positive and had the largest number of people incarcerated for drug-related offenses.⁶⁶ In the beginning, the sterile needles were distributed hand-to-hand through the prison medical unit.⁶⁷ However, in the context of this prison, there was a lack of rapport and trust between the medical staff and the prisoners, leading the prisoners to expect the program to be a “trap.”⁶⁸ The lack of anonymity and confidentiality in the service were leading factors for why the program was only used by 25% to 30% of the prisoners presumed to inject drugs.⁶⁹

Nevertheless, the new model of needle distribution was created: a peer exchange program. Prison Colony 18 selected eight prisoners who acted as secondary exchange volunteers who were trained to exchange sterile needles as well as provide harm-reduction services in four different sites in the prison (see **Figure 8**). Two peer volunteers were assigned to work at each site and, by virtue of having the distributors be peers, the clean needles were virtually available on a 24-hour basis. Soon after this shift, 65-70% of people known to inject drugs were accessing the project.⁷⁰ Between December 1999 and December 2000, peer volunteers in Branesti exchanged 2840 syringes.⁷¹ This peer distribution model has spread in over twenty Moldovan prisons with needle exchange programs.⁷²

⁶⁵ See Jeff Hoover, “Harm Reduction in Prison: The Moldova Model” (2009) Open Society Institute at 13.

⁶⁶ See *ibid* at 14.

⁶⁷ See *ibid* at 15-16.

⁶⁸ See *ibid* at 16; see also Heino Stover & Joachim Nelles, “Ten years of experience with needle and syringe exchange programmes in European prisons” (2003) 14(5-6) *Int J Drug Policy* 1 at 4.

⁶⁹ See Lines, *supra* note 42 at 38.

⁷⁰ See Hoover, *supra* note 65 at 17.

⁷¹ See Lines, *supra* note 42 at 39; Hoover, *supra* note 65 at 17.

⁷² See Hoover, *supra* note 65 at 26.

Figure 8. NGO project coordinator speaking with a volunteer distributor in Prison Colony 18.⁷³



Overarching Lessons

1. Initial reluctance to PNEP is expected.

Initial pushback to the programs was recorded in almost every country, but it was quickly overcome once the programs were implemented. Dr. Nicolae Bodrug, who was the head of Branesti's medical unit and helped establish the PNEP in Moldova, stated that "it took two years to break the ice of mistrust. We had to learn a lot, say strange things, and act oddly in front of a [skeptical] majority."⁷⁴ However, she continued that, overtime "harm reduction became normal...we can look forward confidently to expansion."⁷⁵ Furthermore, staff in prisons in Germany,⁷⁶ who were among the most vocal critics of PNEPs became fervent advocates of keeping the program open when the government made a political decision to shut them down.⁷⁷ Prison staff in Vechta, Germany started a petition, and prison staff in Lichtenberg, Berlin (85% who initially opposed PNEPs)

⁷³ See Hoover, *supra* note 65 at 17.

⁷⁴ See Lines, *supra* note 42 at 40.

⁷⁵ *Ibid.*

⁷⁶ See *ibid* for more information about PNEPs in Germany.

⁷⁷ See Lines, *supra* note 42 at 29.

became the main actors lobbying the government to keep the program operating.⁷⁸

2. *There is no one-size-fits-all PNEP.*

The “ideal” model will not always be the same: “successful models of a particular prison in a particular country cannot necessarily be transferred to another prison in another country.”⁷⁹ An effective PNEP will take into account the context of a particular institution, such as the number of people, the relationship between the prison staff and the prisoners (ex. do they have a relationship based on trust?), and the amount of resources (ex. is there money to implement distribution machines? Are there community workers who are willing and able to provide services?). Each model has its own advantages and disadvantages (see **Figure 9**).

In some institutions, more than one distribution model is used. For instance, some institutions in Spain used community workers as well as the prison health care workers.⁸⁰ Other institutions realized that a specific model was not working after the trial period and switched to a different distribution model. This was the case in Moldova, where there was a switch from distribution by prison health services to the peer distribution model, which ultimately led to a significant uptake in the program.⁸¹

Figure 9. A Summary of the Models of Distribution Used in Other Countries⁸²

Model	Description	Advantages	Disadvantages	Examples of Country of implementation *
Dispensing machines	Equipment is distributed by a	• High degree of accessibility and anonymity	• No opportunity for counselling	Switzerland (Geneva, Bern)

⁷⁸ *Ibid.*

⁷⁹ See *Simons et al v Minister of Public Safety et al*, 2020 ONSC 1431 [Simons] at para 39. This is a quote by Dr. Stover, an expert of PNEPs in Europe.

⁸⁰ See Lines, *supra* note 42 at 32.

⁸¹ See Hoover, *supra* note 65 at 17.

⁸² This information was mainly gathered from Lines, *supra* note 42; UNODC, *supra* note 22; Wong et al, *supra* note 45.

	machine. The prisoners place a used or dummy syringe into the slot, pull the lever, and the machine dispenses a sterile syringe.		or support from staff • Risk of machine sabotage • Risk that the machine would not be restocked properly • No access during lockdowns	Germany
Peer Exchange	Equipment is directly distributed from fellow prisoners who have been trained to deliver the program.	<ul style="list-style-type: none"> • Confidentiality • High level of trust • High degree of access, as peers are always available on site 	<ul style="list-style-type: none"> • Requires resources to train volunteers • Less accurate health information that may be distributed by professionals • Risk of influence due to interpersonal conflict and bias in distributing material • Potential pressure from CSC staff to expose peers • Not suitable for prisons with a high turnover of prison staff and prisoners 	<p>Moldova</p> <p>Belarus</p> <p>Kyrgyzstan</p>
Community workers	Equipment is distributed by external agencies that are not	<ul style="list-style-type: none"> • Confidentiality • Availability of professional information 	<ul style="list-style-type: none"> • Risk of limited access: supply only available when 	Spain

	employed by the prison system.	from providers	volunteers are available (standard working hours) • Risk that the prisoner may have pre-existing relationships with the particular community worker or organization (conflict of interest) • Risk that the program may be cut off in the case the prison ends affiliations with the worker or the group	
Prison health care services	Equipment is distributed by prison nurses, doctors, or other health care professionals within the prisons.	• Easier access compared to distribution by community workers • Availability of professional information from providers	• Lack of trust and belief that prison health care workers would share information with the administration • Risk of limited access; supply only available when health care staff are available (standard working hours)	Switzerland (Hindlebank, Realta) Spain Kyrgyzstan Germany

Figure 10. Additional Considerations for peer exchange programs.⁸³

Additional considerations for peer-based programmes

If a peer-to-peer approach is chosen, the following steps are recommended in view of the high responsibility borne by peer volunteers and their consequent vulnerability to intimidation or corruption:

1. An identified member of prison staff (a senior member of either the health-care or security staff) is responsible for the continued safe running of the peer-to-peer service.
2. Peer volunteers are carefully selected on the basis of demonstrable histories of good conduct during their prison sentence, and of high motivation.
3. Peer volunteers are trained thoroughly. Their training includes vectors and risks of disease transmission, hygienic infection control, and emergency procedures for HIV post-exposure prophylaxis (PEP)⁸⁴ and for the reversal of opioid overdose via naloxone.
4. Peer volunteers have a full supply of latex gloves, bleach and sharps bins.
5. Peer volunteers receive reward/remuneration commensurate with their contribution to the PNSP.
6. Peer volunteers are provided with highly structured supervision, with regular confidential meetings with NGO or clinic staff.
7. Regular confidential surveys of both prisoners and staff are conducted to identify as early as possible any potential instances of corruption of the service.
8. Where malpractice by a peer volunteer is suspected, the volunteer is relieved of his/her duties and a contingency arrangement is put in place.

3. Effective PNEPs have essential elements such as confidentiality, accessibility and separation from disciplinary measures.

While there was no one-size-fits-all model, most effective PNEPs had (or at least aimed to have) essential elements in common, including confidentiality, accessibility, and the fact that they were not linked to disciplinary measures. For one, confidentiality was almost always the main factor that determined whether or not prisoners would actually use the program.⁸⁴ Accessibility was also important both on the level of policy and implementation. To take the Spanish case study as an example: on the policy level, PNEPs were widely accessible because federal policies clearly mandated that the only legitimate reasons to exclude people from the program would be serious mental health issues or violence.⁸⁵ On the implementation level, several Spanish institutions prioritized physical accessibility by establishing multiple models of

⁸³ See UNODC, *supra* note 22 at 32.

⁸⁴ See Lines, *supra* note 42; UNODC, *supra* note 22; Wong et al, *supra* note 45; Hoover, *supra* note 65; Jurgens, *supra* note 13.

⁸⁵ See Lines, *supra* note 42 at 34.

distributions.⁸⁶ Furthermore, aside from confidentiality and accessibility, evidence has also shown that, in order to be effective, it is important that PNEPs are not linked to disciplinary measures. It is crucial for prisoners to know that they will not eventually be punished for their participation in the program.⁸⁷ Linked to this idea, whether or not security staff could find out about their involvement in the program, which might consequently lead to punitive measures, played a leading role in determining whether or not prisoners would participate.

4. A PNEP program does not cause increase in injection drug use.

Research confirms that rates of injection drug use as well as overdoses do not increase with the implementation of PNEPs (see **Figure 11**).⁸⁸ As with community needle and syringe programs, they do not encourage more drug use than already present. Rather, PNEPs have been observed to lead to increased referrals of prisoners to drug treatment programs, especially when complemented by other harm reduction programs.⁸⁹ Moreover, where these programs exist, prisoners experience fewer overdoses. When there is a limited supply of sterile injection equipment and prisoners must “rent” or “borrow” equipment, some feel pressure to inject all of their drugs at once and as quickly as possible.⁹⁰ The availability of sterile injection equipment lifts some of this pressure.⁹¹

⁸⁶ *Ibid* at 32.

⁸⁷ See *ibid*; UNODC, *supra* note 22; Wong et al, *supra* note 42; Hoover, *supra* note 65.

⁸⁸ See Wong et al, *supra* note 42 at 7; Jurgens, *supra* note 13 at 59.

⁸⁹ See Wong et al, *supra* note 42 at 7.

⁹⁰ See HIV/AIDS Legal Network, “Policy brief on the Correctional Service of Canada’s Prison Needle Exchange Program” (11 July 2019), online (pdf): <http://www.aidslaw.ca/site/prison-based-needle-and-syringe-programs/?lang=en>.

⁹¹ *Ibid*.

Figure 11. Summary evaluations of PNEPs in 11 European prisons.⁹²

Prison, country	Drug use	Injection of drugs	Needle sharing
Am Hasenberge, ^a Germany	No increase	No increase	Strongly reduced
Basauri, Spain	No increase	No increase	No data
Hannöversand, Germany	No increase	No increase	Strongly reduced
Hindelbank, Switzerland	Decrease	No increase	Strongly reduced
Lehrter Strasse, Germany	No increase	No increase	Strongly reduced
Lichtenberg, Germany	No increase	No increase	Strongly reduced
Lingen I, Germany	No increase	No increase	Strongly reduced
Realta, Switzerland	Decrease	No increase	Single cases
Saxerriet, Switzerland	No data ^b	No data ^b	No data ^b
Vechta, Germany	No increase	No increase	Strongly reduced
Vierlande, Germany	No increase	No increase	No change

^a In the beginning of the project (1996) sterile syringes were disposed of in several places in the prison and the slot machine was damaged (in opposition to drug search of people by staff when obtaining syringes from the slot machine).

^b Lack of valid follow-up data due to opposition against the questionnaires by the inmates.

5. A PNEP program does not increase rates of needles as weapons.

Research counters the myth that providing sterile injection equipment to prisoners will lead to more needle attacks against correctional officers. In fact, in over 25 years of operation, there has not been a single reported incident of assault with needles from PNEPs anywhere in the world.⁹³ Some may still argue that the risk of using needles as weapons will go up. However, this assumption would not be based on evidence and would counter the data from the international research that has been conducted.

In assessing this concern, it should also be noted that, if so desired, prisoners already have access to things that can potentially be used as a weapon, such as the knives that they eat with;⁹⁴ prisoners with diabetes for instance, are already entrusted with injection equipment, with no reported problems.⁹⁵ Studies have also anticipated that prisoners will be motivated to follow the PNEP procedures, so as to not lose access to the program.⁹⁶ In interviews, prisoners and prison staff have stated:

⁹² See Heino Stover and Joachim Nelles, "Ten years of experience with needle and syringe exchange programmes in European prisons" (2003) 14(5-6) *Int J Drug Policy* 1 at 7. See also Jurgens, *supra* note 13 at 59; Wong et al, *supra* note 45 at 7-8 for the same information.

⁹³ *Ibid.*

⁹⁴ See Emily van der Meulen et al, *supra* note 2 at 27.

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*

*"I don't think that they would be used as weapons because the guys wouldn't want to mess up the program. ... Let's just say they used it as a weapon or something, they know that right away from a security point of view that they are going to remove [the PNEP]."*⁹⁷

*"Once you got yourself a needle, you kept it used as a needle, right? You're not gonna...try and screw it up in any way."*⁹⁸

The Implementation of Needle Exchange Programs in Canada

Even after 10 years of research and advocacy by community organizers, including the 2006 PHAC report conducted at their request,⁹⁹ the CSC remained reluctant to implement PNEPs. This was tightly tied to the politics of the time. The Harper government's Public Safety Minister Steven Blaney said, "[we would] never consider putting weapons, such as needles, in the hands of potentially violent offenders."¹⁰⁰ Instead, the government released the \$64 million National Anti-Drug Strategy (NADS), which specifically focused on law enforcement activities.¹⁰¹ New legislation from NADS created mandatory minimum penalties and increased sentences for drug offences,¹⁰² paving the way for a swollen prison system; all the while HIV and HCV rates continued to rise within these same institutions.¹⁰³

⁹⁷ *Ibid.*

⁹⁸ *Ibid.*

⁹⁹ See Wong et al, *supra* note 45.

¹⁰⁰ Diana Mehta, "AIDS groups call for prison needle programs" (18 October 2013), online: Global News <<https://globalnews.ca/news/910059/aids-groups-call-for-prison-needle-programs/>>.

¹⁰¹ See Department of Justice, "National Anti-Drug Strategy Evaluation" (26 September 2018), online: Government of Canada <<https://www.justice.gc.ca/eng/rp-pr/cp-pm/eval/rep-rap/12/nas-sna/p1.html>>.

¹⁰² *Ibid.*

¹⁰³ See Zakaria, *supra* note 10.

Legal Dimensions

As a result, a legal challenge was initiated in 2012.¹⁰⁴ Applicant Steve Simons joined forces with various non-profit organizations¹⁰⁵ to launch a lawsuit against the government of Canada over its failure to make sterile injection equipment available to federal prisoners. Simons had been a prisoner in Warkworth Institution, a federal prison in Ontario, dependent on intravenous drugs for relief because of extreme joint pain from a work accident.¹⁰⁶ He had been the prisoner health care representative, so he had educated others on taking proper precautions to avoid HIV and HCV infection. Nevertheless, a fellow prisoner with HCV used his needle without his knowledge or consent, which caused him to contract the infection. Once Steve was released from prison, he wanted to make sure that others would not have to suffer in the same way, so he launched this court case. He asked not for a monetary settlement but a declaration requiring the government to make sterile injection equipment available in federal prisons in Canada.¹⁰⁷

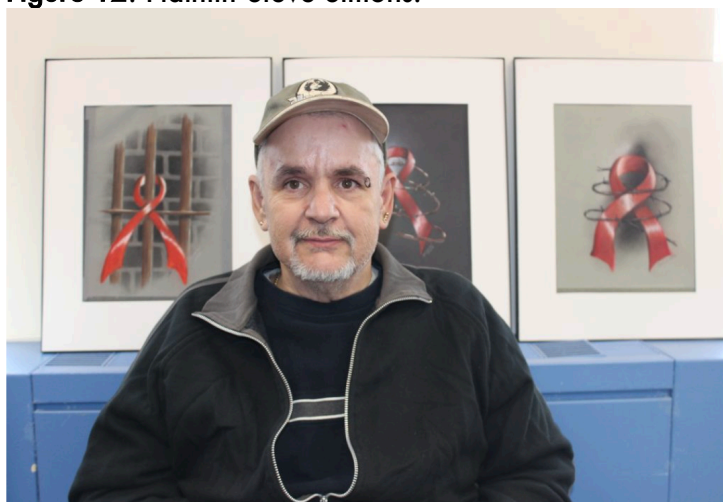
¹⁰⁴ See *Simons et al v Minister of Public Safety et al*, 2020 ONSC 1431 [Simons].

¹⁰⁵ The full list of applicants include: The Canadian HIV/AIDS Legal Network, Prisoners with HIV/AIDS Support Action Network (PASAN), Canada's Source for HIV and Hepatitis C Information (CATIE), and the Canadian Aboriginal AIDS Network (CAAN). Intervenor include: the Pivot Legal Society, West Coast Prison Justice Society, Vancouver Area Network of drug Users, British Columbia Civil Liberties Association, Canadian Public Health Association, Nursing Coalition (Registered nurses association of Ontario, Canadian nurses association, Association of Registered Nurses of British Columbia, Canadian association of nurses in HIV/AIDS care) and Aboriginal Legal Services.)

¹⁰⁶ See HIV/AIDS Legal Network, "Former prisoner Steve Simons writes why a prison needle exchange program is needed" (17 August 2020), online <<http://www.aidslaw.ca/site/former-prisoner-steve-simons-writes-why-a-prison-needle-exchange-program-is-needed/?lang=en>>.

¹⁰⁷ See Simons, *supra* note 104 at para 28.

Figure 12. Plaintiff Steve Simons.¹⁰⁸



The plaintiffs argued that the absence of a PNEP went against not only the guaranties of “essential health care” under Section 86(1)(a) of the *Corrections and Conditional Release Act* but also their rights under the Constitution.¹⁰⁹ They claimed violations of section 7 and 15 of the *Canadian Charter of Rights and Freedoms*. The section 7 argument was that the denial of PNEPs (as “essential health care”) to prisoners was a breach of their right to life, liberty and security of the person.¹¹⁰ The section 15(1) argument was that the failure to provide SIE to these prisoners constituted discrimination on the basis of disability (drug dependence) and also on the basis of sex and race (given the disproportionate number of injecting drug use (IDU) prisoners that are either female or Indigenous).¹¹¹ The CSC denied all of these claims.¹¹² This court case would continue for eight years, until the judgment rendered in early 2020, which I will explain later in this paper.

Political Dimensions

While the court case remained in the works, there was a critical shift in the political landscape: the Liberal Party, represented by Prime Minister Justin Trudeau, was elected into power in 2015. Harper’s National-Anti Drug Strategy was replaced by Trudeau’s Canadian Drugs and Substances

¹⁰⁸ See HIV/AIDS Legal Network, *supra* at note 106.

¹⁰⁹ See Simons, *supra* note 104 at para 13.

¹¹⁰ *Ibid* at para 9.

¹¹¹ *Ibid*.

¹¹² *Ibid*.

Strategy, which reinstated harm reduction as a key pillar, and ushered in progressive drug policies.¹¹³ In fact, prior to election, the Liberal Party even directly addressed the issue of PNEPs stating that there is “compelling evidence” to support PNEPs and that “any changes must rely on evidence to demonstrate that [harm reduction programs] are necessary to ensure Canadians’ safety.”¹¹⁴ The Liberal Party promised to “carefully review statements by groups like the Canadian HIV/AIDS Legal Network that the Conservative government is violating the rights of prisoners under the *Canadian Charter of Rights and Freedoms* by failing to provide prison needle and syringe programs inside prisons.”¹¹⁵

After the election, the Legal Network pushed for change. Penned in an open letter to Prime Minister Trudeau, the plaintiffs explained that they had initially launched this court case because “it was clear that, despite all the evidence, the Harper government would never agree to implement this basic harm reduction measure in federal prisons.”¹¹⁶ In contrast, since the liberal government was “committed to harm reduction, to evidence-based policy, to Charter rights and to the health and welfare of vulnerable Canadians,” the applicants urged the government to take action.¹¹⁷ As a result of the continued advocacy, the government offered to participate in mediation discussions in January of 2017:¹¹⁸ an opportunity for the stakeholders to search for a shared solution. However, with abrupt notice and no explanation, the government withdrew merely one week before the scheduled talks. The HIV Legal Network called this a “stunning decision” and a “profoundly

¹¹³ See Government of Canada, “The New Canadian Drugs and Substances Strategy” (12 December 2016), online <<https://www.canada.ca/en/health-canada/news/2016/12/new-canadian-drugs-substances-strategy.html>>.

¹¹⁴ See HIV/AIDS Legal Network, “Election 2015: Prisoners’ Right to Health—Major Federal Parties Respond” (9 October 2015), online <<http://www.aidslaw.ca/site/election-2015-prisoners-right-to-health-canadas-major-federal-parties-respond/?lang=en>>.

¹¹⁵ *Ibid.*

¹¹⁶ HIV/AIDS Legal Network, “An Open Letter Regarding Prison Harm Reduction” (27 October 2017), online <<http://www.aidslaw.ca/site/wp-content/uploads/2017/11/Ltr-GOC-re-PNSP-litigation-27-Oct-FINAL.pdf>>.

¹¹⁷ *Ibid.*

¹¹⁸ See HIV/AIDS Legal Network, “Government walks away from talks on critical harm reduction measure in Canadian Prisons” (17 January 2017) online <<http://www.hivlegalnetwork.ca/site/government-walks-away-from-talks-on-critical-harm-reduction-measure-in-canadian-prisons/?lang=en>>.

disappointing move,” for it meant that the legal fight needed to continue.¹¹⁹

The Social Dimension

Meanwhile, there was also movement on the community level. Once the court case was launched, there was increased media attention on the issue, and momentum started to build both for and against the PNEPs. Vouching for the program, nearly 250 Canadian organizations signed a statement urging federal and provincial governments to immediately implement PNEPs.¹²⁰ In the statement, medical professionals including the previous Medical Officer of Health for Toronto, stated that “this is a matter not simply of prison health, but of public health. PNSPs have been proven to increase referrals to drug treatment programs, reduce overdoses, and promote workplace health and safety by reducing the likelihood of accidental needle-stick incidents. The overwhelming evidence of their benefits can no longer be ignored.”¹²¹

Opposition voices were also growing. The Union of Canadian Correctional Officers (UCCO) started to mobilize against the program,¹²² alleging that needles from this program could be used as weapons, and that there were plenty of other harm reduction programs in Canadian prisons such as OATs.¹²³ Even once the PNEP was actually established, they continued to express frustration about the fact that they had not been consulted during the implementation process.¹²⁴ They also expressed confusion about the fact that they were supposed to continue treating drugs and needles as contraband while also

¹¹⁹ *Ibid.*

¹²⁰ See HIV/AIDS Legal Network, “Canada can’t wait: the time for prison-based needle and syringe programs is now” (1 June 2016), online (pdf) <<http://www.aidslaw.ca/site/canada-cant-wait/?lang=en>>.

¹²¹ See HIV/AIDS Legal Network, “Nearly 250 Organizations across Canada call for prison-based needle and syringe programs” (1 June 2016), online (pdf) <<http://www.hivlegalnetwork.ca/site/nearly-250-organizations/?lang=en>>.

¹²² See Union of Canadian Correctional Officers, “Prison needle exchange program” online <<https://ucco-sacc-csn.ca/files/prison-needle-exchange-program-pnep/>>.

¹²³ See Union of Canadian Correctional Officers, “Concerns of the Prison Needle Exchange Program” online <https://sencanada.ca/content/sen/committee/421/RIDR/Briefs/UCCO_Brief_2_e.pdf>.

¹²⁴ *Ibid* at 2.

accepting PNEPs.¹²⁵ The UCCO staged multiple protests in order to show their frustration (see **Figure 13** and **Figure 14**).

Figure 13. Members of the Union of Canadian Correctional Officers protesting with signs with their slogan “Not Our Job.”¹²⁶



Figure 14. Members of the Union of Canadian Correctional Officers protesting with a fake syringe.¹²⁷



Canada's Prison Needle Exchange Program

The biggest plot twist was when, four months before a hearing date, in May of 2018, the government suddenly announced its plans to implement PNEPs in all federal prisons.¹²⁸ It would not be implemented all at once, the government stated, but through a phased implementation of pilot programs.¹²⁹ Nevertheless, the applicants could not celebrate. For one, this

¹²⁵ *Ibid* at 2.

¹²⁶ See Union of Canadian Correctional Officers, *supra* note 122.

¹²⁷ *Ibid*.

¹²⁸ See Correctional Service Canada, “Prison Needle Exchange Program” (modified 28 August 2019), online <www.csc-scc.gc.ca/health/002006-2005-en.shtml>.

¹²⁹ *Ibid*.

untimely, one-sided announcement was made without any consultation or notice, neither to the applicants in the case, nor even prison staff. Furthermore, the details of the program revealed that it centered around security concerns, at the expense of prisoners' access.

Participation in the PNEP first required that the prisoner meet with CSC Health Services.¹³⁰ The problematic aspect of the program is that the prisoners are then required to undergo a "threat risk assessment," meaning they must be approved by security staff, and then the Head or Warden of the prison. It requires twice daily "visual inspections" of the distributed equipment. It also requires participants to sign a contract stating that "disciplinary measures" will continue to be implemented if the prisoner is found to be in possession of illicit drugs or paraphernalia, except for the PNEP kit and supplies provided. The fear created by this security-oriented program creates a prison needle exchange program *de jure*, or in name, but in reality, created unrealistic barriers to participation.¹³¹ There are also no clear guidelines that determine when someone is ineligible for the PNEP.¹³² Almost a year has passed since the program was implemented, but there are only a handful of individuals enrolled.¹³³

Another consequence of this sudden announcement was its effect on the court case, since it rendered many of the applicants' arguments moot. Nevertheless, given the continuing insufficiencies in the program, the applicants decided to continue the case by amending their claims.¹³⁴ If they previously targeted the absence of the program as unconstitutional because prisoners were not provided the "essential health care" that was guaranteed under s. 86(1) of the CCRA, the amended claim argued that the existing program was unconstitutional because this essential health care was not "in accordance with professionally accepted standards," also required under s. 86(2)

¹³⁰ *Ibid.*

¹³¹ See Office of the Correctional Investigator, "Office of the Correctional Investigator Annual Report 2018-2019" (25 June 2019), online <<https://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20182019-eng.aspx>>; see also Emily van der Meulen et al, *supra* note 2 at 28-35.

¹³² See factum of the intervener, British Columbia Civil Liberties Association, *Simons vs Minister of Public Safety* (No.CV-12-464162) at para 7. This information was provided in an affidavit in the case.

¹³³ See Office of the Correctional Investigator, *supra* note 131.

¹³⁴ See *Simons*, *supra* note 104 at para 11.

of the CCRA.¹³⁵ “Professionally accepted standards,” the applicants argued, 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.¹³⁶

In April 2020, Justice Belobaba of the Ontario Superior Court ruled against the applicants. Overturning the program would be premature, he declared, because the roll-out of the current program was only partially complete and the program continues to evolve: “passing judgment on the constitutionality of a PNEP that is only one-quarter complete and whose final design remains uncertain would be neither prudent nor just.”¹³⁷ As *obiter dictum*, Justice Belobaba also dismissed the constitutional argument that the current program did not uphold the “professionally accepted standard” under the CCRA; he argued that a strict separation between health and security staff was not a requirement under this law.¹³⁸ Despite the numerous affidavits from prison health experts explaining the importance of this separation, Justice Belobaba declared that although it may be important, it could not be considered necessary.¹³⁹ And like that, the eight-year legal battle came to a disappointing close.

Recommendations for Reform

On the one hand, it is laudable that Canada has taken the first step to implementing a PNEP, even despite the questionable timing and procedure. On the other hand, further steps must be taken in order to make the program truly effective and accessible. A program that does not meet this threshold may, in reality, be worse than not having one at all. It might provide the false impression that prisoners are choosing not to use the program because they do not need it, and not because they are *de facto* inaccessible; it might also create the false impression that there is a comprehensive harm reduction program that successfully upholds the rights of prisoners, and that further progress on this front is unnecessary. Although there may be reluctance and push back during the process of reform, this

¹³⁵ See *ibid* at para 12.

¹³⁶ See *ibid* at para 28.

¹³⁷ *Ibid* at para 24.

¹³⁸ *Ibid* at para 32.

¹³⁹ *Ibid* at para 32.

should not be a reason to stop. International experience has shown that both initial reluctance as well as eventual acceptance, are to be expected. With this in mind, the Canadian government is encouraged to do its due diligence and create reforms to the existing PNEPs. I propose five steps to follow in order to do so.

1. Return to the Human Rights Framework

Before delving into the crux of what the reforms should be, it is important to remember why these reforms are necessary. To do this, we return to the human rights framework that justifies the implementation of the PNEP in the first place. In this framework, we recognize that prisoners have a right to health;¹⁴⁰ they are entitled to a standard of healthcare that is equivalent to that available outside of prison and that conforms to professionally accepted standards.¹⁴¹ While prisoners relinquish certain rights upon incarceration, they do not relinquish their right to healthcare.¹⁴² Furthermore, a harm reduction program is meant to uphold the dignity of those who use drugs and to reduce stigma.¹⁴³ It is easy to lose sight of these theoretical principles when focusing on implementation, but they are important guidelines to ensure that the program achieves the purpose for which it was created.

2. Implement essential elements of an effective PNEP program

The CSC has tried to justify the “threat-risk” model by stating that there is no one-size-fits-all model, and that the Canadian context may call for a model that is different from those that are pre-established.¹⁴⁴ While this is true, the Canadian program lacks the essential underlying elements that effective PNEPs have in common, including confidentiality, accessibility

¹⁴⁰ See *International Covenant on Economic, Social and Cultural Rights*, *supra* note 34 at art 12.

¹⁴¹ See *United Nations Standard Minimum Rules for the Treatment of Prisoners*, *supra* note 38 at rule 24; *Basic Principles for the Treatment of Prisoners*, *supra* note 39 at principle 9.

¹⁴² *Ibid.*

¹⁴³ See *Harm Reduction International*, *supra* note 19.

¹⁴⁴ See *Simons*, *supra* note 104 at para 39.

and separation from disciplinary measures.¹⁴⁵ The current program should be re-evaluated in light of these elements and amended accordingly.

Accessibility: The fundamental problem of the current PNEP is that the fear created by this security-oriented program creates unrealistic barriers to participation.¹⁴⁶ The best way to remove this barrier will be to exclude the involvement of the security staff, and instead turn the responsibilities to the medical staff.¹⁴⁷ If the CSC insists that it is absolutely necessary to have the security staff involved, then it must figure out a way to do so while balancing this need to create accessibility for users. In addition, applicants have also been rejected without justification, for the current PNEP guidelines do not require reasons for exclusion.¹⁴⁸ A clear criterion must be created.

Confidentiality: The current PNEP also compromises the confidentiality of prisoners in various ways. Participation in the program not only requires prisoners to be personally verified by the warden; prisoners must also show a kit for visual inspections during the daily stand-to-count and upon request; they must also personally return used needles to Health Services, without any other disposal options.¹⁴⁹ While acknowledging that complete confidentiality may not be possible, the PNEP must be as confidential as possible, since it remains one of the main factors to determine whether or not prisoners will actually access the program. International models have shown that, unless triggered by a pressing safety concern, such regular and intrusive inspections are not a necessary measure to keep prisons safe.¹⁵⁰ They have also shown the importance of creating easily

¹⁴⁵ See Emily van der Meulen et al, *supra* note 2 at 29 for their recommendation that “prisoner access to PNEPs and sterile injection supplies should be easy, confidential, and not subject to disciplinary consequences.” For further information on the importance of the essential elements, see section three (Learning from International Models) of this paper; see also Lines, *supra* note 42 at 34; UNODC, *supra* note 22; Wong et al, *supra* note 45; Hoover, *supra* note 65.

¹⁴⁶ See Office of the Correctional Investigator, *supra* note 131.

¹⁴⁷ See Simons, *supra* note 104 at para 28.

¹⁴⁸ See Office of the Correctional Investigator, *supra* note 131.

¹⁴⁹ See *Ibid.*

¹⁵⁰ See generally the case studies in Lines, *supra* note 42 at 34; UNODC, *supra* note 22; Wong et al, *supra* note 44; Hoover, *supra* note 65.

accessible disposal options that are in confidential locations and available throughout the day.¹⁵¹

Not subject to disciplinary measures: For one, cutting access to the PNEP should not be used as a disciplinary measure.¹⁵² Unless there is a specific security incident that clearly justifies why they can no longer participate in the program, access should never be restricted or blocked as a means of punishment.¹⁵³ Furthermore, obtaining supplies through the PNEPs should not be considered a reason for disciplinary consequences. Under no circumstances should program participation be documented and reported to parole boards, to be used as a determinant of whether parole should be allowed.¹⁵⁴

3. Continue data collection

In order to make evidence-based changes, it is important to continue collecting data. The government should conduct routine and detailed interim reports that are both quantitative and qualitative.¹⁵⁵ Statistics should be collected on: how many people have applied to the program, how long they have waited, how many were accepted, how many were rejected, and how many were kicked out.¹⁵⁶ The qualitative aspects should cover, among other things, a description of the implementation process, unexpected difficulties in implementation, as well as the reactions and opinions of the prisoners and prison staff (a template for an evaluation questionnaire is attached in **Appendix A**). Such surveys should remain anonymous to protect the confidentiality of everyone involved.

¹⁵¹ See Emily van der Meulen et al, *supra* note 2 at 29: “safer disposal options should also be easily accessible (i.e. in various confidential locations and available throughout the day.”

¹⁵² *Ibid.*

¹⁵³ *Ibid.*

¹⁵⁴ *Ibid.*

¹⁵⁵ See Office of the Correctional Investigator, *supra* note 131. This states that there was supposed to be an interim report released this fall. However, nothing has been released to date.

¹⁵⁶ These questions were crafted with input from Sandra Ka Hon Chu, Director of research and advocacy at the HIV/AIDS Legal Network.

4. *Involve Stakeholders in the Process*

One of the most problematic aspects in the implementation process was the way in which it was created one-sidedly and without consultation. Earlier consultations could have allowed stakeholder concerns to be addressed early and efficiently.¹⁵⁷ Going forward, the government should host stakeholder meetings that involve these various parties, during which they could discuss the interim reports and figure out ways the Canadian PNEP can be improved. At least one stakeholder meeting, in this early stage, before the roll-out of the program continues, will be helpful to avoid complications later on.

In terms of identifying the stakeholders: NGOs such as the Legal Network that has been at the forefront of implementation in PNEPs should be included. Already, with their advice, the government has conceded to changes such as the elimination of the “needs” flag (a flag activated in the Offender Management System when a prisoner is approved for participation), as well as separation from parole (initially, information about the PNEP participation was shared with the Parole Board).¹⁵⁸ Prison staff should also be involved, especially to quell their current frustration with the CSC for their lack of prior consultation.¹⁵⁹ Better understanding their opposition will be crucial to resolving their misconceptions and enhancing their commitment to the program.¹⁶⁰ Countries such as Germany have shown that staff in prisons who were among the most vocal critics of PNEPs have the potential to become its most fervent advocates.¹⁶¹ Prisoners themselves should also be involved: a program about them should include them.¹⁶² Research shows

¹⁵⁷ See Emily van der Meulen et al, *supra* note 2 at 32. See also the importance of meaningful stakeholder engagement, Rajiv Maher and Karin Buhmann “Meaningful stakeholder engagement: bottom-up initiatives within global governance frameworks” (2019) 107 *Geoforum* 231 at 231.

¹⁵⁸ See Simons, *supra* note 104 at para 23.

¹⁵⁹ See Union of Canadian Correctional Officers, *supra* note 123, showing frustration that they were not informed about the PNEP prior to implementation.

¹⁶⁰ See Daniel Mogg & Michael Levy “Moving beyond non-engagement on regulated needle-syringe exchange programs in Australian prisons” (2009) 6:7 *Hard Reduction Journal*, 1 at 9.

¹⁶¹ See Lines, *supra* note 42 at 29.

¹⁶² See Ralf Jurgens, ““Nothing about us without us”—Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative” (2008), online: *HIV/AIDS Legal Network* <<http://www.hivlegalnetwork.ca/site/wp->

that including prisoners in the process is an effective way of helping them build trust in the PNEPs.¹⁶³

5. Timely Implementation

The CSC remains far behind their initial schedule that has aimed to finish implementing PNEPs in all 43 federal prisons by August of 2020.¹⁶⁴ It is currently December 2020, and pilot programs exist in only 11 of the 43 federal prisons.¹⁶⁵ Understandably, a part of this delay has been caused by the Coronavirus (COVID-19) pandemic, but as soon as it becomes safe to continue, CSC should continue to implement PNEPs in all federal prisons without delay. The CSC should reveal new estimated deadlines by when this can be accomplished, and they should be publicly shared for reasons of accountability.

These reforms that have been listed in this section should also be implemented in a timely manner, without unnecessary delay. If it is not possible to implement all the reforms at the same time, CSC should prioritize the reforms in the order that they are listed. For instance, reforms to implement essential elements of an effective PNEP program, should be prioritized over data collection and organization of stakeholder meetings. This said, it is difficult to designate a clear order because these steps are heavily interconnected (for instance, it is clear that timely implementation should be simultaneously conducted with other reforms). All these steps ultimately play a crucial role in implementing an effective PNEP.

Conclusion

Through this paper, I have argued that a prison needle exchange program is an important harm reduction measure that

content/uploads/2013/04/Greater+Involvement+-+Rpt+-+Drug+Policy+-+ENG.pdf>.

¹⁶³ See e.g. Hoover, *supra* note 65.

¹⁶⁴ See respondent's factum in *Simons et al v Minister of Public Safety et al*, 2020 ONSC 1431.

¹⁶⁵ See Correctional Service Canada, *supra* at note 128. The list of federal institutions in which PNEPs have been established so far include: Grand Valley Institution, Atlantic Institution, Fraser Valley Institution, Edmonton Institution for Women, Nova Institution, Joliette Institution, Joyceville Institution (minimum security), Mission Institution (medium security), Dorchester Penitentiary, Bowden Institution, and Warkworth Institution.

should be implemented in all Canadian prisons. It can decrease the risk of serious blood-borne diseases such as HIV and HCV in prisons, and uphold prisoners' right to health that is established as a matter of legal and ethical obligations in domestic and international law. This said, it is clear that this is far from an easy process. There are many things to consider and many people to think about; there is also not one clear answer or model that can be simply emulated. International evidence, however, shows us that many countries go through a trial and error process in the beginning, and that often, ongoing reform is required to establish a successful PNEP. Canada's PNEP still remains in its fledgling stages. The evolution of this program will take the effort of the many parties involved, including the Canadian government, who must take the lead and address the limitations of this current program. This reform will be yet another step forward on this long road to creating a prison needle exchange program that is truly effective and accessible.

Appendix A: Anonymous Evaluation Questionnaire



Annex B. Anonymous evaluation questionnaire for prisoners

(Source: Spain, Ministry of Interior)

Attitudes and opinions on the PNSP and risk practices for HIV and HCV

This survey is completely anonymous. We are not interested in knowing your name or any other information that could identify you; we are only interested in knowing your opinion about certain aspects related to the programme that could help us to improve it. Please mark only one box for each question.

Name of prison _____ Date completed _____

Q1. Do you know that this prison has a Needle Exchange Programme for people who inject drugs?

- ☐ Yes
- ☐ No

Q2. Have you received enough information about the Programme?

- ☐ No, I haven't received any
- ☐ I have received a little
- ☐ I have received a fair amount
- ☐ Yes, I am well informed

Q3. Do you think consumption of injected drugs has increased with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q4. Do you think that the number of personal or cell searches has increased with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q5. Do you think that your cell is being searched more rigorously with the Programme?

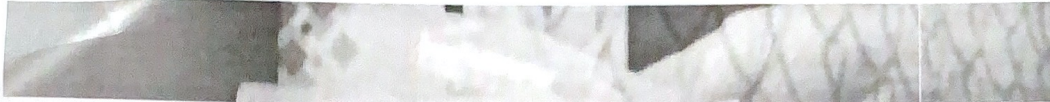
- ☐ Same as before
- ☐ A little more
- ☐ Quite a lot more
- ☐ A lot more

Q6. Do you think that prison officers have more control of people who inject with the Programme?

- ☐ Yes, they have more control
- ☐ No, they have the same control
- ☐ No, they have less control

Q7. Do you think that the number of drug use reports has increased with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot



Q8. Do you think that the number of prison leaves has been reduced with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q9. In general, do you think that conflictive situations between inmates and prison staff have increased with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q10. Do you think that conflictive situations between inmates and health personnel have increased with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q11. Do you think that the current hours for needle exchange are the most appropriate for persons to go when they want to?

- ☐ Yes
- ☐ No
- Why? _____
- What do you suggest? _____

Q12. Do you think that the places for needle exchange are the most appropriate?

- ☐ Yes
- ☐ No
- Why? _____
- What do you suggest? _____

Q13. Do you think the persons in charge of dispensing the syringes deserve your trust?

- ☐ Yes
- ☐ No
- Why? _____
- What do you suggest? _____

Q14. From your point of view, do you think that the Programme is running satisfactorily in this prison?

- ☐ Unsatisfactorily
- ☐ Not very satisfactorily
- ☐ Quite satisfactorily
- ☐ Very satisfactorily

Q15. What the positive aspects of the programme for you?

Q16. And the negative aspects?



Q17. Do you think it is worthwhile to go ahead with this Programme?

- ☐ No
- ☐ Yes
- ☐ Yes, but making changes

What would you change? _____

Q18. Have you consumed heroin in the last 30 days?

- ☐ Yes
- ☐ No

Q19. What route did you use?

- ☐ Injected
- ☐ Smoked
- ☐ Snorted
- ☐ Other _____

Q20. Have you consumed stimulants (cocaine/amphetamines) in the last 30 days?

- ☐ Yes
- ☐ No

Q21. What route did you use?

- ☐ Injected
- ☐ Smoked
- ☐ Snorted
- ☐ Other _____

Q22. If you are an injecting drug user, how many times do you usually reuse the same needle or syringe?

- ☐ I never use it more than once
- ☐ I sometimes reuse it
- ☐ Usually 2-3 times
- ☐ Usually more than 4 times
- ☐ More than 10 times

Q23. If you are an injecting drug user, how often in the last 30 days have you used needles or syringes previously used by other inmates?

- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Q24. If you are an injecting drug user, how often in the last 30 days have you lent your previously used needles or syringes to other inmates?

- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always

Q25. If you are an injecting drug user, have you shared other items for injection such as spoons, filters, containers for dissolving the drug, etc.?

- ☐ Never
- ☐ Occasionally
- ☐ Often
- ☐ Always



Q26. Do you participate in the Needle Exchange Programme?

- ☐ No, I've never used it
- ☐ I've used it very little
- ☐ I use it quite often
- ☐ I use it a lot

Q27. If you are an injecting drug user and do not use the Needle Exchange Programme regularly, what are your reasons for using it? _____

Q28. Some people inject but do not use the Programme. Why do you think they don't use it? _____

Q29. What do you think could be done so they would use it? _____

Q30. Did you use a condom in your last sexual relations?

- ☐ Yes
- ☐ No

Q31. SEX

- ☐ Male
- ☐ Female

Q32. AGE (in years)

- ☐ Under 21
- ☐ 21 to 25
- ☐ 26 to 30
- ☐ 31 to 35
- ☐ Over 35

Q33. What is your status in prison?

- ☐ Awaiting trial
- ☐ Convicted

Q34 Is this your first time in prison?

- ☐ Yes
- ☐ No, I've been in prison 2 to 4 times
- ☐ No, I've been in prison more than 4 times

PLEASE MAKE ANY OBSERVATIONS OR COMMENTS BELOW

THANK YOU VERY MUCH FOR YOUR COOPERATION

(This survey is completely anonymous. We are not interested in your name or any other information that could identify you; we are only interested in knowing your opinion about certain aspects related to the programme.)



Annex C. Anonymous evaluation questionnaire for prison staff

(Source: Spain, Ministry of Interior)

Attitudes and opinions on the PNSP and risk perception for HIV and HCV.

This survey is completely anonymous. We are not interested in knowing your name or any other information that could identify you; we are only interested in knowing your opinion about certain aspects related to the programme that could help us to improve it. Please mark only one box for each question.

Name of prison _____ **Date completed** _____

Q1. Are you concerned that some prisoners may become infected by HIV and/or hepatitis from sharing syringes?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q2. Do you think that drug use has increased in the prison with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q3. Do you think that the number of drug use reports has increased with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q4. Do you think that implementation of the Programme has placed more emphasis on searches?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q5. Do you think that the Needle Exchange Programme has caused demotivation when controlling drugs inside the prison?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q6. In general, do you think that conflictive situations between inmates and prison warders have increased with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot



Q7. Do you think that conflictive situations between inmates and health personnel have increased with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q8. Do you think the number of accidents during searches has increased with the Programme?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q9. How much do you think the Needle Exchange Programme has changed safety conditions in the prison?

- ☐ It made them much worse
- ☐ It made them a little worse
- ☐ It has made them a little better
- ☐ It has made them much better
- ☐ It has not changed them

Q10. Do you consider yourself to be informed about the Needle Exchange Programme currently in use in the prison?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q11. Do you think the operating rules of this Programme are appropriate?

- ☐ Not at all
- ☐ A little
- ☐ Quite appropriate
- ☐ Very appropriate
- ☐ Not known

Q12. Do you think the current hours for needle exchange the most appropriate for inmates to go when they want?

- ☐ Yes
- ☐ No
- Why? _____
- What do you suggest? _____

Q13. Do you think that the places for needle exchange are the most appropriate for inmates?

- ☐ Yes
- ☐ No
- Why? _____
- What do you suggest? _____

Q14. Do you think that the staff in charge of dispensing the syringes is appropriate?

- ☐ Yes
- ☐ No
- Why? _____
- What do you suggest? _____



Q15. Do you think that inmates are complying with Programme rules?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q16. From your point of view, do you think that the Programme is running satisfactorily in this prison?

- ☐ Not at all
- ☐ A little
- ☐ Quite a lot
- ☐ A lot

Q17. What are the positive aspects for you? _____

P18. And the negative aspects? _____
How would you change the Programme? _____

Q19. SEX

- ☐ Male
- ☐ Female

Q20. AGE (in years)

- ☐ Under 30
- ☐ 30 to 45
- ☐ 46 or older

Q21. What body or group do you belong to?

- ☐ Security
- ☐ Treatment
- ☐ Offices and services
- ☐ Volunteer group

Q22. How long have you been working in prisons?

- ☐ Less than 4 years
- ☐ 4 to 10 years
- ☐ More than 10 years

PLEASE MAKE ANY OBSERVATIONS OR COMMENTS BELOW

THANK YOU VERY MUCH FOR YOUR COOPERATION

(This survey is completely anonymous. We are not interested in your name or any other information that could identify you; we are only interested in knowing your opinion about certain aspects related to the programme.)

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