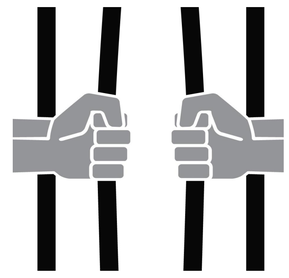
SECURITIZING PRISONER HEALTH

A realist review of Canada's Prison Needle Exchange Program



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BACKGROUND

Throughout the 1990s, 2000s, and 2010s, civil society and human rights groups advocated for prison-based syringe distribution due to elevated rates of injection drug use, HIV, and hepatitis C virus among incarcerated individuals, culminating in a lawsuit in 2012.

In 2018 the Correctional Service of Canada (CSC) responded by implementing a Prison Needle Exchange Program (PNEP). Implementation of the PNEP has been slow and has faced significant critiques and challenges. As of 2024, the PNEP is only available at eleven of forty-three federal prisons in Canada. Eventual future scaleup is planned.

Prison needle syringe programs globally:

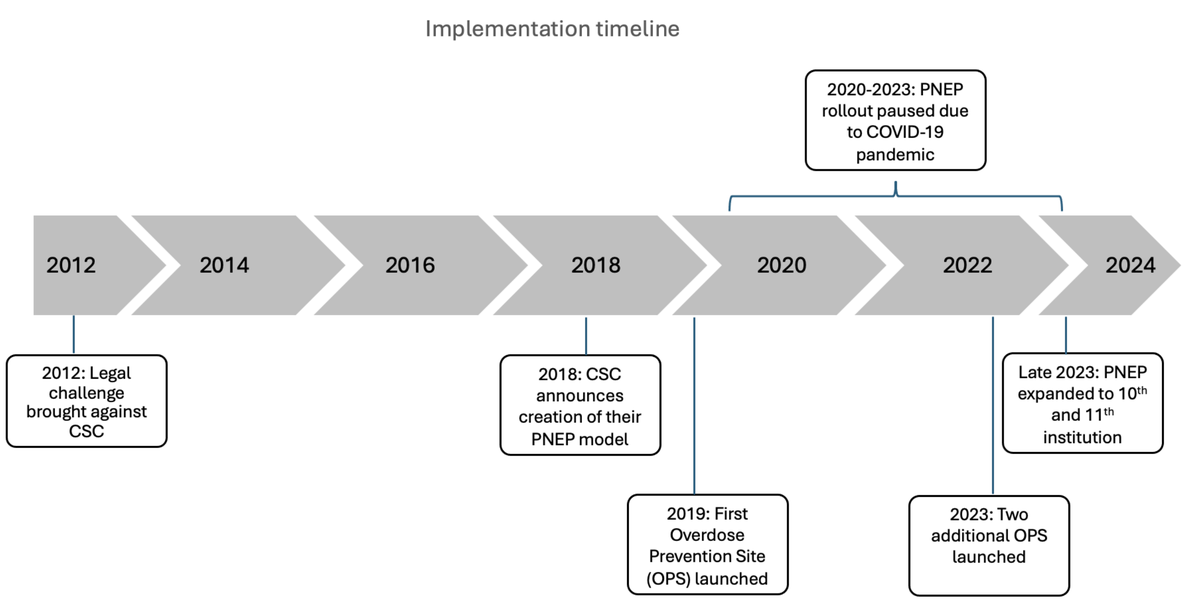
- 1st PNSP: Established Switzerland in 1992
- PNSPs operating in: 11 countries, 60 prisons
- Distribution modalities: vending machines, external NGO workers, fellow incarcerated persons, healthcare staff.
- Reduced rates of HIV and HCV; stabilization or decrease in rates of substance use; improved linkage to healthcare, HIV and HCV treatment, and OAT. [1-3]

Estimating drug use prevalence in Canadian prisons:

- 17% of people in men's prisons and 14% in women's prisons reported injecting drugs in the preceding six months while incarcerate [4].
- Some federal prisons estimate the number of people using drugs to be as much as 70% [5].

Legal bases for prison needle syringe distribution:

- UN Minimum Standard Rules for the Treatment of Prisoners → clinical independence
- UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders → equivalence of care
- Canadian Charter of Rights and Freedoms → security of the person
- Corrections and Conditional Release Act → essential healthcare
- Correctional policy → professionally accepted standards



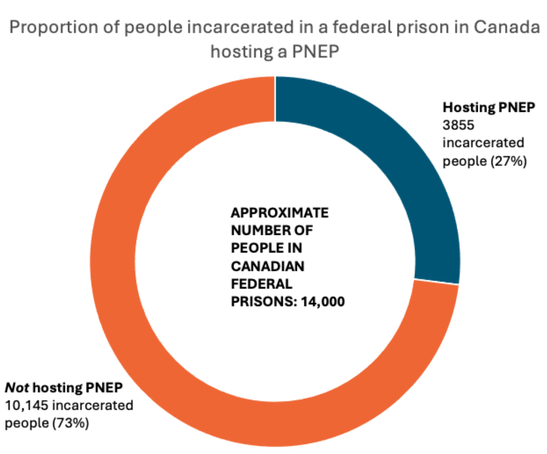
METHODS

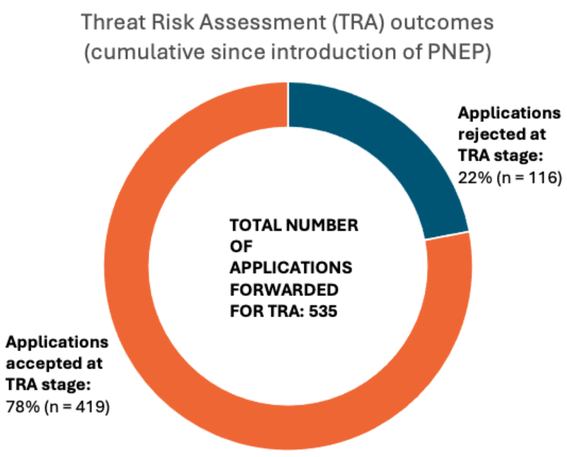
We employed a realist review framework, a method of evaluating complex policy interventions [9].

Realist review asks: "what is it about this intervention that works, for whom, in what circumstances, in what respects, and why"

By recognizing social context and integrating environmental considerations, realist reviews consider policy outcomes and implications in addition to efficacy.

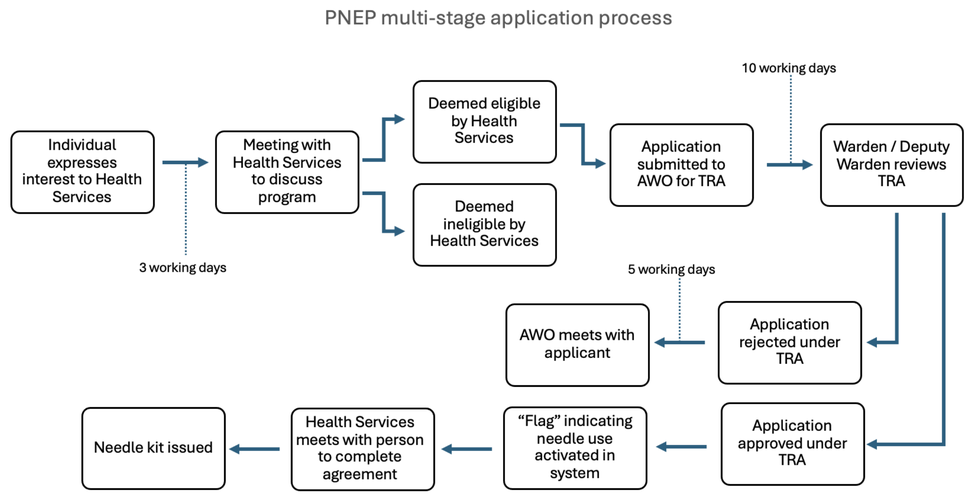
We drew on program evaluations, correctional policies, harm reduction best practice guidance and professional standards & government data acquired through Access-to-Information requests.





SOURCES

[1] Dolan, K., Rutter, S., & Wodak, A. D. (2003). Prison-based syringe exchange programmes: A review of international research and development. Addiction, 98(2), 153–158.
[2] Lazarus, J. V., Safreed-Harmon, K., Hetherington, K. L., Bromberg, D. J., Ocampo, D., Graf, N., Dichtl, A., Stöver, H., & Wolff, H. (2018). Health outcomes for clients of needle and syringe programs in prisons. Epidemiologic Reviews, 40(1), 96–104.
[3] Stöver, H., & Hariga, F. (2016). Prison-based needle and syringe programmes (PNSP): Still highly controversial after all these years. Drugs: Education, Prevention & Policy, 23(2), 103–112.
[4] Zakaria, D., Borgatta, F., Jarvis, A., & Thompson, J. M. (2010). Summary of emerging findings from the 2007 National inmate infectious diseases and risk-behaviours survey. Correctional Service of Canada.
[5] Office of the Correctional Investigator (OCI). (2022). Annual report 2021-2022.
[6] Stöver, H., & Nelles, J. (2003). Ten years of experience with needle and syringe exchange programmes in European prisons. International Journal of Drug Policy, 14(5), 437–444.
[7] United Nations Office on Drugs and Crime (UNODC). (2014). A handbook for starting and managing needle and syringe programmes in prisons and other closed settings.
[8] van der Meulen, E., Claivaz-Loranger, S., Clarke, S., Ollner, A., and Watson, T. M. (2016). On point: Recommendations for prison-based needle and syringe programs in Canada. Canadian HIV/AIDS Legal Network.



FINDINGS & ANALYSIS

CSC's security-oriented model included several underlying assumptions including that:

- Needles represent as inherent danger to correctional officers
- Threat Risk Assessment are as effective measure to manage presumed risks
- The involvement of security staff in adjudicating applications is not seen as impeding participation

By contrast, evidence from prison needle syringe programs globally demonstrates that carceral syringe distribution does not result in increased drug use, injection initiation, accidental needle-stick incidents experienced by correctional staff, or needles being used as weapons [1, 6].

The involvement of security staff impedes access and uptake, undermines trust and confidence in healthcare:

- Warden / security staff assesses entitlement to program through Threat Risk Assessment
- Correctional officers monitor for non-compliance with program requirements & issue sanctions for violations
- Healthcare staff employed by corrections, subject to correctional policies & embedded in penal culture, leading to "dual loyalty" [10].
- Frequent confidentiality breaches of health information & resulting lack of trust in healthcare staff
- Profiling, targeting, stigma, vitriol, discretionary punishment experienced by PWUD at hands of correctional officers [11].

Mutation of principles of prison needle syringe distribution:

- The CSC PNEP model rejects globally recognized standards respecting prison syringe program development, including prisoner involvement in program design, multimodal distribution models, instead insisting on hand-to-hand and 1-for-1 exchange.
- Mutation further unfolds at the local level through site-specific policies, deferring heavily to security-oriented preoccupations as opposed to health ones. Examples include: incarcerated people denied program enrollment if they are bunked with a cellmate who is not registered in the program & requirements that participants keep needle kit visible at all times, undermining privacy [12].

RESULTS

Results indicate serious deficits in access, uptake, & retention.

- The "Threat Risk Assessment" to determine eligibility function as major impediments to program efficacy;
- 22% of people seeking to enroll in the PNEP are denied access;
- Elevated rates of program discontinuation & extremely low uptake, particularly among women.
- Three of the five women's prisons with a PNEP have zero participants. In June 2023, less than twenty percent of approved individuals were using the PNEP [13].

Enrollment has remained largely unchanged since 2020, hovering at roughly fifty participants nationally.

POLICY IMPLICATIONS & RECOMMENDATIONS

1. Elimination of the Threat Risk Assessment and removal of security staff from ensuring compliance with program requirements;
2. Abandonment of one-for-one exchange and instead, diversification of modes and points of access within each institution;
3. Distribution of additional kinds of sterile drug use supplies to align with individuals' needs and drug use trends, such as inhalation equipment;
4. Eradication of sanctions for possessing personal drug use equipment that is not approved by CSC;
5. Proactive education and training measures to address drug use stigma and harm reduction literacy among all prison staff;
6. Health promotion efforts to increase awareness of the existence of the PNEP among those incarcerated;
7. Re-delegating penal healthcare provision from CSC to health authorities external to prison authorities;
8. Revising CSC's zero-tolerance drug policy to align with pragmatic and evidence-informed approaches to drug use.

The Canadian experience provides a cautionary tale to other jurisdictions considering implementing a PNSP

[9] Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2005). Realist review: A new method of systematic review designed for complex policy interventions. Journal of Health Services Research & Policy, 10(1_suppl), 21-34.
[10] Pont, J., Stöver, H., & Wolff, H. (2012). Dual loyalty in prison health care. American Journal of Public Health, 102(3), 475-480.
[11] De Shalit, A., van der Meulen, E., Chu, S. K. H., & Thomas, R. (2024). Drug use stigma and reprisal: Barriers to prison needle exchange in Canada. The Prison Journal, 104(3), 344–364
[12] Leonard, L. (2020). Evaluation of the Prison Needle Exchange Program interim report. March. Ottawa, CA: Correctional Service of Canada.
[13] Correctional Service of Canada (CSC), Access to Information request (ATI). (2024). PNEP enrollment, expressions of interest & rates of TRA refusal. File # a-2023-00373
[14] McAlinden, A.-M. (2012). The governance of sexual offending across Europe: Penal policies, political economies and the institutionalization of risk. Punishment & Society, 14(2), 166–192.
[15] Michaud, L., & van der Meulen, E. (2023). "They're just watching you all the time": The surveillance web of prison needle exchange. Surveillance & Society, 21(2), 154–170.