



**ON POINT:**

# Recommendations for Prison-Based Needle and Syringe Programs in Canada



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**Recommendation #1:** Prisoner access to PNSPs and sterile injection supplies should be easy, confidential, and not subject to disciplinary consequences.

**Recommendation #2:** Prisoners should have regular access to information, education, and support from trained personnel regarding safer drug injection.

**Recommendation #3:** PNSPs should adopt a hybrid or multi-model approach to distribution within each institution.

**Recommendation #4:** PNSP implementation and delivery should include ongoing and meaningful consultation with, and education for, relevant stakeholders to ensure the accessibility and positive health outcomes of the program.

**Recommendation #5:** Prisoners should have an active role in determining PNSP programming, structure, and policy.

**Recommendation #6:** The justice system, including the Correctional Service of Canada, should move toward addressing drug use as a social and health issue.

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## Introduction

Prison-based needle and syringe programs (PNSPs) provide sterile injection equipment to prisoners who inject drugs. Like community-based needle and syringe programs, PNSPs have been shown to be very effective in international contexts. Currently, however, Canadian prisons do not offer these programs.

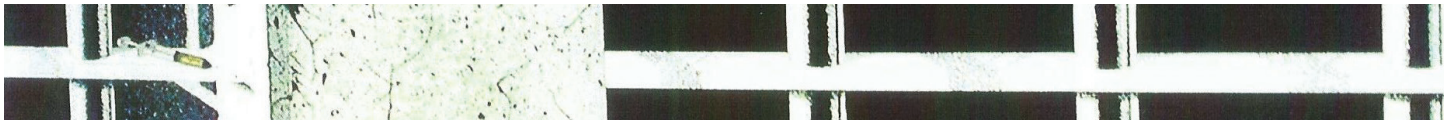
Since the early 1990s, a growing body of evidence has established the need for and benefits of PNSPs, and community organizations responding to HIV — as well as a growing number of other expert bodies — have repeatedly recommended their implementation in Canada. After 20 years of discussion and presentation of the public health and human rights case for PNSPs, it was evident there was no reasonable prospect of the federal government agreeing to their implementation within the foreseeable future. Therefore, in September 2012, Steven Simons (a former prisoner), along with the Canadian HIV/AIDS Legal Network, Prisoners with HIV/AIDS Support Action Network (PASAN), Canadian Aboriginal AIDS Network, and CATIE initiated a constitutional court challenge seeking orders that would compel the Correctional Service of Canada (CSC) to make sterile injection equipment available in federal prisons.

As the case progresses through the court system, community advocates, academics, infectious disease specialists, and others have been engaged in a variety of research and public educational activities in support of PNSPs, building on the extensive international work of the previous two decades. This report highlights three phases of these activities, each building on the previous one, which consisted of a stakeholder meeting (phase 1), prison site visits in Switzerland (phase 2), and a community-based research project (phase 3). We focus here mainly on the third phase, the primary aim of which was to develop a series of recommendations for PNSP implementation in Canadian federal prisons.

The community-based study was led by Dr. Emily van der Meulen from the Department of Criminology at Ryerson University, and the Research Team included Seth Clarke and Annika Ollner from PASAN, Stéphanie Claivaz-Loranger from the Canadian HIV/AIDS Legal Network, Krysta Williams from the Native Youth Sexual Health Network, and Dr. Tara Marie Watson, a prison health researcher. The study was generously funded by the Ontario HIV Treatment Network (OHTN) and received approval from the Ryerson University Research Ethics Board.



# The Need for PNSPs in Canada



In Canada, CSC is the government agency that manages the federal prison system and oversees people who have received a sentence of imprisonment of two years or longer. The provincial/territorial correctional systems administer sentences of imprisonment of two years less a day, as well as detain people who are awaiting trial or sentencing. Currently, CSC operates 43 federal prisons, including four Indigenous “healing lodges,” across five administrative regions (Atlantic, Quebec, Ontario, Prairie, and Pacific). Institutional security classifications are minimum, medium, and maximum security, with recent changes leading to many prisons having more than one security level.<sup>1</sup>

## Prison Living Conditions and Prisoner Populations

The living conditions and climate of federal prisons have deteriorated over the past decade, which is in part the result of a significant growth in the number of people incarcerated, thus leading to serious overcrowding and 21% of the prison population being double-bunked<sup>2</sup> (Office of the Correctional Investigator [OCI], 2013a). Prisoners frequently lack meaningful activities in which to engage while incarcerated, causing high levels of boredom, frustration, and alienation (Crewe, 2006; OCI, 2010). The Office of the Correctional Investigator (2013a) has also noted an increase in prison violence and “use of force” interventions by correctional officers, including the use of pepper spray on prisoners.

Within this context, the federal prison population is comprised of a disproportionate number of individuals who come from low-income backgrounds, have less formal education than the general population, and have mental health care needs (Chu & Elliott, 2009; Fazel & Danesh, 2002; OCI, 2013a, 2013b). Most federally incarcerated women have also experienced sexual and physical abuse; substance use and depression figure more prominently among women in prison than men (Canadian Human Rights Commission, 2003). As well, federal prisoners are

disproportionately racialized (Indigenous, 23%; Black, 9.5% [OCI, 2013b]) and are dealing with the history and ongoing consequences of colonization and racism.

Over the past two decades, the number of Indigenous peoples incarcerated in Canada’s federal prison system has continued to grow. Currently, while Indigenous people make up about 4% of the Canadian population, they represent approximately 23% of the federal prison population (OCI, 2013b). This situation has unfolded despite the fact that in 1999 and again in 2012, the Supreme Court of Canada ruled that courts, especially with regards to sentencing decisions in the case of Indigenous persons, must take into account the diverse and far-reaching socio-economic effects that histories of colonialism, displacement, and residential schools have had on Indigenous communities. Data further show that Indigenous prisoners serve more of their time in custody, waiting longer for parole than their non-Indigenous counterparts (Chu & Elliott, 2009; Kyle, 2015). Indigenous people, both inside and outside prison, are also among those who are most targeted in current anti-drug “law and order” policies, which result in pervasive social and physical outcomes that reinforce inequities (Marshall, 2015).

The over-incarceration and over-punishment of Indigenous peoples can be tied directly to colonialism and its ongoing effects, which have led to profoundly negative implications for Indigenous peoples’ health and well-being, both within the prison context and in the general population. In 2008, the rate of HIV among Indigenous people, for example, was 3.6 times higher than in the general Canadian population.<sup>3</sup> Such disproportionate numbers are similar in prisons where incarcerated Indigenous people have rates of HIV and hepatitis C virus (HCV) significantly higher than other prisoner groups (Public Health Agency of Canada [PHAC], 2010). The absence of PNSPs is thus particularly damaging to Indigenous communities (Chu & Elliott, 2009).

1 For more information on CSC facilities and security, see <http://www.csc-scc.gc.ca/facilities-and-security/index-eng.shtml>.

2 This refers to a cell that was originally meant to house one prisoner but now houses two.

3 For more Indigenous HIV statistics please see the Canadian Aboriginal AIDS Network fact sheet at <http://www.caan.ca/regional-fact-sheets/>.

## Drug Use and Harm Reduction Programming in Prison

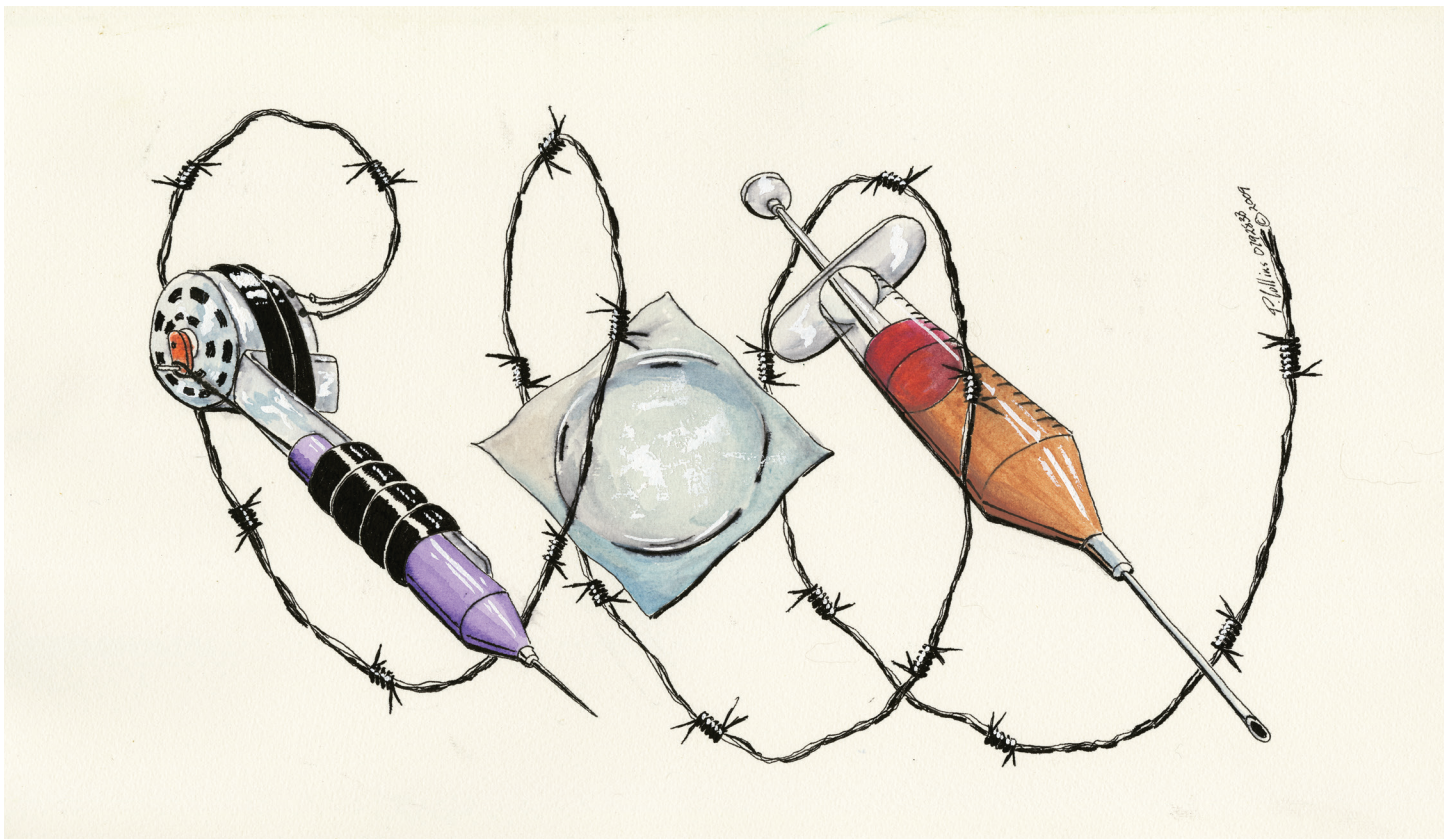
A significant number of prisoners have a history of drug use prior to incarceration; research has shown that 30% of women and 14% of men in federal prisons were incarcerated on drug-related charges (DeBeck et al., 2009). According to the most recent Correctional Investigator's Annual Report (2014), 80% of men entering the federal system were identified as having a current substance use problem, and almost two-thirds were under the influence of a substance when they committed their offence. Much of this is compounded by "tough-on-crime" legislation, including the *Safe Streets and Communities Act* of 2012 which continues to treat drug use as a criminal justice issue to be met with punishment and other negative consequences, with the health and social welfare of people who use drugs increasingly of minimal concern.

Members of the Research Team who do regular prison in-reach have also found that prisoners in need of pain management are often regarded as displaying drug-seeking behaviour. This suspicious and prohibitive environment leads to prisoners' legitimate health issues being disregarded or insufficiently treated. Prisoners who are receiving prescription medications for pain

can have their medication tapered and cut off if they are suspected of diverting or hoarding their medication. These conditions, in turn, can add to the likelihood that prisoners will resort to the underground drug market within the prison setting.

The increasing size of the federal prison population, along with a heightened level of surveillance with regards to drug use, including random urinalysis through CSC's adherence to the *National Anti-Drug Strategy* adopted by the federal government in 2007, has added to the risks faced by prisoners who use drugs. CSC spends millions of dollars on security measures to prevent drugs from entering prisons (OCI, 2012), yet both legal and illegal drugs get into prisons and prisoners use them (PSEP, n.d.), with 14% of women and 17% of men admitting to injection drug use while incarcerated (Zakaria et al., 2010).

Reflecting an acknowledgment by previous governments of the reality of drug use among prisoners, and as a result of important advocacy work by community organizations, the federal prison system currently does offer some harm reduction programming, including opiate substitution treatment (e.g., methadone), bleach, condoms, and some educational materials for prisoners regarding how to reduce the possibility of HIV or HCV infection. However, discussions with current and former pris-



oners indicate that prison-based harm reduction tends to be inconsistent and not always accessible. Educational pamphlets and other materials on harm reduction, for example, are not always available. Some institutions will have materials describing safer injection and safer tattooing practices, whereas other institutions will censor or ban these materials when community organizations seek to bring them in as part of their educational in-reach to prisoners.

Bleach is commonly referred to as a key harm reduction practice in federal prisons, as CSC provides it explicitly for the purposes of disinfecting injection equipment (Weese, 2010). In some institutions it is distributed in one-ounce bottles by “bleach reps” — prisoners whose job it is to offer bleach to other prisoners. In some cases, bleach reps are provided with an insufficient amount of bleach to meet the needs of all individuals on their range or cellblock. In most medium- or maximum-security institutions in Ontario, however, bleach is distributed via machines that will only dispense one ounce of bleach per five-minute period. Members of the Research Team who work closely with current prisoners hear regular complaints that the machines are broken, empty, and/or infrequently filled. In some prisons, the bleach machines are under surveillance or not readily accessible within prisoners’ living areas. As well, any prisoner other than a bleach rep holding more than one ounce of bleach is considered to be in possession of contraband, which is an offence under section 2 of the *Corrections and Conditional Release Act* (the law governing federal institutions); thus, the prisoner is considered to have committed a disciplinary offence that attracts penal consequences.<sup>4</sup>

It is also worth noting that while bleach is a useful disinfectant for blood spills, it is not considered sufficient for the inactivation of HCV or HIV inside a used syringe, particularly in prison settings where injection drug use takes place under rushed and clandestine circumstances, leaving insufficient time to adhere to syringe-disinfecting protocols (WHO, UNODC, and UNAIDS, 2007). Bleach is rarely, if ever, distributed by harm reduction programs in the community, and best practice dictates the distribution of unused, sterile injection equipment instead (Strike et al., 2013, 2015). However, such equipment is not currently available inside federal prisons for prisoners who inject drugs.

## HIV, Hepatitis C, and Public Health Consequences

Because of the scarcity of sterile needles and syringes in the prison setting, people who inject drugs are likely to share injecting equipment, which significantly increases the possibility of transmitting HIV and/or HCV (e.g., Chu & Peddle, 2010; Dolan et al., 2003; Small et al., 2005; Treloar et al., 2015). Prison-based research suggests that prisoners who contracted HCV while in prison attributed transmission to injection drug use with previously used or shared equipment (Treloar et al., 2015). Research from community-based settings shows that when people who inject drugs have access to needle and syringe programs, they are less likely to share their injecting equipment (e.g., Bruneau et al., 2008; Gibson et al., 2001; Hurley et al., 1997; Ksobiech, 2003; Macdonald et al., 2003; Strike et al., 2013; Wodak & Cooney, 2005).

PNSPs can have the same beneficial effects as community-based needle and syringe programs. In jurisdictions where PNSPs operate, evaluations that monitored transmission rates in prisons have not recorded any cases of HIV or HCV infection attributed to injection drug use since the implementation of the program (Dolan et al., 2003; Lines et al., 2006; Stöver & Nelles, 2003). Indeed, PNSPs can lead to positive health outcomes for HIV and HCV prevention, which is especially important in the prison setting where HIV and HCV rates are significantly higher than in the community. The estimated HIV prevalence among federally incarcerated people in Canada is 10 times more than the estimated prevalence in the general population, while the estimated rate of HCV among federal prisoners is between 30 and 39 times that of the general population (PHAC, 2014; Trubnikov et al., 2014; Zakaria et al., 2010; Zou, Tepper, & Giulivi, 2001). While these high rates of HIV and HCV within federal prisons represent a significant public health issue, also of concern is that rates are even higher for specific prisoner populations. For example, among Indigenous women in federal prisons, more than 1 in 10 is reported to be living with HIV and nearly 1 in 2 is living with HCV (Zakaria et al., 2010).

The rates of HIV and HCV in prison also have broader public health impacts, since the vast majority of prisoners return to their families and communities — with whatever health condition they may have acquired while in prison.

4 For more information, see CSC’s Guidelines on Bleach Distribution at <http://www.csc-scc.gc.ca/politiques-et-lois/800-6-gl-eng.shtml>.

Society also bears the financial costs of these high rates of HIV and HCV. Treating a person with HIV in prison costs roughly \$30,000 per year (CSC, 2009), and a course of treatment for HCV costs an estimated \$60,000 (Webster, 2015). Between 2005 and 2010, CSC's bill for hepatitis treatment rose almost sevenfold, increasing to roughly 4% of its health budget (Webster, 2012). Preventing instances of HIV and HCV infection (or HCV re-infection, which is a major concern for people who inject drugs) is much less expensive than treating an infection after it occurs and, therefore, could have a significant impact on already strained health budgets.

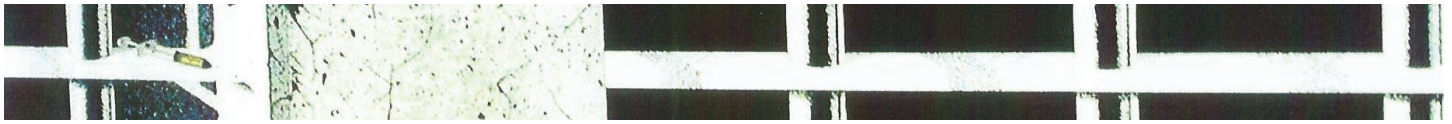
Given this larger context, over the past 20 years a number of notable Canadian health and human rights organizations have recommended that PNSPs be implemented in our federal prisons. These organizations have included the Correctional Investigator of Canada, the CSC's own Expert Committee on AIDS and Prisons, the Ministerial Council on HIV/AIDS (the federal body of experts advising the federal health minister), the Canadian Medical Association, the Ontario Medical Association,

and the Canadian Human Rights Commission. Internationally, PNSPs have been recommended by numerous UN agencies, including the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization, and the United Nations Office on Drugs and Crime (Chu & Elliott, 2009).

Despite this widespread support, however, CSC remains resistant to implementing PNSPs in Canada (Standing Committee on Public Safety and National Security, 2012; Watson, 2014). By denying such programs, Canada is failing to uphold the "principle of equivalence," a principle well settled in international law, which requires that prisoners have access to a standard of health care equivalent to that available outside of prisons, including access to preventive measures comparable to those available in the general community (Chu & Elliott, 2009; see also United Nations, 1990; UNODC, 2014; WHO, 2007).



# PNSPs around the World



The first PNSPs were introduced over 20 years ago in Switzerland. Since then, they have been introduced in over 60 prisons worldwide, in both men's and women's institutions and those of various security levels (i.e., minimum, medium, and maximum security). PNSPs have been established in both military and civilian prisons, as well as in prisons that have barracks-style units, single-person cells, and cells where people are double- or triple-bunked.

## Evaluations and Evidence

Similar to the positive evaluations of community-based needle and syringe programs, evaluations of PNSPs consistently demonstrate their effectiveness at reducing the sharing of injection equipment, in addition to showing consistent signs of reduction of HIV and HCV transmission. These evaluations also demonstrate that PNSPs effectively address other health-related harms associated with shared injection equipment in prisons (overdose, abscesses, etc.) and make prisons safer environments in which to live and work (see Dolan et al., 2003; Hoover & Jürgens, 2009; Jacob & Stöver, 2000; Lines et al., 2005, 2006; Nelles et al., 1997, 1998).

Reviews of the existing international evidence and literature were conducted in Canada, both by a CSC study group in 1999 and subsequently in 2006 by the Public Health Agency of Canada (PHAC), the federal agency that focuses on preventing chronic diseases and responding to public health crises and infectious disease epidemics. In the first instance, the CSC study group was convened to examine the implications of PNSPs in federal correctional institutions, with participants from CSC staff (including security and health services) and the federal department Health Canada, along with prisoners, community organizations, and members of the public. Then, in 2006, at the request of CSC, PHAC completed an exhaustive report to provide advice on the effectiveness and adverse outcomes, if any, of PNSPs from a public health perspective.

Both the CSC study group and the PHAC review came to conclusions similar to those of the international evaluations described above. The CSC study group concluded that PNSPs are "an effective and well-proven method of reducing the harms associated with injection drug use" (CSC, 1999, p. 5). The PHAC review concluded that PNSPs:

- decreased needle-sharing practices among prisoners;
- increased referrals of prisoners to drug treatment programs;
- decreased the need for health care interventions related to injection-site abscesses; and
- decreased the number of overdose-related health care interventions and deaths.

With respect to institutional security and safety, the PHAC review concluded that PNSPs do **not** result in:

- syringes being used as weapons;
- increased institutional violence;
- increased needle-stick injuries;
- increased seizures of illegal drugs or drug paraphernalia; or
- increased drug use or increased initiation by prisoners of injection drug use (PHAC, 2006).

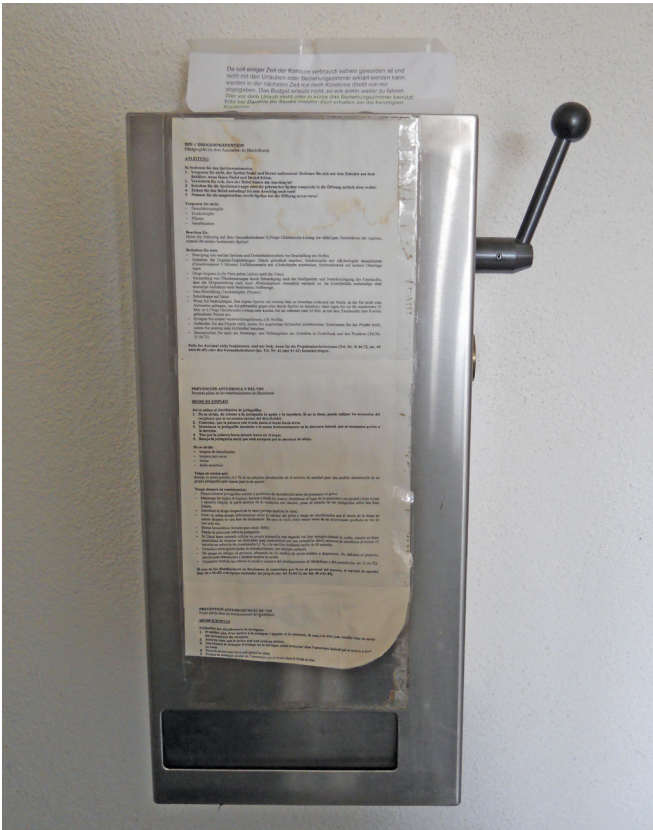
Thus, international and Canadian evaluations and evidence have shown significant benefits and high levels of support for PNSPs.

## Models and Approaches

In prisons where PNSPs exist, they tend to employ four key models of distribution, with some prisons drawing on a combination: (a) distribution by syringe-dispensing machines, (b) distribution by trained prisoners in a peer worker model, (c) hand-to-hand distribution by representatives from NGOs or external health professionals, and (d) hand-to-hand distribution by prison health care staff (UNODC, 2014).

**Distribution by dispensing machines:** These devices can be installed in various locations in a prison. Typically, a prisoner places a used syringe into a slot, pulls the lever, and the machine dispenses a sterile syringe. There can also be other injection-related supplies easily accessible on top of or beside the machines. Dispensing machines provide a high degree of accessibility and anonymity, provided that they are in a discreet location and not under surveillance. They do not, however, provide the opportunity for counselling or support from staff, unless such support is offered in conjunction with the machines. In Switzerland's women-only Hindelbank Prison, for example, there are six dispensing machines in locations away from surveillance cameras and not in direct view of correctional officers, which allows women to access supplies when needed. This multi-level prison (minimum, medium, maximum) has had a PNSP since 1994.

**Distribution by peer workers:** In a peer-based distribution model, prisoners receive injecting equipment directly from fellow prisoners who have been trained to deliver the program. In some prisons in Moldova, for example, peer volunteers are responsible for distributing and collecting injection equipment in bulk, thereby ensuring the anonymity of service users with respect to health care or other prison staff. They also provide information and other harm reduction supplies, such as condoms. This model allows for a high degree of access to sterile injection equipment, as peers are on site and available during evenings and weekends (UNODC, 2014). Some of the potential disadvantages of this model include the possibility of less accurate health information than would be provided by professional health care providers, thus increasing the need for ongoing support and training of peer volunteers (see Lines et al., 2006), as well as the possibility that injection equipment could be used more easily as goods within the underground prison economy (Stöver & Nelles, 2003).



*Pictured above: Dispensing machines installed in Hindelbank Prison in Switzerland.*

**Distribution by NGOs or external personnel:** In this model, sterile injection equipment is distributed by external agencies that are not employed by the prison system. This may allow for greater participation in the program as prisoners' fears over confidentiality can be reduced and PNSP participation may be known only by the NGO staff. This model can also facilitate greater connections with local organizations in the community that provide health and other support services, which can facilitate greater continuity of care and may be beneficial post-release (UNODC, 2014). In Spain, for example, some prisons have employed distribution by non-governmental organizations, where NGO staff were available daily for distribution of equipment to prisoners (Lines et al., 2006). In other contexts, however, access to supplies can be reduced as distribution is dependent on how often the NGO can conduct prison in-reach.

**Distribution by prison health services:** In the final model, prisoners receive injection equipment from prison nurses, doctors, or other prison health care professionals (UNODC, 2014). This PNSP approach includes personal contact with and counselling from health professionals. However, in some prison contexts this model may result in a lack of confidentiality, which can significantly limit prisoner participation in the program, and some prisoners may be uncomfortable seeking supplies from

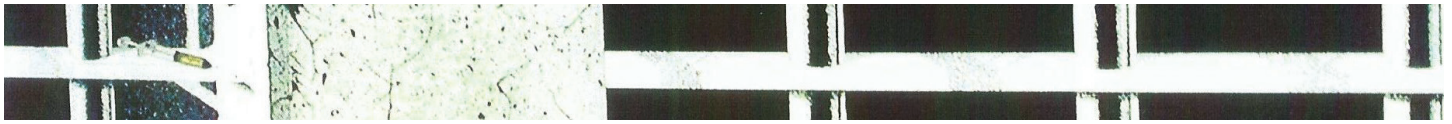
their health care providers. As well, supplies can only be given when health care staff are available (typically during standard work hours). An example of this model can be found at Champ-Dollon, one of Europe's most overcrowded prisons, located just outside Geneva, Switzerland. This prison is a men's and women's institution with over 850 prisoners and maximum security features. The average stay for prisoners is just a few weeks, as many are on remand, resulting in a high degree of turnover, significant overcrowding, and a challenging prison environment. Despite this, the PNSP has been functioning successfully and without incident since 1996. Prison health care is provided by the University Hospitals of Geneva (HUG), which are external to and independent from the correctional authorities.

Regardless of the distribution model, or combination of models, prisoners who are part of the PNSP must typically keep their supplies in a pre-determined location in their cell and injection equipment must stay within the kit or puncture-proof container to help prevent instances of prisoners or staff being accidentally pricked by a needle. At Champ-Dollon Prison in Switzerland, for example, prisoners are given injection supplies and a clear puncture-proof tube in which to keep their syringes, pictured here.

*Pictured below: Injection supplies given to prisoners at Champ-Dollon Prison in Switzerland*



# Three Phases of PNSP Research and Activities



Given the need for PNSPs in Canadian federal prisons and the successful examples from international contexts, we developed a multi-phase, multi-year undertaking that involved broad consultation and primary research to create PNSP implementation recommendations for Canadian federal prisons. Two organizations were instrumental in this undertaking — PASAN and the Canadian HIV/AIDS Legal Network. Combined, these organizations have worked on the issue of PNSPs for multiple decades.

**PASAN** is a provincial community-based AIDS service organization that provides education, community development, and non-judgmental support within a social justice framework to Ontario prisoners, youth in custody, former prisoners, and their families and other supporters in relation to HIV and HCV. Since 1991, PASAN has developed the most comprehensive HIV programming in Canada focusing specifically on prisoners' needs. [www.pasan.org](http://www.pasan.org)

**The Canadian HIV/AIDS Legal Network** promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research and analysis, advocacy and litigation, public education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS. [www.aidslaw.ca](http://www.aidslaw.ca)

## Phase 1: Stakeholder Meeting

The first phase consisted of a networking and partnership-building meeting that brought together experts to inspire engaged dialogue on PNSP implementation in Canada and to develop a preliminary framework for PNSP recommendations. The stakeholder meeting was funded by the Canadian Institutes of Health Research and was held January 23–25, 2014, at Ryerson University.

Over the course of three days, over 30 Canadian and international researchers, health care providers, and key stakeholders, including people with lived experience of prison and representatives from HIV, Indigenous, women's health, harm reduction, and prisoners' rights organizations, met to

discuss PNSPs in Canada. The event opened with a public panel discussion featuring key experts, which was video-recorded by the Ontario HIV Treatment Network, and is available for viewing at [www.prisonhealthnow.ca](http://www.prisonhealthnow.ca). The subsequent two days of invitation-only meetings saw attendees co-create an evidence-based framework for PNSP implementation. Collectively, participants identified the necessary criteria for the successful, effective establishment of PNSPs in Canada based on lived experience in prisons, knowledge of prison contexts through programming and in-reach activities, practice providing sterile injection equipment in the community, research findings, and international knowledge and experience. These discussions set the stage for further research and organizing related to PNSPs in Canada in the subsequent phases.

## Phase 2: Prison Site Visits in Switzerland

The second phase was funded by a Ryerson University Health Research Grant and included travel to Switzerland, where PNSPs have been operational for over twenty years and have been the subject of positive evaluations (Hoover & Jürgens, 2009; Lines et al., 2006; Nelles et al., 1997; Stöver & Nelles, 2003). In May 2014, two of the stakeholder meeting organizers observed operational PNSPs at three Swiss prisons:

**Champ-Dollon Prison** — a high-security men's and women's institution located near Geneva. It has had a functioning PNSP since 1996 and distributes sterile injection equipment via health care practitioners who operate independent of the prison administration.

**Hindelbank Prison** — a women's multi-level institution located near Bern. It has had a functioning PNSP since 1994, and needles and syringes are distributed through both health care practitioners and automatic dispensing machines.

**Oberschöngrün Prison** — a men's minimum-security institution located in Solothurn. It was the first prison in Switzerland to implement a PNSP in 1992, and injection equipment is distributed by health care professionals.

Witnessing the ways in which PNSPs successfully function and meeting with correctional officers, health care staff, and one of the prison directors was particularly helpful for envisioning what could also be successful in the Canadian context.

### Phase 3: Community-Based Research

This primary research phase, funded through a grant from the Ontario HIV Treatment Network, consisted of data collection and a capacity-building process that included consultation with former prisoners in Ontario and a number of key community and medical professionals from across the country.

To capture current prison-based practices and policies, CSC was approached to obtain research access for a study about health and infectious disease in federal prisons. The Research Team submitted a full research application, seeking to hold focus groups with current prisoners and a survey with prison health care staff, but the request was denied, thus prohibiting access to these important informants. Although this introduced a limitation in terms of producing recommendations based on the most current practices inside federal prisons, we were able to recruit other people with lived experience whose expertise was invaluable (i.e., former prisoners who could speak more freely outside the prison setting), as well as highly knowledgeable stakeholders, for both the focus groups and interviews.

The study's Research Team included representatives from Ryerson University, PASAN, Canadian HIV/AIDS Legal Network, and the Native Youth Sexual Health Network. Together, we collaboratively developed all of the research materials including the research ethics application, focus group and interview guides, consent documents, and more. We also collaboratively conducted the data collection, analysis, and reporting.

**Native Youth Sexual Health Network** is an organization by and for Indigenous youth that works across issues of sexual and reproductive health, rights, and justice throughout the United States and Canada. [www.nativeyouthsexual-health.com](http://www.nativeyouthsexual-health.com)

#### Focus groups and interviews with former federal prisoners:

Focus groups can be effective in research on topics that are sensitive or challenging to discuss (Linhorst, 2002; Warr, 2005) and because deeper insights can be gained through the group context (Packer-Multi, 2010). In late 2014 and early 2015, we held four focus groups in community locations in Toronto and

Ottawa. Groups ranged in size from 3 to 6 participants, for a total of 19 participants. Of those, 6 self-identified as women (including trans and Two-Spirit women) and 13 identified as men. Each person had experience with injection drug use and had been incarcerated in a Canadian federal prison within the previous six years. The Toronto focus groups were hosted at Sistering, Aboriginal Legal Services of Toronto (ALST), and PASAN. The Ottawa focus group was hosted by the Drug Users Advocacy League (DUAL).

**Sistering** is a women's organization in Toronto that offers practical and emotional support to women who are homeless, under-housed, and/or low income. They provide drop-in and outreach programs that support women to take greater control over their lives. [www.sistering.org](http://www.sistering.org)

**Aboriginal Legal Services of Toronto (ALST)** provides services to the Aboriginal community in Ontario. ALST's Aboriginal name, received by way of a traditional naming ceremony, is "Gaa kina gwiiwaabamaadebwiwin," meaning "all those who seek the truth." The organization assists Aboriginal community members to exercise control over justice-related issues and factors that affect them. [www.aboriginallegal.ca](http://www.aboriginallegal.ca)

**DUAL** is an independent group of drug consumers, ex-consumers, and their allies who fight for the rights of those who use drugs in the Ottawa area. It supports complete harm reduction and works to reduce stigma, with the aim of improving the safety and education of and towards drug consumers. [www.dualottawa.ca](http://www.dualottawa.ca)

We also worked closely with HIV/AIDS Regional Services (HARS) in Kingston, Ontario, and other organizations across the province to recruit former prisoners for in-depth interviews via telephone or Skype. Interviews done in this manner provided an important option for people who prefer to share their knowledge and experiences in a one-on-one context rather than in a group session and/or who would otherwise have been unable to participate in the study because of their location. We conducted a total of 11 interviews with former federal prisoners in London, St. Catharines, and Niagara Falls, as well as with former prisoners in Toronto and Ottawa who had not been able to attend the initial focus group sessions. Three of the interview participants identified as women and eight as men.

**HIV/AIDS Regional Services (HARS)** provides HIV education and services, including counselling, advocacy, condom distribution, needle distribution, prison support, and a resource library, to people who live in Kingston and the surrounding area. [www.hars.ca](http://www.hars.ca)

At the start of each focus group or interview, after getting the participant's informed consent, we administered a brief demographic survey that asked how long they had spent in a federal prison, in which federal prisons they had been incarcerated, whether they had injected drugs while inside, whether they had been involuntarily transferred, and more.

Focus group participants' ages ranged from 37 to 62 (with an average age of 47). Eight of the 19 had been incarcerated in a federal prison only once in their lives; the remaining 11 had received multiple federal sentences, some as many as 6 or 7 times. The total number of years spent in a federal prison ranged from 2 to 23 (with an average of nearly 8 years). Most people had been incarcerated in more than one federal prison, and 8 had spent time in a federal prison outside of Ontario. Twelve of the 19 focus group participants said they had injected drugs while inside, 10 said they had been involuntarily transferred from one prison to another, and 12 had to do a urine test while incarcerated (although interestingly, some of the people who injected drugs while in federal prison did not have to undergo urinalysis, whereas others who had not injected drugs had their urine tested).

Interview participants' demographic data were similar to those of focus group participants, with an age range of 35 to 55 (again with an average of 47). Five had been incarcerated in a federal prison only once in their lives. The total number of years spent in a federal prison ranged from 2 to 28 (with an average of just over 10 years). As with the focus group participants, most interview participants had been incarcerated in more than one federal prison, and three had spent time in a federal prison outside of Ontario. Eight of the eleven interview participants said they had injected drugs while inside; seven said they had been involuntarily transferred from one prison to another; and all but one had to do a urine test while incarcerated.

After collecting the demographic data, we asked both focus group and interview participants the same sets of questions. These included questions about the context of injection drug use in prison, sharing of injection equipment, potential benefits and drawbacks of each of the four main PNSP models, special considerations for different prisoner populations (e.g., Indige-

nous or women prisoners), workplace and staff safety concerns that might arise following the implementation of PNSPs, different implementation barriers and how they could be reduced, and the best location for rolling out the first PNSP in Canada.

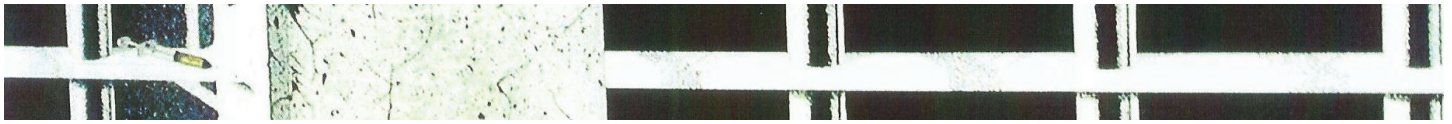
#### **Interviews with community and medical professionals:**

In addition to consulting former prisoners who have lived experience and expertise on the topic, we also wanted to learn from community and medical professionals who support current and former prisoners. As such, we conducted 10 one-on-one Skype or phone interviews with specifically targeted participants, including community-based prisoner rights advocates, Indigenous harm reduction practitioners, and infectious disease specialists, each of whom had direct experience supporting, working with, and/or providing services to people who are currently or have previously spent time in federal prisons. Participants were from Vancouver, Red Deer, Thunder Bay, Peterborough, Toronto, Barrie, Kingston, and Montréal.

The community and medical professionals we interviewed were also given a brief demographic survey to capture more information about the kind of work they did, how long and where they had been working in this capacity, and the different prison populations with which they interacted most closely. They were subsequently asked the same interview questions as the former prisoners, as noted above.



# Key Data Collection Findings



After transcribing all the interviews and focus group discussions, members of the Research Team set out to collaboratively analyze the data. We found a number of important themes, as well as both similarities and differences running across the various transcripts, the most significant similarity being the high level of support for PNSPs among all research participants. Below, we outline some of our key findings and present excerpts from the interviews and focus groups, beginning with a closer look at some of the reasons why the former prisoners and the community and medical professionals were supportive of PNSPs.

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The research participants for this study were 30 former prisoners and 10 community and medical professionals. Given the degree of marginalization and criminalization that many former prisoners experience, all were assured that the Research Team would keep their participation in the study confidential and that no names used during the interviews or group sessions would be transcribed. The community and medical professionals were given the opportunity to participate in the study with their legal names or they could opt to remain anonymous.

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## Research Participant Support for PNSPs

All of the research participants expressed a high level of support for PNSPs. Many, however, also voiced some skepticism about implementation within the current framework of CSC's anti-drug policy, asking, for example, *"How would you be punished? Like is it going to affect parole?"* (DUAL focus group). We found that hesitation about the potential barriers posed by CSC policy and practice were balanced with hopefulness about such programs overall.

The health benefits associated with PNSPs were seen as especially compelling: in particular, the capacity to prevent harm by reducing the rate of HIV and HCV transmission. As one community harm reduction expert put it, in a context in which PNSPs are available *"prisoners are safe — they are using clean sharps, they are not spreading HIV and hep C, which guards can be at risk for, especially hep C. It's a safe, clean way to do what's already been going on"* (Chris Ciceri). Or as one of the infectious disease doctors told us: *"It is obvious that there currently isn't enough injection drug use equipment [in prison]. That's one of the reasons why there are hep C cases in prisons"* (anonymous medical professional).

**Chris Ciceri** is currently the Home Support Services Coordinator at an agency in her community. Previously, Chris spent a decade working with prisoners and people living with HIV. She provided direct support and counseling to male and trans prisoners at Warkworth Institution, and was instrumental in opening the first needle exchange program in her city.

**This medical professional** chose to remain anonymous. They have four years of experience conducting prison health care delivery and training for prison guards on substance use in federal prisons. They have experience working with Indigenous, women, and trans prisoners.

Former prisoners likewise talked about the health benefits of PNSPs, stating, for instance: *“hep C of course would be dropped [and] sharing of needles... I mean you wouldn’t have to hide [syringes] as much if it was allowed”* (Interview #1). Currently, syringes are considered contraband in the federal prison system, so prisoners who are found with such items receive disciplinary consequences. As such, prisoners are forced to hide or conceal their injection equipment, which can result in other prisoners and prison staff, particularly correctional officers who conduct searches of prisoners’ cells, accidentally getting pricked by hidden needles. Many of the participants in this study recognized the potential of PNSPs to reduce the harms associated with hiding equipment: *“Obviously if people weren’t hiding their needles, [accidental needle-stick instances] wouldn’t happen. If you had a needle exchange program, it would seem like you would be less motivated to hide your needles”* (Wendy Wobeser).

**Dr. Wendy Wobeser** has been a prison doctor for over 20 years, delivering HIV, HCV, and tuberculosis (TB) care in numerous federal prisons across Canada. She is currently Associate Professor in the Department of Medicine at Queen’s University and has conducted research on prison health, specifically on HIV and TB. Her current research will evaluate testing and treatment outcomes for HCV in correctional settings.

Others noted that even if a needle-stick accident were to happen, prisoners tend not to share injecting equipment when they have access to a PNSP, and so the potential harms would be substantially reduced: *“I would rather be poked by a needle that has been used once than eighteen times”* (Jennifer Vanderschaeghe).

**Jennifer Vanderschaeghe** has been the Executive Director of the Central Alberta AIDS Network Society (CAANS) for the past 11 years. CAANS is a charitable organization that provides harm reduction services and is dedicated to the prevention of sexually transmitted and blood-borne infections in the community.

Participants also identified the potential benefits of PNSPs to the health care system in general, especially in relation to the costs associated with treating someone who has contracted HIV or HCV through needle sharing: *“[Used syringes] create a frequent flyer for going to see the doctor or the hospital or clinic ... because let’s say it’s hepatitis C that they contracted ... it could all be alleviated if they actually gave out safe needles as opposed to taking a chance”* (Interview #10). This argument extended to the community, with some former prisoners noting that PNSPs have the potential to reduce the likelihood that people will require expensive medical care post-release, *“because these people will get out of jail eventually, and they have hep C, HIV ... They’re going to be back in the communities, and yeah, I think it’s a good idea”* (Sistering focus group).

Community harm reduction experts also recognized the fiscal advantages of PNSPs to strained health care systems: *“People say, ‘Why should I pay for needles?’ Well, ok, don’t pay for needles. Do you want to pay for HIV, hepatitis C treatment, HIV medication for the rest of someone’s life? From a strictly pragmatic point of view, it makes much more sense to give people clean needles”* (Diane Smith-Merrill).

**Diane Smith-Merrill** has worked with current and former prisoners in Kingston and the surrounding area for over 13 years. She is engaged in prison health care delivery, conducting prison-based workshops, and providing one-on-one support to men in federal prison. She has worked at various correctional institutions across Ontario.

Finally, we found that research participants expressed support for PNSPs out of an awareness of the benefits of harm reduction programming in the community, which they suggested could have similar positive impacts within the prison setting, such as access to broader health education and knowledge. As one participant noted, *“It’s not only a way to distribute needles, it’s also a way to find out about abscesses and to find out about other medical things”* (Interview #11).



## Former Prisoner Insights on PNSP Models

In each of the interviews and focus groups with former prisoners, we asked research participants to consider the advantages and disadvantages of each of the four main PNSP models. Although participants expressed varying perspectives, there was overall agreement that a single-model approach to PNSPs would not meet all prisoners' needs; as such, prisons should consider implementing at least two of the models highlighted below.

### Dispensing machines

Former prisoners' overall responses to this model were quite positive. The main advantage identified was anonymity, as there would be no requirement for human contact. Some participants noted that a proxy (e.g., another prisoner) could exchange equipment at the machine on another's behalf, further protecting the confidentiality of program users.

Potential disadvantages of this model were also raised, with surveillance of the machines by security (which could potentially lead to negative consequences such as searches of an entire range) and machine sabotage identified as the primary concerns. Other drawbacks included access limitations during lockdowns and access delays if machines were not re-stocked regularly and consistently. These concerns mirrored those that currently exist in some institutions regarding bleach dispensing machines, as noted previously.

Based on participants' comments, implementation of this model would be more successful if dispensing machines were regularly re-stocked, simple to use, not under the surveillance of cameras or staff, and easily accessible. Some suggestions were made for machine placement: machines on each range, in washrooms, in a health care setting, and in the recreation area.

#### Advantages:

##### Anonymous, easy to use, potential for easy access

*"It is not going to say it was this person or that person. [Staff] would have no way of knowing. ... I just know that the guys and anybody that uses it would feel a lot more comfortable with the machine."* (Interview #10)

*"I like the box, and you put that somewhere like in a bathroom or showering room and do it in the privacy where no one can see who's going to the machine."* (PASAN focus group)

*"That's good, I like it. You put a used one in and you get a new one."* (Sistering focus group)

#### Disadvantages:

##### Possible surveillance, sabotage, and access issues

*"Knowing CSC, they would have a camera on that machine."* (Interview #9)

*"Unless someone starts to rip the machines off and all that just to get at."* (ALST focus group)

*"I can see that there would be problems because nobody is going to want to go and bother them to fill the machine."* (Interview #10)

## Peer workers

This model elicited more of a mixed reaction from former prisoners, though it was more positive than negative. Those in favour of the peer model highlighted the understanding, comfort, and trustworthiness that peers would bring to the program, especially if the peers themselves had previous experience with drug use. Other positive comments were made about confidentiality of the service, the knowledge and health education that could be provided through the peers, and a non-judgmental approach that could and should be expected of peer workers trained and willing to play this role. A small number of participants suggested that the prison's Inmate Committee could also be involved in delivering the program.

The two main disadvantages discussed were the potential of abuse of the program through corruption, and the influence of interpersonal conflict and bias between individual peer workers and program users. Some participants were also concerned about gossip on the part of the peers and lack of confidentiality for other reasons, such as pressure from CSC staff and "ratting out" of service users to security.

Participants suggested that this model would be more successful if the right individuals were selected to act as peer workers (i.e., prisoners who were trusted and respected by the population) and if there was at least one worker for each range/unit.

### Advantages:

#### High levels of trust, understanding, confidentiality, and knowledge

*"The trust is there so it's easier to go and ask them for things. Or even ask questions because you assume that person knows general health. ... There can be anonymity too. You could go see that person without anyone else knowing, it's not on paper. It's not used against you."* (Interview #1)

*"Again, you gotta pick somebody who's trusted, right? Somebody who has the prisoners' respect, that's how you get things done."* (Interview #5)

*"We had a peer health coordinator in Frontenac, and people could go talk to them about HIV, hep C, whatever you wanted to ... And it was all kept confidential."* (Interview #9)

### Disadvantages:

#### Risk of corruption, bias/beefs, and gossip

*"CSC would probably put pressure on the person to give names ... they put pressure on us all the time, to rat each other out, which happens a lot in federal prisons."* (Interview #9)

*"There's going to be corruption involved. Like with any other black market in prison there's going to be like ... the gangs are going to get their fingers in the pie so to speak."* (Interview #4)

*"An altercation — there could be a conflict of interest between the person that's handing out the syringes to the prisoners, right? So that can always be a thing too; I mean if you've had a beef inside or whatever."* (Sistering focus group)

*"Peer workers talk too much."* (ALST focus group)

## Community workers

This model received a high level of support from former prisoners. The main perceived advantage of community worker distribution was confidentiality of the service, with high levels of trust that program participation would be kept private. Other advantages included the availability of harm reduction information through such providers, receiving non-judgmental service, and the fact that the service would be delivered by professionals.

The disadvantage of this model most highlighted by participants was the issue of access — primarily, whether or not community workers would be able to administer the program during a lockdown, as well as if the institution would be resistant to the program itself. Some perceived that community worker distribution would only reduce the amount of needle-sharing and not eliminate it. Other participants highlighted that prisoners might avoid a program provided by community workers, either because of not wanting the community to know about their substance use or because of pre-existing relationships with that particular community worker or organization.

It was suggested that this model would be more successful if community workers were able to bring in and leave behind a large amount of injection equipment, so that supplies could still be distributed in case of a lockdown. Participants felt that this model would be more palatable to corrections if each unit of injection equipment was catalogued and accounted for. As well, the community workers/agency would need to distinguish themselves from correctional personnel and clarify their independence in order to build trust with prisoners. Another suggestion was offering community-specific services so that prisoners from different cultural or religious groups could receive supplies and harm reduction information from members of their own background or religion.

### Advantages:

#### High levels of trust, professional knowledge, support, and confidentiality

*“Those kinds of people, they aren’t gonna rat you out to guards, right. They are working for you.” (ALST focus group)*

*“Yes, if you had ... an organization that people trust, that the [prisoners] trust. Like even the chapel, right? The reverend. Anybody other than staff.” (Interview #5)*

*“Nobody knows more about harm reduction than the people who work for those organizations.” (Interview #4)*

*“I just think interacting with somebody and giving a little bit of education and support and not being looked down on because they’re injecting inside” (Sistering focus group)*

### Disadvantages:

#### Access restrictions, disclosure of drug use to community

*“It’s like anything with Corrections Canada, if they don’t feel like letting ‘em in, they’re not gonna let ‘em in.” (DUAL focus group)*

*“In a security lockdown, nobody’s coming in or out, unless it’s food.” (DUAL focus group)*

*“Some people in jail don’t want the communities to know, you know?” (Interview #7)*

## Health care workers

Of the four models presented, former prisoners raised the most reservations about health care worker distribution, citing a lack of trust and lack of confidentiality as particular concerns. Those who offered positive feedback about this model acknowledged that health care worker distribution would allow for greater regulation and control, and would likely be the most palatable model for CSC.

Interestingly, a number of former prisoners across the group sessions raised the topic of supervised injection facilities within the prison. They saw PNSPs and supervised injection as opportunities for useful harm reduction services to be offered through health care.

Overall, however, there was a general negative response to this model. It was expressed that because of a lack of trust in prison health care workers and a belief that they would share information with prison security staff or the administration, many substance users would not make use of the program. For some, concerns over the lack of anonymity were directly associated with concerns over the ability to be granted parole. Other factors that could negatively affect the success of this model included health care workers' employment relationship to CSC (in Canada, prison health care is not provided through an independent, external body), the assumption that many health care staff would not agree with or support PNSPs, and possible delays because of existing difficulties in timely access to health care. Some participants also thought that the power and control that would be afforded to health care staff could potentially lead to staff withholding access as a means of punishing prisoners.

Based on participant comments, this model would be most successfully implemented if nurses who were in a designated PNSP-specific role delivered the program and, importantly, if the nurses were compassionate and non-judgmental.

### Advantages:

#### Integration into existing health services, most acceptable to CSC

*"Why not let the government do as they do outside, have it for the federal [prisons]." (ALST focus group)*

*"As long as they did it in a medical environment ... somebody that's fully trained on it, you know what I mean? Dispensing them properly and handing them out." (Interview #6)*

*"The health care department ... were really on top of what people were being dispensed and what was handed in ... and they are really quite diligent about making sure that rules and regulations are being followed as far as that goes." (Interview #3)*

*"I think the nurses were the way to go ... because there is a lot of judgment from the doctors ... there's always that air of authority. ... [Nurses have] got more of a humanity level still and, I mean, being in a penitentiary and doing that job and still maintaining a sense of humanity is really tough." (Interview #3)*

### Disadvantages:

#### Lack of trust and confidentiality, risk of negative consequences for participation, abuse of power

*"A lot of people don't want the nurses knowing because you automatically feel ... the nurses will tell the guards, the guards will tell your PO [parole officer], the PO will tell the parole board. There's a lot of lack of trust. A lot of lack of trust." (Interview #1)*

*"Not from a health care worker ... health care is just like the [security] staff, there's no difference. The health care is the same as the guards, to the prisoners. ... They're all working together to keep us in, as far as we're concerned." (Interview #5)*

*"It's hard to build a relationship with somebody that still works for the institution." (Interview #11)*

*"I didn't want to have to go to Nurse Ratched<sup>5</sup> to get a fucking needle, sorry, you know what I mean, it's like, 'didn't you already do one today?'" (Sistering focus group)*

5 Reference to the fictional, abusive nurse in the 1962 novel and 1975 film *One Flew over the Cuckoo's Nest*.

## Considerations for Women, Trans, Indigenous, and Racialized Groups

After discussing the main PNSP models and approaches, we asked all research participants—that is, the former prisoners and the community and medical professionals—if they had specific comments or thoughts on how PNSPs could better support the needs of diverse prisoners, including women, trans, Indigenous, and racialized groups. While Canada’s prison population is as diverse as its general population, there are certain people who are disproportionately incarcerated. It is thus important to consider these groups to ensure that PNSPs meet a range of needs.

Women who are incarcerated in Canadian prisons, for example, are more likely than their male counterparts to experience health complications from past physical and sexual abuse, poverty, pregnancy, and malnourishment, among other conditions (Canadian HIV/AIDS Legal Network, 2012). For Indigenous and Black women, these experiences are compounded by the legacies of colonization, slavery, and racism (Canadian HIV/AIDS Legal Network, 2012). As well, Indigenous, racialized, and immigrant men may experience incarceration differently than Canadian-born white men, the latter group typically used as the standard to develop prison-based programs. Furthermore, trans prisoners face unique barriers because of the binary female-male gender divide in the prison system, which can result in gender-based violence, harassment, and discrimination for people who are unable or who do not want to conform to gender norms.

Vulnerabilities that are caused by gender, class, race, culture, and ethnicity are thus significantly heightened in a prison setting, where access to appropriate services is already diminished, resulting in intensified risk for those who experience marginalization and discrimination. Such increased risk of harm makes it that much more pressing for PNSPs to consider gender, cultural, and racial differences among prisoners.

Overall, when asked to consider such differences, interview and focus group participants offered a few but not many concrete considerations for women, trans, Indigenous, and racialized prisoners. Given the abovementioned contexts, members of the Research Team wondered if the relatively few distinct recommendations for specific prisoner groups may reflect the lack of tailored prison-based programming in existence and/or that there was too little time during the focus groups to explore these issues in detail. That said, some participants pointed to

the particular importance of consulting women throughout the PNSP process, suggesting that *“sensitivities need to be looked at and [we need to speak] to the women to find out what makes the most sense to them in [PNSP] delivery”* (Diane Smith-Merrill). Other participants noted the benefits of peer support and education specifically for women who are in prison: *“Women take a course ... and learn how to peer support”* (Interview #7).

In addition, the Indigenous community harm reduction and prisoner rights advocates we interviewed had the most to say about Indigenous-specific and culturally appropriate PNSP services. All of the Indigenous community advocates talked about the effects of colonization, saying, for example, *“What people don’t understand is that we’re Indigenous to this territory, we don’t have any other place to go. We don’t think like the colonizer, even after you colonized us for 500 years ... I would like to see people not go to jail”* (Wanda Whitebird).

**Wanda Whitebird** is a Women’s Outreach Worker at the Ontario Aboriginal HIV/AIDS Strategy in Toronto. She has been doing prison in-reach and supporting Indigenous prisoners for over 30 years. She also served as the first female Native Liaison Officer in Canada, conducting spiritual and ceremonial work.

The significance of colonization to Indigenous prisoners’ lives and experiences was routinely raised by Indigenous participants. Some of the Indigenous community advocates also talked about residential schools more specifically, pointing to their ongoing legacy: *“In terms of ... Aboriginal men and women being incarcerated ... I really truly believe on falling back to their ancestry of residential schools ... I truly believe that our Aboriginal population that’s inside are [using drugs] because they have never gotten the proper treatment or proper counselling”* (Melissa Maracle). Consulting and working with both Indigenous Elders and Indigenous people who inject drugs were deemed essential to a successful PNSP.

**Melissa Maracle** is an Outreach Worker in the Ontario Aboriginal HIV/AIDS Strategy’s Kingston office. She conducts prison in-reach across Ontario, delivering group workshops and educational sessions on drug use, HIV, HCV, and general health and wellness for Indigenous male prisoners.

A common theme across these interviews was the importance of Indigenous prisoners connecting with their community members, with some participants noting, for instance, “If it’s a First Nations organization coming in and they are connecting with First Nations people in the prison, that can really give a sense of community and a sense of belonging” (anonymous Indigenous outreach worker).

**This Indigenous outreach worker** chose to remain anonymous. They have worked in harm reduction over the past 14 years, providing one-on-one support to current and former prisoners in various settings.

Some of the community harm reduction and prisoner rights advocates with whom we spoke considered the ways in which in-reach and prison-based programming by members of Indigenous organizations, as well as by members of other ethno-racial and cultural organizations are particularly beneficial for those communities in prison. As such, involvement of these organizations in PNSP delivery can have a positive impact on populations of prisoners that are overrepresented in the prison system: “The African/Caribbean/Black community, the Natives,

*we are so overrepresented in the prison system, we should have organizations from those communities coming in and doing outreach ... just to bring that sense of community and belonging and connectedness”* (anonymous Indigenous outreach worker). A few of the former prisoner participants remembered having access to different ethnic and religious leaders and community groups while incarcerated, which they considered an important step toward getting their needs met.

## Considerations for PNSP Rollout

Our final questions for the research participants centered on PNSP implementation. We solicited their advice about what types of institutions (i.e., what security level, men’s or women’s institutions, etc.) and which specific prisons would be most suitable for beginning the rollout of PNSPs in Canada. Most of the specific prisons suggested for rollout are located in Ontario, which we attribute to the fact that almost all of the former prisoner research participants had experienced incarceration in Ontario federal prisons. Other federal prisons in other parts of the country, of course, also would be suitable for PNSP rollout.

With regards to security level, most of the participants suggested initiating the first PNSPs in institutions that were either minimum or medium security, although a few recommended maximum security. Some felt that minimum security institutions would be good places to start the rollout because they would allow prisoners to obtain injection equipment with more confidentiality and likely fewer repercussions, since minimum security prisons tend to have more “*areas where the cameras are not on absolutely everything*” (Jasmine Cotnam). Other participants suggested medium-security prisons because they house a spectrum of prisoners. One of the potential advantages of medium-security institutions is that they generally have a greater ease of movement for prisoners than a maximum-security prison, while lacking the potential sense of imminent release.

**Jasmine Cotnam** is currently a System Advocate at People Advocating for Change through Empowerment (PACE), a consumer survivor initiative in Thunder Bay. She works with both men and women who have been in prison. She is also living with HIV and is a former prisoner and former injection drug user.



The few who recommended starting PNSP implementation in maximum-security settings did so because prisoners who spend more time in more confined conditions tend to share syringes more often and are therefore most in need of PNSPs. Also, participants suggested that maximum-security prisons were seen as likely to present the most implementation challenges and so successful uptake in this context would allow for a potentially smooth transition to implementing PNSPs in lower security-level prisons. Overall, most participants recognized that PNSPs would need to be tailored to the security level and context of each individual institution.

While participants did not reach consensus about which security level would be best to begin rolling out PNSPs, specific institutions were frequently suggested as the most appropriate places to start. Prisons that already allow community organizations to come in and distribute harm reduction and other materials, as well as institutions with approachable and supportive wardens and staff were viewed as the most appropriate starting points in the Canadian context.

Prison	Security Level	Institution Type	Why First Implementation Here?
Bath Institution Bath, Ontario	Medium	Male	Recommended because it has been used as a pilot for other programs in the past and was seen as the <i>"guinea pig of everything"</i> (DUAL focus group). Also suggested because of its diverse prisoner population.
Millhaven Institution Bath, Ontario	Maximum	Male	Recommended on the premise that starting at one of the 'toughest' prisons would make the transition to other prisons smoother: <i>"Start at the toughest and work your way down"</i> (Diane Smith Merrill). Also recommended because of its diverse prisoner population: <i>"It has probably the biggest variety of prisoners"</i> (Interview #4).
Collins Bay Institution Kingston, Ontario	Medium	Male	Recommended because of the high rate of drug use and resulting need for safer injection practices, with participants noting: <i>"There is a lot of drug users in Collins Bay"</i> (Interview #6) and <i>"Collins Bay has been one of the worst ones for violence and drug use"</i> (Interview #1).
Joyceville Institution Kingston, Ontario	Medium	Male	Recommended because of its approachable prison staff, with one participant referring positively to the warden, <i>"I would go to Joyceville ... she's been around ... start with her"</i> (DUAL focus group). Others suggested increased need because there are <i>"a lot of first-timers"</i> (Wanda Whitebird).
Beaver Creek Institution (formerly Fenbrook) Gravenhurst, Ontario	Medium	Male	Recommended because of its approachable prison staff: <i>"The Fenbrook staff that we had ... were really cool. They seemed ... more susceptible to listening ... to the inmate committee"</i> (Interview #9).
Grand Valley Institution for Women Kitchener, Ontario	Multi-level	Female	Recommended because of its diverse prison population and housing arrangements — <i>"You got the houses, you got ... the minimum, medium there, and then you got the max unit ... Grand Valley would be an awesome place"</i> (ALST focus group) — and because it is the only women's institution in Ontario.
Warkworth Institution Campbellford, Ontario	Medium	Male	Recommended for its knowledgeable infectious disease nurses: <i>"I would have to say Warkworth only because the infectious disease nurses there are so awesome"</i> (Chris Ciceri).
Kent Institution Agassiz, British Columbia	Maximum	Male	Recommended because of the high rate of intravenous drug use at the institution, and thus a great need for PNSPs: <i>"Kent, maximum, which has 100% heroin addicts"</i> (Interview #2).

# Lessons from Switzerland: A Successful PNSP Example



A number of participants suggested that it would be beneficial to look at international success stories in order to tailor PNSPs to the Canadian context: *“Look at other models in other countries and see how successful [they are], how those models have been. Pick the right one that would fit for us here”* (anonymous Indigenous outreach worker). At the same time, others noted that what works elsewhere might not work here: *“You can’t adopt a model from another country or another location or prison and plop it down and think it will work”* (Susan Craigie).

**Susan Craigie** worked as the Prison Outreach Coordinator for Positive Living B.C. for five years. During this time, she conducted educational workshops and provided direct support and counselling for male and female federal and provincial prisoners with HIV and HCV co-infection in all British Columbia prisons and correctional centres.

With this in mind, let us consider the example of a highly successful PNSP at Hindelbank Prison in Switzerland, a multi-level women’s institution. Upon entry, new prisoners meet with the nurse who runs the PNSP. The different aspects of the program are explained, and if they choose to use it, they are given a kit with one syringe and five detachable needles. The building of a trusting relationship with the nurse is a key factor in the PNSP’s success.

In addition to being able to obtain sterile injection supplies from the PNSP nurse, Hindelbank Prison also has a number of syringe-dispensing machines located in discreet areas in the prison. Thus, if the PNSP nurse is not available on a particular day, prisoners can use the dispensing machine. The aim of the program is to provide sterile equipment and an opportunity for prisoners to forge safe and trusting relationships with health care staff. Prisoners who use the program are required to keep their equipment in a designated puncture-proof container in their room. While prisoners are not penalized for having injection equipment in their cell (which would be evident during cell room searches), there are negative consequences for drug use itself (confirmed through urine testing) and for possession of drugs.

A key point of consideration is that prior to PNSP implementation at Hindelbank in 1994, the prison and its staff underwent a full year of training and educational workshops on HIV, HCV, drug use, and other health topics to increase staff knowledge of PNSPs and staff support for the program. When the program was finally introduced, correctional officers and other staff had some apprehension but were not resistant to its implementation. There has been a high level of staff support for the program ever since.





Evaluations of PNSPs in other countries concluded that the provision of sterile injection equipment has not meant condoning the use of illegal drugs in prisons. Drugs remain prohibited within institutions that offer PNSPs, and PNSPs do not interfere with the prison's safety and drug prevention strategies (Lines et al., 2005; Stöver & Nelles, 2003). Indeed, the fear that PNSPs would undermine anti-drug, abstinence-based approaches has not materialized. Rather, the evidence shows that PNSPs can actually increase the uptake of ongoing drug treatment services (CSC, 1999; Dolan et al., 2003; Lines et al., 2005; PHAC, 2006).

## There Will Be an Increase in Drug Use

Another common concern is that PNSPs will lead to an increase in drug use in prison. We know, however, that the availability of sterile syringes does not result in an increased number of drug injectors, an increase in overall drug use, or an increase in the amount of drugs seized in the institutions in which PNSPs exist (Dolan et al., 2003; Lines et al., 2005; Stöver & Nelles, 2003). Again, both CSC (1999) and the PHAC (2006) reached similar conclusions.

*“Drugs are going to be used regardless.” (ALST focus group)*

*“It’s not like the needle and injection use is going to increase, it’s already there ... it would be safer, it’s actually less of a concern.” (Chris Ciceri)*

Many of our participants confirmed that drug use is already prevalent in Canadian prisons, and people are using various methods to consume them, with few options for safer injection or harm reduction. Sterile equipment does not contribute to increased drug use but rather helps mitigate possible transmission of disease and other medical harms that are likely to occur through needle sharing, rushed injecting, and unsafe disposal of equipment.

*“Somebody, somewhere, is ... injecting something every day. Whether it’s injecting their medication pills, or injecting drugs that have been smuggled in ... they’re injecting something.” (Interview #8)*

*“Instead of injecting ten ... times a day, you only inject once every four hours. [Prisoners] begin to control the substance use, instead of the substance use controlling them. They can get needles that have not been used before ... it’s a win-win situation.” (Wanda Whitebird)*

## Prisoners Will Use Needles as Weapons

One of the biggest apprehensions about PNSPs, especially for correctional officers, is that prisoners will use the needles as weapons. While this is an understandable concern, we found no international data to suggest that needles have been used as a weapon in any prison where a PNSP exists, including in maximum-security prisons.

Evaluations and reviews of existing PNSPs explicitly state that there are no reported cases of needles and syringes being used as weapons, against either staff or other prisoners (Dolan et al., 2003; Lines et al., 2005; Stöver & Nelles, 2003). Indeed, international research has concluded that the fears of violence and other negative consequences have not materialized when PNSPs were implemented (Dolan et al., 2003; Lines et al., 2005). Reports from both CSC (1999) and the PHAC (2006) reached similar conclusions, even highlighting that PNSPs “can enhance the occupational health and safety for CSC staff” (CSC, 1999, p. 2). Many of our research participants expressed concern for the health of correctional officers and agreed that PNSPs are a way of improving occupational health and safety overall.

*“This is the pragmatic approach to reduce the risk to prisoners and guards ... [PNSPs] actually makes it a more safe working environment.” (Wendy Wobeser)*

In assessing this concern over violence in the prison context, it also should be noted that many things that are easily accessible in prison can be used as a weapon. Pens, pencils, toothbrushes, cutlery, and books, for example, all of which are common items in prison settings, can be used in violent incidents and can cause harm.

*“There are other weapons that are a lot shrewder, that are a lot more effective than a syringe.” (Interview #10)*

*“Prisoners, you know, they have knives, they have knives to eat with.” (anonymous medical professional)*

Moreover, some federal prisoners are already entrusted with injection equipment (e.g., diabetic prisoners who require equipment for insulin injections) and are taught to safely dispose of used injection equipment, with no reported problems encountered. Based on the available evidence, we anticipate that prisoners will be motivated to follow correct PNSP procedures and disposal, and may even support each other in these efforts, so as not to lose access to the program.

*"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 PNSP]." (Interview #10)*

*"Nobody wants to be the one guy who ruins it for everybody in there." (Interview #4)*

*"How dare you use a needle that we need as a weapon! You must be the stupidest person ever." (ALST focus group)*

*"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." (DUAL focus group)*

## There Will Be an Increased Risk of Needle-Stick Incidents

Another common claim is that PNSPs will lead to more instances of correctional staff being pricked by a used needle. Even in the absence of PNSPs, however, it should be remembered that injection equipment, particularly makeshift "rigs," are already present so the risk of an accidental needle-stick incident already exists to some degree. As noted previously, since needles and syringes are considered contraband, prisoners tend to hide them in their cells and other locations around the prison, which means that correctional officers can be accidentally pricked with a needle during searches. Without PNSP access, many prisoners will share the same equipment, sometimes for many months, thus dramatically increasing the likelihood that the injection equipment may have been contaminated by a blood-borne virus.

*"Everybody hides them in all different kinds of places because they can't be seen with them." (Interview #7)*

*"Guards that do searches or, even when you come across a used one and prick yourself ... There's harm everywhere, so [PNSPs] would definitely be a benefit." (Interview #1)*

With a PNSP in place, authorized injection supplies are not contraband items that need to be concealed, and prisoners are required to keep them in a predetermined spot in their cell, usually inside a puncture-proof container, for example the one pictured here from Hindelbank Prison in Switzerland.



*Pictured above: Puncture-proof container from Hindelbank Prison.*

As a result, cell searches do not carry the same potential for an injury. Here again, the experience with PNSPs operating for years in various prisons around the world is instructive: with the practice of storing injection equipment in a hard plastic safety case and in a visible location, many institutions reported an increase in staff security, including a significant reduction in accidental needle-stick instances to staff from hidden syringes during cell searches (Lines et al., 2005).

*"[With a PNSP, prisoners] are gathering [injection supplies] and putting it in the safe box ... so the stick injuries should be non-existent." (Interview #11)*

*"It's about having the open, authentic reality that there are needles everywhere. Have some guidelines where they should be or where you expect them to be ... therefore nobody has to hide them. Whatever you can do to encourage people to keep them out in the open, I think you will have a safer environment." (Jennifer Vanderschaeghe)*

The distribution of sterile syringes, as well as their safe storage, can increase health and safety for everyone in the prison setting. Educating and training correctional officers and others on the ways in which PNSPs enhance, rather than undermine staff safety can go a long way in ensuring that drugs and equipment are not conflated, and that prisoners are not stigmatized or punished for obtaining sterile injection equipment.

# Recommendations for PNSPs in Canada

The recommendations below are based on the three phases of research and advocacy activities outlined above (the stakeholder networking meeting in January 2014, Swiss prison site visits in May 2014, and primary data collected between October 2014 and April 2015), as well as available international evidence published over the last two decades. While the recommendations were specifically developed for the Canadian federal prison system, they may also be applicable to provincial/territorial prison systems and prisons in international contexts.

In addition to referring to the guidelines for planning and implementing PNSPs developed by the United Nations Office on Drugs and Crime (2014), we suggest the following:

## **Recommendation #1**

Prisoner access to PNSPs and sterile injection supplies should be easy, confidential, and not subject to disciplinary consequences.

## **Recommendation #2**

Prisoners should have regular access to information, education, and support from trained personnel regarding safer drug injection.

## **Recommendation #3**

PNSPs should adopt a hybrid or multi-model approach to distribution within each institution.

## **Recommendation #4**

PNSP implementation and delivery should include ongoing and meaningful consultation with, and education for, relevant stakeholders to ensure the accessibility and positive health outcomes of the program.

## **Recommendation #5**

Prisoners should have an active role in determining PNSP programming, structure, and policy.

## **Recommendation #6**

The justice system, including the Correctional Service of Canada, should move toward addressing drug use as a social and health issue.

## Recommendation #1

Prisoner access to PNSPs and sterile injection supplies should be easy, confidential, and not subject to disciplinary consequences.

To promote PNSP uptake, injection supplies must be easy for prisoners to obtain. Supplies should be available in **multiple locations** in the institution and should be **accessible throughout the day**. The choice of supply locations in the institution should encourage, not deter, access. For example, prisoners should be able to obtain supplies without the fear of being watched by correctional officers, other staff, fellow prisoners, or surveillance cameras. **Safer disposal options should also be easily accessible** (i.e., in various confidential locations and available throughout the day).

To ensure that prisoners have all of the provisions needed for safer use, injection supplies that are recommended or considered “best practice” and available in community settings should be available in prisons. These supplies include needles/syringes, “cookers” or mixing containers, filters, sterile water

for injection, alcohol swabs, and tourniquets (see Strike et al., 2013). In addition, **supplies must be maintained and refilled** as needed. Lack of consistency and accessibility have been documented regarding bleach distribution, as noted earlier; PNSPs will be considerably more successful if they do not face the same challenges.

In addition, unless there is a specific security incident, **PNSP access should not be restricted or blocked**. In the event of a disruption (e.g., a lockdown), efforts should be made to distribute injection supplies to prisoners who request such services. Obtaining supplies through the PNSP should not be considered a security incident, nor should program participation be documented and reported to parole boards or other such parties. In other words, using the PNSP should not result in any disciplinary consequences.



## Recommendation #2

Prisoners should have regular access to information, education, and support from trained personnel regarding safer drug injection.

The distribution of injection equipment should be accompanied by **accessible information and education** regarding safer injection practices, HIV and HCV transmission and prevention, and other support as needed. Peers (which may include both current and former prisoners), community workers, prison health care staff (e.g., infectious disease nurses and doctors), and correctional staff can all have roles to play in delivering PNSP services and related education (Strike et al., 2015).

All personnel who are involved in PNSP administration, delivery, or evaluation need to receive **adequate training** and should demonstrate knowledge of PNSP operation and harm reduction principles. In particular, all personnel who are responsible for delivering the program should receive training about non-judgmental attitudes towards prisoners who may use drugs, and should maintain a supportive and open-minded attitude when providing services. In several cases in jurisdictions where PNSPs operate, staff members were reluctant at the start but grew to support the programs over time as the benefits were experienced first-hand (Lines et al., 2005).



### Recommendation #3

PNSPs should adopt a hybrid or multi-model approach to distribution within each institution.

To promote access that meets different prisoners' needs, each institution should ideally have **at least two PNSP models in operation**, with preference towards **dispensing machines plus a model that offers support and face-to-face interaction**, such as peer distribution.

Having a variety of access points for sterile injection equipment will **reduce barriers** to access and **improve anonymity** for service users. For some people, interacting with another person in a hand-to-hand model may be an impediment to access and machine distribution is preferable. Others may prefer hand-to-hand distribution and use the opportunity to ask questions about safer use practices and risks associated with drug use.

Community standards and best practices encourage **multiple access points for injection supplies and supports**, so as to encourage consistent and ongoing safer use. This principle holds true in the prison context as well, and prisoners should be able to obtain sterile injection equipment in a variety of ways.



## Recommendation #4

PNSP implementation and delivery should include ongoing and meaningful consultation with, and education for, relevant stakeholders to ensure the accessibility and positive health outcomes of the program.

To ensure that PNSPs become trusted, accessible, and well-maintained programs, meaningful consultation involving those administering the program, correctional staff, health care staff, prisoners, and other relevant stakeholders must occur **prior to the initial set-up and extend beyond it.**

Training of all parties involved in program delivery must also **begin prior to PNSP implementation and continue post-implementation** to ensure that the delivery of information and education stay up-to-date. These activities should also help promote program buy-in from varied stakeholders. Indeed, well-designed training protocols are particularly needed for correctional staff to promote their understanding of the need for PNSPs and how these programs can contribute to institutional health and safety (e.g., by reducing infectious disease among prisoners, reducing chances of accidental needle-stick instances, etc.).

Therefore, prior to implementing PNSPs, the **views and attitudes of correctional staff and prison officials should be evaluated carefully** to better understand their stated opposition to such programs. This process will not only contribute to in-depth knowledge of how stakeholders navigate conceptualizations of PNSPs, but also allow stakeholders to play an active role in developing solutions to PNSP use, thereby enhancing their commitment to the process and acceptance of the final product (Mogg & Levy, 2009).

Thus, introducing a needle and syringe program in prison should include **substantial and ongoing education for, and consultation with, correctional officers** and prison officials on the benefits of PNSPs. It is important to note, however, that implementation of PNSPs should not be contingent on staff approval or endorsement.





## Recommendation #5

Prisoners should have an active role in determining PNSP programming, structure, and policy.

To ensure that PNSPs meet the needs of those who will use the program, **prisoners should be involved in decision-making processes that determine PNSP programming, structure, and policy.** Prisoner feedback on all elements of PNSP implementation and operation (e.g., concerns about access to supplies, confidentiality, preferences for educational content, preferences for PNSP models, etc.) should be **incorporated wherever possible.**

Many marginalized communities, including people who use drugs, have argued in support of a **'nothing about us without us'** approach to programming and services (Jürgens, 2008; National Treatment Agency for Substance Misuse, 2007; Schiffer, 2011). It is internationally recognized that **peer involvement is fundamental** to the success of interventions for people who use drugs; this is also the case within the prison context. Studies have found that peer health promotion in prison helps change attitudes and behaviours among prisoner populations, which is effective in reducing instances of HIV transmission (Wright et al., 2011).

Given the disproportionate impact of drug criminalization and correctional policies on Indigenous and racialized peoples, as well as their higher rates of HIV and HCV in and out of prison, it is particularly important that prisoner representatives from these communities are actively engaged in PNSP set-up, implementation, and ongoing programming decisions. Indeed, **culturally specific knowledge, experience, and supports** in PNSP programming are necessary for addressing the ongoing legacies of colonization and racism.

Prisoners' active involvement in PNSP design and implementation can help to increase their trust and confidence in accessing PNSPs. Prisoners understand the environment they live in and the factors that influence their ability and motivation to access programs and services better than any other stakeholder within the system. It is, therefore, essential that prisoners' experiences and knowledge are central to PNSP implementation and management.



## Recommendation #6

The justice system, including the Correctional Service of Canada, should move toward addressing drug use as a social and health issue.

PNSPs have proven to be effective at reducing health-related harms within prisons that retain zero-tolerance and punitive policies towards the possession and use of drugs, with Switzerland as one example. We recommend, however, that correctional frameworks in Canada fundamentally shift their view of drug use towards a **health and social welfare approach**. Currently, drug use in prison is seen as deviant and non-compliant behaviour in need of coercive correction, rather than as a health and social well-being issue. This orientation fails to recognize the root causes of individuals' substance use issues.

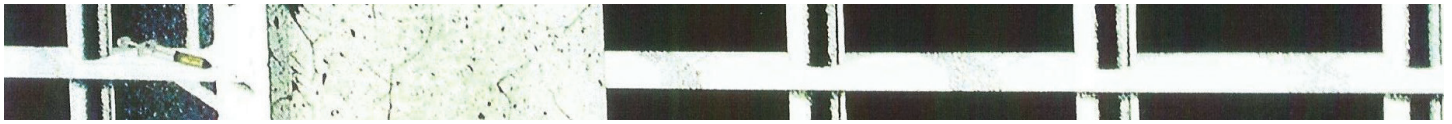
For those prisoners dealing with concurrent drug use and mental health issues, mental health supports also need to be fundamentally shifted **away from a security mentality** and toward creating more therapeutic environments. Likewise for prisoners with pain management needs, prison health care should focus instead on patients' **pain issues as a complex and multi-layered health concern** and resist the pressure to treat requests for pain management as non-health-related recreational requests or signs of behaviour in need of diversion and control.

We thus recommend the **cessation of current practices of delivering punitive consequences** to prisoners who are found to be using drugs inside prison, such as restrictions on family visits, loss of work (and thus income), and institutional charges. These practices only serve to further isolate and punish individuals who are often already struggling within the prison system.

While a shift away from zero-tolerance policies with respect to drugs is not a requirement for the success of PNSPs, it should be recognized that such anti-drug policies ultimately play a part in creating the conditions for problematic and more chaotic substance use practices in prison, and thus contribute to the need for PNSPs in the first place.



# Conclusion



The criminalization of drugs is a central and consistent factor in the conviction of people who are incarcerated in the federal prison system. Many of these people are also struggling to overcome both physical and emotional/psychological pain management issues, have experience with mental health systems, are survivors of the residential school system, are survivors of childhood abuse, and/or are living with the experience of trauma. Effective and comprehensive harm reduction programming is therefore essential to support diverse prisoner populations.

International evidence and experience have consistently demonstrated that such programs are effective at reducing the negative health consequences associated with injection drug use, do not increase violence inside prisons, and can be implemented in a variety of forms within different prison settings so as to best support different prisoner populations. PNSPs enhance overall public health, and improve the health and safety of the prison environment for prisoners and prison staff. Our research supports these findings and goes one step further by providing concrete recommendations on how to implement these important programs. PNSP implementation in Canada can and should happen immediately.

While PNSPs have been recommended by numerous health and human rights organizations, both in Canada and internationally, resistance to such programs is, in part, the result of a lack of understanding about how they could be introduced realistically and effectively, as well as incorrect assumptions about how they function. By involving a broad cross-section of key stakeholders and those who were formerly incarcerated, we hope that our PNSP recommendations can lead to a more effective harm reduction policy in Canadian prisons and to advancements in knowledge and public opinion on this health and human rights issue.

The health of our prisons affects the health of our families, friends, and communities. It is time to take seriously the need for harm reduction in Canadian federal prisons and to implement PNSPs.

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## Artist Bios:

**Pete Collins** was a prolific artist, writer, and musician, as well as an advocate and a warrior for prisoner's rights and justice. Pete was active in trying to improve prison conditions, drawing attention to systemic issues within the system and raising awareness about HIV/AIDS, access to health care, harm reduction, racism, and more. Pete died on August 13, 2015 in the palliative care unit at Millhaven Institution, after a long battle with cancer. He was denied compassionate release and was therefore unable to spend his last days with his family. You can see his artwork on the front cover as well as pages 4, 6, and 25 of this report.

**Nshannacappo** is a Nakawe (Saulteaux) graphic novelist, artist, writer, and poet who specializes in black and white western style dragons, superheroes, and Aboriginal protagonists. As a writer he loves fantasy, sci-fi, and long form poetry. Nshannacappo is a spiritual believer in the traditions of his people: Creator, the Seven Grandfathers, and the Medicine Wheel. By education he is a Social Service Worker, by passion he is an artist/poet. He is a longtime supporter of prisoners' rights and believes that harm reduction is vital to curbing hep C and HIV/AIDS among prison populations. You can see his artwork on pages 14 and 22 of this report, and online at [www.facebook.com/nshannacappo/](http://www.facebook.com/nshannacappo/)





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