

HARD TIME FOR HARM REDUCTION

PERSPECTIVES ON PRISON PROGRAMS



On February 24, 2026, the HIV Legal Network hosted the webinar *Hard Time for Harm Reduction: Perspectives on Prison Programs*.^[1] The discussion brought together advocates, healthcare professionals, researchers, frontline workers, and individuals with lived experience to examine harm reduction and healthcare in Canadian prisons.

The event was the second of two webinars focused on growing challenges facing harm reduction in Canada. It explored how prison systems respond to the needs of people who use drugs in the context of the ongoing toxic drug crisis. While speakers highlighted areas of progress, a central theme emerged: structural barriers rooted in security-focused approaches continue to limit meaningful access to harm reduction and healthcare in prison settings, with harmful implications for people who use drugs.

OPENING REMARKS

Anne-Rachelle Boulanger, Policy Analyst at the HIV Legal Network, opened the webinar by grounding the discussion in the principles of harm reduction. Harm reduction recognizes that people who use drugs deserve dignity, respect, safety, and access to care.^[2] It aims to reduce the health, social, and legal harms associated with drug use through evidence-based interventions such as supervised consumption services (SCS), naloxone distribution, opioid agonist therapy (OAT), and access to sterile drug equipment.

Anne-Rachelle emphasized the urgency of the discussion in the context of Canada's toxic drug crisis. Over the past decade, more than 53,000 people in Canada have died from toxic drug incidents.^[3] Many individuals entering prisons have experienced substance use disorder, toxic drug incidents, or exposure to the increasingly toxic drug supply. At the same time, prison systems are structured around surveillance, discipline, and control. These priorities often conflict with healthcare approaches grounded in consent, trust, and patient-centred care.

Anne-Rachelle introduced the HIV Legal Network's work examining Canada's prisons.^[4] Most recently, the HIV Legal Network published *Hard Time Persists: Healthcare and Harm Reduction in Canada's Prison System*, in which they assessed healthcare and harm reduction policies and practices across provincial, territorial, and federal prisons.^[5] The report identifies progress. For example, in several jurisdictions, responsibility for prison healthcare has been transferred from Ministries of Justice to Ministries of Health. That shift has the potential to strengthen

accountability, including prioritizing patient health, informed consent, and confidentiality. At the same time, the report identifies significant gaps. One of the gaps relates to OAT. While access to OAT in prison has expanded in recent years, there have been policy and practice shifts that risk narrowing treatment — with potentially fatal consequences.^[6]

PANELISTS

The panel brought together diverse perspectives from across frontline service delivery, legal advocacy, research, and lived experience:

Alicia Gordon	An Indigenous woman, mother, and certified Gladue Writer who serves as a Restorative Justice Coordinator. She brings a perspective shaped by lived experience of incarceration, substance use, and gender-based violence, and has worked as a Court Support Worker, System Navigator, and Community Correctional Worker. Her work centres on healing, restorative justice, and supporting others to navigate complex systems with dignity and hope.
Anton McCloskey	A social worker and Manager of Prison Programs at PASAN (Prisoners with HIV/AIDS Support Action Network), a community-based organization providing harm reduction, HIV, and hepatitis C support to people in prison. ^[7] He works primarily with Indigenous communities and people in federal prisons, and his work is grounded in self-determination, liberation, and community-led advocacy.
Omar Ramcharran	A Federal In-Reach Community Development Coordinator with PASAN, providing frontline harm reduction education, support, and reintegration services in federal prisons. They bring over 15 years of professional, academic, and lived experience related to HIV and substance use, and their work focuses on addressing systemic barriers in health and social systems.

<p>Nicole Kief</p>	<p>The Executive Director of Prisoners’ Legal Services (PLS), a legal clinic that supports people in federal and provincial prisons in British Columbia in challenging unlawful treatment and rights violations.^[8] She previously served as Policy Director and Legal Advocate at PLS, and has worked on strategic litigation and advocacy to advance systemic prison justice. Prior to this, she worked with the American Civil Liberties Union on initiatives addressing the school-to-prison pipeline and voting rights.</p>
<p>Jen Smith</p>	<p>A social worker with over 15 years of experience in harm reduction and social justice across Canada. She currently works with Correctional Health Services in Newfoundland and Labrador at Her Majesty’s Penitentiary, where she provides frontline care in a complex correctional environment. Her work focuses on supporting individuals experiencing substance use, mental health challenges, and systemic marginalization.</p>
<p>Dr. Claire Bodkin</p>	<p>A queer femme, family physician, and mother living on Anishinaabe territory on the Saugeen Peninsula. She cares for patients admitted to hospital, in the emergency department, in clinic, and at home. She has a focus on care for people who use drugs and queer and trans people. Her research with McMaster University centres around community-driven participatory research methods, the health of people who are incarcerated, and the health of people who use drugs.</p>

1. WHAT IS CURRENTLY HAPPENING IN PRISONS

In the first block of the discussion, panelists described a system marked by increasing barriers to harm reduction, significant resource constraints, and persistent tensions between healthcare and institutional security. Across jurisdictions, these challenges are experienced through three interrelated dynamics: reduced access to harm reduction services, growing operational pressures within institutions, and systemic gaps in healthcare delivery and oversight.

Omar and Anton highlighted the growing barriers to harm reduction within prisons. The closure of supervised consumption sites in the community alongside restrictive legislative changes such as Bill 6 in Ontario (which further punishes public drug consumption in the province) has limited access to harm reduction supplies and programming in communities outside prison.¹⁹¹ These changes are reflected in institutions where there is severe healthcare understaffing, with some institutions relying on only one or two public health nurses to serve populations of several hundred people. Panelists noted that these conditions are likely to increase the risk of HIV and hepatitis C transmission. They also pointed to widespread confusion and inconsistency in the implementation of OAT policies as well as a lack of meaningful pre-release support, leaving individuals vulnerable to the toxic drug supply upon release.

These constraints are compounded by operational pressures within institutions. Jen described how prisons in Newfoundland and Labrador are operating beyond capacity, with aging infrastructure and limited staffing. At the same time, the impacts of the toxic drug supply are increasingly visible, with individuals entering custody while intoxicated or in acute withdrawal. Despite these challenges, she identified some progress following the transfer of prison healthcare to the provincial health authority, which has enabled more timely access to OAT and hepatitis C treatment upon intake.

These systemic pressures are further shaped by institutional priorities that place security above care. Alicia provided a lived experience perspective on how this dynamic plays out in practice. Individuals experiencing withdrawal may be left to rely on one another for support, and access to medical care can be delayed for weeks. She described being required to limit medical concerns to a small number of issues at a time, and shared a personal experience in which a broken arm went untreated until staff suspected her of having contraband, prompting further medical attention. She also underscored the lack of adequate mental health care, despite the central role of trauma in shaping substance use.

Nicole highlighted that individuals entering custody in severe withdrawal are sometimes placed in segregation, not as a disciplinary measure but because it is the only setting where continuous monitoring is possible. This practice reflects the absence of appropriate medical spaces within correctional facilities.

At a broader level, these challenges are reinforced by gaps in data and accountability. Claire noted that current practices are inconsistent with national clinical guidelines and can increase the risk of serious health consequences, including death. She also emphasized the lack of transparent and reliable data on prison healthcare. Without clear information on the prevalence of substance use disorders, access to treatment, or health outcomes, it is difficult to assess needs, evaluate changes, or ensure accountability.

Across these perspectives, a consistent picture emerged of a system in which access to harm reduction and healthcare is uneven, constrained, and shaped by structural dynamics that prioritize security over health.

2. WHERE IS PROGRESS EMERGING?

In the second block of the discussion, panelists were invited to reflect on areas where healthcare and harm reduction have been prioritized within prison settings. While speakers emphasized that these examples remain uneven and often fragile, they identified some promising developments that demonstrate what more effective, health-centred approaches can look like in practice.

Alicia described how participation in a treatment program during her incarceration provided an important foundation for her journey and her recovery. In her experience, incarceration presented a critical window of opportunity to engage in programming. These programs can support relapse prevention and help individuals begin planning for life after release. At the same time, she noted that access is often restricted by strict behavioural requirements, such as remaining “conflict free” for extended periods, which can limit participation in environments that are inherently stressful and unstable.

Nicole highlighted that, following a human rights complaint brought by PLS in 2018, Correctional Service Canada substantially reduced its OAT waitlist, from several hundred individuals to a small fraction of that number by 2025.^[10] Additional reforms included the creation of a National Medical Advisor for OAT. She also noted positive developments in British Columbia, where the transfer of prison healthcare to the Provincial Health Services Authority has been associated with improved oversight and a reduction in healthcare-related harms.^[11]

From a clinical perspective, Claire emphasized that effective care in prison should reflect established standards in the community. This includes building trust, offering a range of evidence-informed treatment options, and developing individualized care plans grounded in patient goals and autonomy. She underscored that incarceration does not diminish the state's obligation to provide appropriate healthcare. Rather, it reinforces a legal and ethical duty of care to ensure that individuals have access to services equivalent to those available outside prison.

Jen described how the transfer of prison healthcare to a health authority in Newfoundland and Labrador has supported a more patient-centred and non-judgmental approach to care. She emphasized the importance of meeting individuals where they are, focusing on reducing harm and supporting survival rather than imposing abstinence-based expectations. She also highlighted the development of proactive release planning practices, including regular interdisciplinary meetings to coordinate healthcare, housing, and community supports prior to release. These efforts can help strengthen continuity of care and reduce risks associated with the transition back into the community.

Finally, speakers highlighted the value of peer-led and skills-based programming in supporting well-being and long-term reintegration. Anton emphasized that boredom and lack of meaningful activity are significant factors shaping substance use in prison. He pointed to initiatives such as vocational training programs and peer education models, including the Peer Education and Knowledge program, as important tools for building skills, fostering connection, and supporting harm reduction.^[12] At the same time, he noted that these programs are often limited by insufficient institutional support and resources, restricting their availability and impact.

Taken together, these examples illustrate that more effective, health-centred approaches are both possible and already emerging within prison systems. However, their uneven implementation underscores the need for sustained investment, institutional support, and structural reform to ensure that such practices can be expanded and maintained.

3. WHAT NEEDS TO CHANGE?

In the final block of the discussion, panelists were asked to identify the structural, legal, and cultural shifts required to make healthcare a meaningful priority within prison systems. Across perspectives, speakers emphasized that incremental improvements are insufficient without broader systemic reform.

A central recommendation was the need to establish independent prison healthcare systems. Anton, Nicole, and Claire all emphasized that healthcare should be transferred out of correctional services and into Ministries of Health. Panelists noted that this shift would help align prison healthcare with community standards and international human rights frameworks, including the United Nations Mandela Rules.^[13] Claire further stressed that current practices must be brought into line with national clinical guidelines for opioid use disorder, expressing concern that existing policies often diverge from established medical evidence.

Speakers also called for a fundamental rethinking of institutional approaches to risk, particularly with respect to medication diversion. Nicole and Claire challenged the assumption that diversion of medications such as buprenorphine-naloxone is inherently harmful, noting that restrictive policies are often based on limited evidence. In some cases, diverted medication may function as a form of harm reduction, helping to reduce exposure to the toxic drug supply. Omar also emphasized the importance of confidentiality in healthcare settings, noting that the lack of privacy within correctional environments undermines trust and discourages individuals from seeking care.

The discussion further underscored the need to strengthen continuity of care and support individuals beyond the point of release. Jen described the significant barriers individuals face upon re-entering the community, including limited access to housing and long wait times for treatment services. Alicia similarly emphasized that reducing waitlists for care within prisons must be paired with meaningful reintegration planning, including access to stable housing and community-based supports. Anton highlighted the role that community organizations can play in bridging this gap, calling for expanded access for external service providers to deliver programming and support within institutions.

QUESTIONS AND ANSWERS

During the question-and-answer period, panelists reinforced these themes through practical examples and reflections. Claire pointed to the Drumheller Overdose Prevention Site as an example of a successful harm reduction intervention, noting that initial resistance from correctional staff shifted over time as the program demonstrated clear benefits for both health outcomes and institutional safety.^[14] Alicia described advocacy efforts that led to the removal of strip search requirements for people accessing OAT, illustrating how targeted reforms can improve dignity and access to care.^[15]

Panelists also addressed the sources of ongoing barriers to healthcare. Nicole noted that limitations arise from both formal policies and frontline implementation, with correctional staff often acting as gatekeepers to care. This dynamic can undermine access to services and erode trust in healthcare systems within prisons.

Finally, speakers identified concrete actions for those seeking to support change. Anton emphasized the importance of engaging directly with people in prison, including through volunteer and pen pal programs, to ensure that advocacy efforts are grounded in lived experience. Nicole encouraged continued advocacy for the full implementation of the Mandela Rules and broader accountability in prison healthcare systems.

Taken together, these recommendations highlight the need for coordinated structural reform, increased accountability, and sustained community engagement to ensure that healthcare in prisons is delivered in a manner consistent with human rights and public health principles.

CONCLUSION

In closing, Janet Butler-McPhee, Co-Executive Director of the HIV Legal Network, thanked the panelists and participants for engaging in a critical discussion on harm reduction and healthcare in prisons. She reaffirmed the HIV Legal Network's ongoing commitment to advancing drug policy grounded in evidence, human rights, and the lived experiences of people who are incarcerated.

Echoing a central theme of the discussion, she emphasized that as long as prisons continue to exist, they carry a fundamental obligation to uphold the right to health. This responsibility is particularly urgent for people who are already marginalized and disproportionately impacted by criminalization and the toxic drug crisis. She invited participants to remain engaged in this work, including by connecting with the HIV Legal Network, sharing feedback, and continuing to support advocacy efforts aimed at improving health outcomes and accountability within prison systems.

View the webinar and find associated materials [here](#).

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