

Article

“They’re Just Watching You All the Time”: The Surveillance Web of Prison Needle Exchange

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Abstract

In 2018, the federal prison authority in Canada began implementing Prison Needle Exchange Programs (PNEPs) at select institutions. Despite longstanding and successful models of prison-based syringe distribution internationally, Canada’s correctional service introduced a highly restrictive security-based approach, placing prisoners who access the program into a surveillance web that implicates diverse actors and relies on methods such as bio-surveillance and security risk assessments. We examine these and other surveillant functions of the PNEP through the first-hand experiences of thirty former prisoners who were incarcerated at one of the prisons with such a program. These experiences point to how the surveillance web is constituted by multiple lines of sight and flows of information across health and security fields. It is further comprised of risk management practices and discretionary punishment carried out by correctional officers as well as the targeting and social sorting of people who use drugs. Former prisoner narratives also demonstrate how the PNEP is reflective of emerging forms of exclusion and processes of securitization that operate through the identification, management, and containment of specific groups. As a whole, the PNEP model implemented in Canada, and the practices that undergird it, target people who use drugs for increased surveillance, resulting in extremely low rates of program enrollment despite pervasive drug use in prison, and undermining access to an essential health care service to which prisoners are entitled. The study findings point to novel forms of carceral surveillance that enmesh observational, technological, and bureaucratic practices, and demonstrate how prisoner health and therapeutic objectives can be subsumed by securitarian logics.

Introduction

As research on contemporary surveillance technologies and practices has proliferated in recent decades, one area that has received less critical attention is surveillance in carceral institutions. And yet, surveillance in these settings has continued to evolve in conjunction with broader technological advancements and cultural shifts. Low-tech forms of surveillance such as direct observation endure and are supplemented by emerging and novel forms like bio-surveillance methods. These are often used in combination to target behaviours deemed unwanted or problematic by carceral authorities, for example drug use. Socio-political changes that have begun—unevenly—to regard drug use as a “health issue” and the expansion of community-based harm reduction initiatives have come to bear on carceral settings, resulting in remade practices, institutional arrangements, and partnerships between surveillance actors. This article turns to one manifestation of these shifts in carceral practices in Canada—Prison Needle Exchange Programs (PNEPs). In 2018, propelled by a court challenge and civil society pressures, the federal agency that oversees sentences of two years or more, the Correctional Service of Canada (CSC), began the roll-out of PNEPs to select federal prisons across the country, with nine eventually implemented as of 2022 (Chu et al. 2022; Correctional Service of Canada 2019b).¹ Drawing on primary data from a community-driven study with people who had been recently

¹ In 2021, CSC reported on its website that PNEPs had been implemented at eleven of its federal prisons, but in 2022 the website had been revised to include a list of just nine prisons with the program.

released from one of those institutions, we examine the operation of contemporary carceral surveillance, its embedded relationship with prison health care, and former prisoners' experiences of such practices.

Surveillance studies scholars have long called for inquiry that moves beyond Foucault and the panopticon, pointing to the motivations for contemporary surveillance that extend past the disciplinary and the punitive; that attend to questions of visibility, invisibility, and erasure; that speak to the ways in which the targets and agents of surveillance are in a continuous state of redefinition; and that disrupt the care/control dichotomy (Browne 2016; Moore 2011; Murakami Wood 2016; Yar 2003). To this end, we mobilize McCahill's (2002) concept of the "surveillance web" to examine CSC's PNEP. The surveillance web departs from panoptic models that emphasize centralized observation. This concept is instructive for understanding the enlistment of multiple actors and human linkages, the flows of information and lines of sight within carceral settings, and the decentralized and networked character of surveillance in prison, all of which underscores the need for accounts of surveillance that extend beyond the technological (see Moore 2011). We further draw on Bigo's (2006, 2008) "banopticon" and Lyon's (2003) "social sorting," among other concepts, to illustrate the ways in which carceral surveillance operates through practices of stratification and profiling in the creation of categories of exclusion and to highlight the coordinating role played by securitarian logics in the deployment of the PNEP.

We begin the following with an overview of PNEPs in Canada, their legal basis, and the specific model developed by CSC that includes, significantly, a "Threat Risk Assessment" to determine program eligibility. Next, we provide a summary of the scholarly literature on carceral surveillance, including the role played by bio-surveillance technologies and their relationship to prison health and health care. In the article's third section, we briefly introduce the study upon which our analysis is based, providing methodological and socio-demographic information about the research process and participants. And in the fourth and final section, we draw on excerpts from the participant interviews and group our analysis into four thematic areas: lines of sight; flows of information; risk management and discretionary punishment; and identification and social sorting.

Prison Needle and Syringe Programs: The Canadian Context

CSC's implementation of PNEPs at nine of the country's forty-three federal correctional institutions was the result of decades of advocacy from civil society groups and current and former prisoners, culminating in a legal challenge arguing that the failure to provide access to sterile injection equipment represented a violation under both the *Canadian Charter of Rights and Freedoms* and sections 86 and 87 of the federal *Corrections and Conditional Release Act*, which stipulates CSC's obligation to provide essential health care, and the conformity of this care with professionally accepted standards. Arguments for the legal justification for prison syringe programs also point to the *United Nations Standard Minimum Rules for the Treatment of Prisoners*, known as the Mandela Rules, which Canada has adopted. Rule 24 lays out the principle of equivalence in health care standards for people who are in prison relative to that which they would receive in community settings.

Internationally, prison syringe programs have been an important carceral harm reduction measure in over sixty prisons in over ten countries since 1992 (United Nations Office on Drugs and Crime 2014). Numerous evaluations over the past three decades have demonstrated their effectiveness in men's and women's prisons of differing security levels at reducing overdoses and injection-related abscesses while also decreasing the sharing of injection equipment and the transmission of HIV and hepatitis C, all while simultaneously increasing referrals to drug treatment programs (Correctional Service of Canada 1999; Dolan, Rutter, and Wodak 2003; Lazarus et al. 2018; Lines et al. 2005). Evaluations have further found that prison syringe programs do not increase rates of injection drug use or needle stick incidents, nor have needles been used as weapons against guards or other prisoners, contrary to the claims of PNEP opponents (Public Health Agency of Canada 2006; Stöver and Nelles 2003; Stöver and Hariga 2016). Among the key features that contribute to the success of these programs globally are trust in those who are administering or running the program, easy and confidential or anonymous access, and the belief that information regarding drug use

would not be shared with others by prison health care staff (i.e., prison authorities, correctional officers, parole boards, etc.). So, while one might expect reduced uptake of prison-based syringe distribution compared to community-based programs due to the prison environment and risk of identification, international evidence shows that models have been successfully deployed and utilized when the health and confidentiality/anonymity needs of people in prison are adequately addressed.

Despite the ample international evidence and best-practice approaches, CSC implemented a needle and syringe program that does not reflect professionally accepted standards, is not in keeping with public health principles, and is largely driven by a perceived threat to prison safety and security. Among the myriad programmatic shortcomings is the enforced principle of exchange wherein program participants are allocated one syringe, as opposed to receiving quantities that reflect their actual need based on their patterns of drug use, which may be multiple injections throughout the day (Correctional Service of Canada 2019a; van der Meulen 2017). This kind of strict one-to-one exchange has long been abandoned by virtually all syringe programs in the community (Strike et al. 2013; Strike et al. 2015). The storage requirement for the PNEP kit creates another significant barrier, as kits must be in locations visible to guards and often other prisoners, which undermines privacy and creates opportunities for exposure and related reprisals. The threat of disciplinary measures for non-compliance with PNEP rules is also substantial, generating additional risks for people who are enrolled (see Correctional Service of Canada 2022b).

Other issues with CSC's PNEP approach, some of which will be explored in the discussion of our research findings below, include application delays, limited availability and operating hours of prison health care staff, variations in institutional standing orders, stigmatizing attitudes on the part of prison staff, and concerns regarding surveillance and increased scrutiny (Correctional Service of Canada 2019a; Leonard 2020). Inconsistency and ambiguity regarding eligibility criteria has also been identified as a substantial problem, as has the general lack of promotion of the program, with the majority of incarcerated individuals (as well as some prison staff members) unaware of its existence at their own institution (Office of the Correctional Investigator 2022). Due to these and other issues, participation in the PNEPs across the country has been extremely low, particularly when considered against the pervasiveness of injection drug use in federal prisons (Office of the Correctional Investigator 2022; van der Meulen 2017). As of 2020, less than half of the institutions operating a PNEP had any people enrolled, and one third of those had not received a single expression of interest (Leonard 2020). More recently, some PNEPs stopped providing services due to the COVID-19 pandemic (Office of the Correctional Investigator 2022).

Perhaps the most significant barrier to PNEP enrollment and participation rates is the program's burdensome multi-step application process that positions prisoner health needs first and foremost in security terms (Correctional Service of Canada 2019a). To apply to join the PNEP, people must first submit a request to the prison's Assistant Warden of Operations who then completes a Threat Risk Assessment to determine whether that individual's enrollment is deemed to pose a "manageable" or "unmanageable" risk to the institution. While Threat Risk Assessments are used to make other health-related decisions as well, for example prisoners' access to EpiPens and needles for insulin in the case of diabetes, it functions differently in relation to the PNEP due to the exceptional governance and stigmatization that result from disclosing one's use of illicit drugs in prison. If the risk is deemed to pose an "unmanageable" risk, the application to enroll in the PNEP is denied, giving wide discretionary power to prison administrators. And indeed, recent data from CSC (2022a) reveals that 23% of applications to join the PNEP are rejected on the basis of the Threat Risk Assessment. As the Correctional Investigator of Canada, the country's prison ombudsperson, has observed, "Too much of what should be an exclusively health and harm reduction program has been shaped by security concerns" (Office of the Correctional Investigator 2019: 17). In general, prisoner risk assessments are used for a range of purposes, including to assess risk of engaging in violence, risk of suicide, risk of recidivism for determining parole eligibility, and to determine treatment eligibility (e.g., substance use treatment) (Austin 2006; Shaw and Hannah-Moffat 2000). CSC also uses risk assessments to determine the likelihood of drug use or drug trafficking (Correctional Service of Canada 2022b), for creating a "criminal profile" and correctional plan (Correctional Service of Canada 2022c), and for the purposes of security classification (Correctional Service of Canada 2022d).

While risk assessments are rationalized based on their purported scientific objectivity, they remain highly susceptible to the subjective influences of those conducting the review (Austin 2006). To be sure, such assessments have been widely criticized for their embedded biases against women and racialized prisoners, their failure to account for the unique social and economic realities of Indigenous peoples, and their conflation of social and economic marginalization with level of risk and/or dangerousness (Austin 2006; Bourgon et al. 2018; Cardoso 2021; Martel, Brassard and Jaccound 2011; Shaw and Hannah-Moffat 2000). The use of a risk assessment to determine PNEP eligibility, we suggest, is consistent with the rise of new penology, an approach that seeks to identify, manage, and contain potential threats based on projection, privileging bureaucratic efficiency over social goals (Feeley and Simon 1992; Garland 2001). Actuarial and surveillant techniques are employed to classify and sort individuals into groups based on the presumed risks and dangers they pose. This practice reflects carceral social sorting (Bauman and Lyon 2013; Lyon 2003) and can be seen as a rejection of rehabilitative principles given that the primary concern is the containment and incapacitation of purportedly "risky" subjects. Those subjects are in turn delineated and profiled for differential treatment in service of inclusion and/or exclusion.

Carceral Surveillance Literature: Situating the PNEP

The literature on surveillance in prison settings points to a range of both expressly stated or formalized surveillance by correctional authorities, which may be written in policy, and various informal or implicit surveillance practices. Formal prison surveillance can include efforts to detect or prevent specific behaviours such as drug use, drug exchange, or self-harm; the coordination of institutional responses to critical security incidents; the gathering of intelligence for disciplinary or criminal proceedings; the inspection and management of prison employees and volunteers; the censoring of incoming materials deemed to undermine institutional order or considered contraband; and much more (Allard, Wortley, and Stewart 2006; Brewer et al. 2016; Cliquenois and Champetier 2013; Kaun and Stierstedt 2020; McCorkel 2003; McElligott 2007; Monaghan 2013; Pereira et al. 2021; Wortley 2002). Implicit or informal surveillance by prison authorities can comprise the compilation of sensitive information on prisoners' behaviour (e.g., interactions, intimate relationships), including information that is subsequently used in therapeutic settings by prison staff, as well as horizontal or lateral surveillance between people who are incarcerated (Liebling 2000; McCorkel 2003). Other manifestations of surveillance occupying ambiguous purposes (as well as ambiguous legality) include the monitoring of prison visitors such as researchers, family members, and legal counsel (Chantraine and Scheer 2022; Correctional Service of Canada 2021).

In addition to the diversity of individuals subjected to formal and informal surveillance efforts, the literature points to a broad array of surveillance techniques employed in carceral settings. Technologically mediated approaches are among the most common, including CCTV cameras; drones; wiretapped or recorded phone calls; and biometric, ion, and full body scanners (Allard, Wortley, and Stewart 2006; Correctional Service of Canada 2021; Hannem et al. 2019; Kaun and Stierstedt 2020; Ministry of the Solicitor General of Ontario 2016; Thurton 2019; Wortley 2002). The outcomes or impacts of these tech-oriented approaches are not always clear. In one study, for example, prison video surveillance was found to have no effect on incidences of violence (Debus-Sherrill, La Vigne, and Downey 2017). Bio-surveillance methods like urinalysis, hair testing, and wastewater monitoring, generally used to detect individual or group prevalence of drug use, are also increasingly deployed (Brewer et al. 2016; Wortley 2002). Such methods, however, have not entirely supplanted low-tech methods such as analog logbooks and medical charts, which continue to play a critical role in facilitating the transmission of information between various actors in prison environments, including between health care and security staff (Bell 2006).

While relational forms of surveillance feature less prominently in the scholarship—which tends to highlight technological developments—the most enduring form of carceral surveillance remains the direct observation by correctional officers and other staff (Liebling 2000). This is especially the case in the prison-based therapeutic contexts of substance use and sex offender treatment programs (McAlinden 2012; McCorkel 2003; McKim 2008). Indeed, treatment settings are rife with the gathering of personal and intimate information by staff through a range of surveillant means that are mobilized in service of

diagnosing, encouraging self-disclosure, or monitoring for adherence to program requirements (McCorkel 2003). A further relational dimension at play is the horizontal or lateral surveillance (Andrejevic 2004) between and among prisoners themselves, which at times is facilitated by prison authorities who encourage prisoners to gather intelligence and report back the information collected, in other words, engage in "snitching" (Bell 2006; Gibson-Light 2022; McCorkel 2003; Wortley 2002). In effect, this downloads the responsibility for surveillance from the prison authority onto people who are incarcerated, which can result in the internalization of correctional logics and agendas (Gibson-Light 2022).

We note, too, that the literature on carceral surveillance highlights several areas where surveillance practices are deployed in the interest of—or through appeals to—improving the health of people in prison, including by way of health promotion, prevention, and treatment. An examination of health-based rationales for surveillance expansion is especially relevant for our research on CSC's PNEP. Epidemiological surveillance has long been embedded in prison settings, albeit unevenly, to determine disease burden and inform disease mitigation efforts (Beaudry et al. 2020). The case of monitoring for drug use and signs of drug overdose provides one example where observation for the purposes of health and for institutional order become blurred, reflective of trends regarding the circulation of sensitive health care data among people who use drugs in non-custodial settings and in public health more generally (French 2014; Michaud, van der Meulen, and Guta 2022; O'Byrne and Bryan 2013). Routine practices conducted by health care staff, such as charting or the documentation of medication dispensing, can become accessible to other prison staff under certain circumstances and redeployed for surveillance-related purposes (see Correctional Service of Canada 2022e for the regulations governing information sharing in federal prisons).

Two themes pertaining to surveillance and prison health are worth emphasizing in particular. The first involves the ways in which disease outbreaks such as COVID-19 or tuberculosis can provide opportunities for the expansion of carceral surveillance practices (see Elger et al. 2020; Evans and Mussell 2022; Piché 2021; Xavier et al. 2021). Pereira et al. (2021), for instance, show how the COVID-19 pandemic accelerated the use of surveillance technologies both inside and outside of prisons, most notably the use of electronic monitoring as an alternative to custodial sentences, as some prison authorities sought to reduce COVID-19 transmission by alleviating overcrowding. The second key theme concerns the myriad ways in which health surveillance practices can become transmuted or folded into surveillance in the interest of security and institutional order. Campbell (2004: 83) describes how technologies employed in prison health care settings for diagnosis, testing, or care can become redeployed as "technologies of suspicion," which exist on a continuum between benign surveillance and "coercive compassion." For Campbell (2004), these technologies extend beyond individual uses (e.g., health management) and become rolled out more broadly as a form of "generalized targeting" to identify and manage select populations, which in turn intensifies surveillance directed at those groups—a process others have referred to as "target hardening," as will be discussed in more detail below (Carroll-Mayer, Fairweather, and Stahl 2008; McCahill 2002; Stenson 2005).

Methods and Methodology

Data collection followed a community-driven and participatory research approach (Baker Collins 2005; Dupont 2008; Fine and Torre 2006; Goodman and Sanders Thompson 2018), and was led jointly by the article's second author from Toronto Metropolitan University and the HIV Legal Network, an organization promoting the human rights of people living with or affected by HIV or AIDS in Canada and internationally, in collaboration with PASAN, a prisoner health and harm reduction agency that provides support, education, and advocacy to people who have experienced incarceration, their families, and communities. A range of HIV, prisoner rights, harm reduction, Indigenous, and other organizations in cities where a prison with a PNEP is located supported recruitment by forwarding the study poster and Facebook ad through their various networks and to their service users.

Those who were interested in participating contacted the research team through a 1-800 telephone number or study email and underwent a screening process. To be eligible, participants needed to be eighteen years of age or older and released from a federal prison after the PNEP was implemented in that institution. Thirty

interviews with eligible individuals were conducted by phone or Zoom between September 2021 and April 2022, with each interview lasting an average of thirty to sixty minutes. Participants were given a \$50 honorarium, along with a \$10 subsidy for public transit if they needed to travel to a private location in order to be interviewed. After completion, audio recordings were transcribed verbatim for qualitative analysis, with all personally identifying information removed.

Each member of the research team examined the transcripts on their own before meeting as a group to identify prevalent primary and secondary themes, a collaborative coding and analysis process in which the Principal and Co-Investigator are experienced (see van der Meulen and Chu 2022; van der Meulen, De Shalit, and Chu 2018). An inductive thematic qualitative logic (see Saunders et al. 2018) was adopted to shore up new themes and codes relating to the operations, impressions, and experiences of the PNEP. The identified themes were then iteratively developed into a codebook, consisting of nineteen primary codes, which were inputted as nodes into the data analysis software, NVivo. One new code and fifteen sub-codes were added, and existing codes modified, during the coding process.

This article draws on interview excerpts to highlight the research participants' first-person experiences. Of the interviewees, sixteen identified as men, fourteen as women, and one as trans. Fifteen identified as White, eleven as Indigenous/Metis, two as Black, one as mixed Latina/White, and one as minority. Most had been incarcerated in multiple federal prisons, and many had also experienced incarceration in multiple provinces. The number of times participants had received a federal prison sentence ranged from one to eleven times, and the total number of years in federal prisons ranged from one to thirty, with an average of approximately eight years. Twelve had injected drugs while in prison and an additional ten had consumed drugs by other means (e.g., smoking, ingesting, snorting) while incarcerated. Below, we have included the gender and racial self-identification of the participants for each corresponding quote, as well as the provinces in which they were residing at the time of the interview (Ontario: ON; British Columbia: BC; Nova Scotia: NS; Alberta: AB).

The PNEP Surveillance Web: Theorizing the Findings

According to McCahill (2002), the surveillance web is composed of a series of connections between discrete systems that are coordinated, highly integrated, and able to transcend social and temporal barriers. While this concept bears certain similarities with the surveillant assemblage (Ericson and Haggerty 2000), for instance the lack of clearly delineated boundaries, McCahill's (2002) web differs in that it emphasizes the central role played by human linkages and emergent partnerships. As such, it highlights the social dimensions of surveillance, and in particular, that social relations are embedded within surveillance technologies, wherein individuals play a mediating force through the exercising of discretion. This role of human mediation can serve to either accentuate or mitigate the scope and intensity of surveillance (Gates 2011; Graham and Wood 2003). In McCahill's (2002) framework, risk is central to how the surveillance web operates: it is the pretext for observation and collection of information. Within this schema, risk pre-empted and necessitates a target that is presumed to present liability. As a result, as surveillance methods are refined so too are the targets of its gaze. Through this process, individuals who are the focus of the surveillance web become aggregated into groups of people who are presumed to pose similar threats and are stratified—or "sorted"—accordingly.

While McCahill (2002) initially theorized the surveillance web in relation to CCTV in an English housing estate and shopping mall in order to explore new partnerships between private security and public policing, the concept has since been taken up by scholars to examine a range of practices in a variety of settings, including the work of CCTV operators (Smith 2008), gendered labour in erotic dance (Law and Bruckert 2016), and crime governance in urban environments (Stenson 2005). For several reasons, we argue that this framework is also instructive to understand experiences of PNEPs in federal prisons in Canada. First, the central role of social relations in the surveillance web (as opposed to purely technological ones) is useful in that it points to the extent to which prison staff retain discretionary power in mediating access to a particular health service. Second, the emphasis of the surveillance web on networked human linkages is helpful in

thinking through the relationships and flows of information between prison health care staff and correctional officers, as well as between the health care mandate and security mandate of CSC more broadly (unlike some other jurisdictions where prison healthcare services fall under an independent health authority). Third, the emphasis of the surveillance web on the creation of surveillance targets elucidates how CSC's current PNEP model operates through the classification of individuals into categories stratified by risk.

We thus lay out the key findings from our interviews with people who were recently released from a federal prison that has a PNEP through the lens of the surveillance web. Below, we group our results into four central themes: (1) lines of sight of surveillance practices; (2) flows of information through which surveillance operates; (3) risk management and related responses on the part of guards to perceived threats; and (4) the identification, classification, and social sorting of people who use drugs while in prison.

Lines of sight: "It would put them on some radar" (Interview 26; Indigenous woman, BC)
 Law and Bruckert (2016) draw on the surveillance web to map the surveillant practices in strip clubs, emphasizing the notion of lines of sight in order to bring attention both to the multidirectional/multiform nature of surveillance and to the partiality of surveillance coverage (e.g., "blind spots"). We borrow this notion of lines of sight to explore the first of our key thematic areas, highlighting the range of actors, various directions, and multiple forms of surveillance pertaining to drug use in prison. The Threat Risk Assessment, which prisoners are subjected to as a precondition of enrollment and which we discuss in greater detail later, is the initial PNEP surveillance practice that prisoners are exposed to, making their drug use known to prison authorities and setting into motion the diverse practices of watching described in this section. In addition, the former prisoners with whom we spoke noted diverse motivations for PNEP and drug use-related surveillance practices. These included ensuring compliance with program requirements for those enrolled, intelligence gathering for the purposes of identifying people using drugs, managing the behaviours of people who are incarcerated, and collecting information as a pretext for punitive reprisals. Taken together, and as the title of this article illustrates, study interviewees experienced near total surveillance while in prison, saying: "They're just watching you all the time" (Interview 24; White woman, BC).

Many shared with us the myriad techniques employed by the institution, where CCTV and direct observation by guards figured most prominently:

"If we want to exchange a needle nobody will do it, because it's in front of a guard, it's in front of cameras, it's in front of everybody. [...] There're cameras that see you changing needles, there's guards that see you turning needles in, and nobody wants to be found out like that. [...] There's no place in the jail that you can go where there's no camera, except in the staff offices." (Interview 23; White man, BC)

"There's cameras up and down the laneways, up and down.... Security are going to see everything in the camera." (Interview 7; White man, ON)

These excerpts echo the findings from previous Canadian research on the need for sterile syringe programs in prisons, describing how CCTV cameras placed above bleach distribution machines, which CSC provides as a harm reduction tool, functioned as a means of identifying who is using drugs while in prison (van der Meulen et al. 2016; van der Meulen, De Shalit, and Chu 2018). In the current study, a majority of interviewees emphasized the lack of discretion afforded to PNEP participants, whereby lines of sight were generated by prison health care services provided in plain view of guards, with one person stating: "You stand in line, and it's, you know, it's a wide-open area so there's no privacy" (Interview 5; Indigenous woman, ON).

Lines of sight in this context are not only visual (embodied or technologically facilitated) but also involve bio-surveillance such as drug testing and urinalysis that activate increased attention and scrutiny. While CSC's (2019a) PNEP guidelines state that enrollment in the program does not provide reasonable grounds for increased frequency of urinalysis, the people we interviewed contradicted these claims, saying: "Yeah,

you'd have to take urine tests regularly. They call them random, but they're not random" (Interview 21; White woman, NS). In this way, urine testing can be considered a disciplinary measure when certain incarcerated populations are especially targeted for assessment. Further, CSC policy stipulates that positive urinalysis can lead to punitive sanctions (Correctional Service of Canada 2022f), as a participant recounted: "They could even go to segregation if they were found to have a bad urine test" (Interview 1; Metis woman, ON).

In addition to surveillance from prison officials, interviewees discussed lateral surveillance (Andrejevic 2004) by fellow prisoners as constituting an additional line of sight. This kind of surveillance generally stemmed from the lack of discretion afforded by PNEP requirements, including routine inspections, rules for the storage of syringe kits resulting in general visibility of injection equipment, and verbal statements by guards revealing an individual's drug use intended to be heard by others. At times, lateral surveillance was carried out in alignment with institutional rules, with incarcerated people surveiling each other and reporting back to the guards:

"You don't want other people knowing so people aren't trying to steal [your syringes] from your cell or whatever the case may be. It's like, you want to keep your business on the DL [down low], but they [guards] want to publicize it, so that even if they're not searching, they got someone in that unit that's going to tell on you." (Interview 21; White woman, NS)

"Word of mouth. [...] It was your housemates that told on you, you know, things like that. They like to pit us against each other." (Interview 24; White woman, BC)

At other times, however, lateral surveillance was employed in service of the collective interest, in this case to maintain access to the PNEP and mitigate risks that it may be shut down. This underscores the multiform dimensions of surveillance (Law and Bruckert 2016) suggestive of alternative ways of thinking through surveillance that is inclusive of potentially beneficial or collectivist motivations (Hong 2017). Accordingly, a number of interviewees mentioned that there may be retaliation if one's actions resulted in the loss of privileges for others:

"Once you get that needle, that needle is worth a lot of money in jail usually, and people value that, and they want to use it as a tool, right? And... they don't want to F that up. If they did, it'd mess it up for everybody else in the jail. That person would get in trouble from other inmates, you know." (Interview 30; Indigenous man, AB)

All told, former prisoners' experiences emphasize diverse lines of sight—surveillance cameras, observation by guards, scrutiny from other prisoners—highlighting the multidirectional and multiform nature of PNEP-related surveillance. These lines of sight were mediated to a large extent by the discretionary practices of institutional staff and complemented by flows of information, particularly between administrators, guards, and prison health care staff.

Flows of information: "They say it's confidential? Bullshit" (Interview 16; White man, ON)

Thinking about the movement of sensitive information as networked flows helps to make the surveillance web more discernible in the federal prison setting. Here, flows of information refer to the movement of personal data (such as PNEP enrollment, drug use habits, health status, etc.) between and across various prison actors, including guards, health care staff, and administrators. The surveillance web's reliance on human linkages, as well as on "existing organisational, occupational and individual concerns" (McCahill 2002: 186), illustrate especially clearly its function as a mediating force in carceral contexts. With these flows and transmission of information, confidentiality becomes a central concern. Rule 26 of the Mandela rules, the United Nations minimum standards for the treatment of prisoners, adopted by Canada, enshrines the right to confidentiality regarding in-prison health care. Such provisions are also laid out in CSC policy, which states: "the confidentiality of an offender's personal health information will be maintained" except

in certain circumstances, such as security incidents (Correctional Service of Canada 2022e). However, by adding the clause that security-related concerns are justification for overriding the confidentiality of health information, substantial discretionary latitude is given to prison staff and administrators. In the context of PNEPs, we see how the overriding of confidentiality enabled by prison policy interplays with extralegal violations of confidentiality (Chu et al. 2022). The pervasiveness of extralegal violations as recounted here raises questions regarding the sufficiency of formal protections that are laid out in policy or law. Indeed, the people we interviewed reported practices on the part of prison health care personnel and correctional officers that routinely undermined their confidentiality, for example saying:

“Medical, there’s nothing confidential about medical.” (Interview 20; White woman, NS)

“The guards are kept in the loop, they know what to watch for.” (Interview 9; White man, ON)

Flows of information stemming from routine violations of confidentiality and privacy (as well as overriding of confidentiality provisions as permitted by correctional policy in the event of security concerns) complement and reinforce the lines of sight described previously. In some cases, the lack of confidentiality and information flows between health and security stemmed from the limited discretion of health care staff: “I’ve never seen anybody take needles back [to the PNEP office]. I’ve never seen anybody exchange them, and I think it’s because of the fear of health care telling on them, or something slipping out” (Interview 24; White woman, BC). Section 86 of the *Corrections and Conditional Release Act* mandates that CSC must “support the professional autonomy and the clinical independence of registered health care professionals,” and yet the dual loyalty of health care staff toward their patients and toward the prison authority who employs them can function to undermine principles of confidentiality in practice (Pont, Stöver, and Wolff 2012).

Attempts at meaningful confidentiality are further thwarted by the role played by guards in ensuring compliance with various PNEP program requirements, such as the visual inspections of the PNEP kit, as mandated in the PNEP guidelines (Correctional Service of Canada 2019a):

“We’re going to have this needle in our cell, and they [guards] are going to know, so they’re going to want to see it every day at counts and stuff like that. You would literally have to stand for count in your room and show them your needle, so then it would make it so everybody else knew.” (Interview 21; White woman, NS)

On top of the regular visual inspections by guards, many interviewees assumed that guards had access to the list of people enrolled in the PNEP, saying:

“When you first apply for the program to get the needle exchange, they never gave you the needles but the guards had access to the list of people who all wanted to get on it, right? So they knew you were using needles.” (Interview 22; Indigenous man, ON)

Others were unsure whether guards had the actual enrollment list, and instead assumed that they were engaged in more generalized forms of profiling and surveillance:

“I’m not sure 100% if the guards knew who was using the program or not. It’s more like the guards knew that these people were in the drug subculture.” (Interview 12; White man, ON)

“The guards come through randomly and would ask to see people’s sharps [needles]. But, I mean, the guards really never knew who was on the program, and that’s the thing I thought was really weird. Like, they come through at 11 o’clock count or 10 o’clock

count, and they would ask to see people's sharps, if they were on the program. [...] The guards aren't supposed to know who's on the program, but then they ask to see... they're allowed to call, 'I want to see your sharps.' So you have to produce your PNEP kit to show that it's intact, but then they know you're on the program." (Interview 3; Indigenous woman, ON)

"They actually disrupted the whole household because during counts, every count, they would be asking about these needles to everybody. They just go in and ask the whole house, every day, multiple times a day." (Interview 6; Minority woman, ON)

Conflicting understandings among the interviewees about the extent to which guards had legitimate (or illegitimate) access to the names of people enrolled in the PNEP underscores an ambiguity in how information flows unfold. In this respect, uncertainty regarding access to PNEP registration lists by guards functions generatively, similar to classic panoptic models that, in addition to inciting changes in self-governance, contribute to an opacity in how the program operates and anxiety about meaningful confidentiality within it.

The flows of information regarding health care and PNEP participation is characteristic of how the surveillance web operates by facilitating and producing "patterns of sociation" (McCahill 2002: 7). The shared jurisdiction of the PNEP between health and security creates novel affiliations between guards and prison health care staff, with new modes of interaction and social organization produced through emergent forms of information sharing. Indeed, by establishing the PNEP centrally as a security concern, variously constituted flows of information and novel affiliations between health and security are mobilized in service of surveillance techniques and security mandates. This is reflective of emerging models of governance that others have pointed to that merge the medical with the penal, but in which the therapeutic is fully subordinated to penal aims (Kaye 2020).

Risk management and discretionary punishment: "Those are the ones they like to harass" (Interview 2; Black man, ON)

Where the surveillance practices described in the previous sections generally revolve around threat *detection*, the practices discussed here primarily concern threat *response*. Prison administration and correctional officers variably deem PNEP-related risks as threats to the institutional order (e.g., the circulation of contraband) and staff safety (e.g., needle stick incidents²), requiring effective management. PNEP risk mitigation measures are laid out in correctional policies and documents, such as the Threat Risk Assessment, and include the use of lockdowns, drug detection dogs, and urinalysis. Yet the techniques deployed by guards in response to perceived risks extend beyond these measures, encompassing extralegal punitive reactions, vitriol, and harassment. In various ways, formal risk management policies interplay with the discretionary punishment doled out by guards in the name of risk containment.

Interviewees cited the exaggerated fears of needles, rooted in drug user stigma, as a pretext for harsh responses such as prolonged lockdowns, frequent examination of personal effects, and repeated strip-searches:

"There are circumstances where needles have gone missing, and when that happens, the whole jail is put on lockdown until they find it. And if they don't find it, we're on lockdown for a couple days." (Interview 1; Metis woman, ON)

"If somebody, like let's say a friend of mine, that they know who was a drug user stayed in my cell, they'd let him come to my cell and three, four minutes later, they'd rush the

² Fears of being accidentally pricked by a PNEP needle during a cell search are unfounded. As of 2020, no needle stick incidents with PNEP equipment had occurred at any federal prison (Leonard 2020).

cell quick. [...] They handcuffed you, they searched you, they strip searched you, they ransacked your cell, ripped it all apart." (Interview 22; Indigenous man, ON)

Former prisoners noted these risk management practices and punitive responses were felt most deeply by those identified by guards as enrolled in the PNEP:

"There'll be more searches, they might get called for more urine tests, they might be subjected to dry cell, or whatever the case may be. So, if the guards are aware that you're in the Prison Needle Exchange Program, they're going to punish you." (Interview 12; White man, ON)

"They make you feel like you're going to be safe [when you join the PNEP], but in the end, you're not. They wreck your cell, they lock you down, they give you trouble for it." (Interview 15; Indigenous man, ON)

As the above interviewees describe, consequences once someone is found by guards to be enrolled in the PNEP result overwhelmingly in the intensification of surveillance. Sanctions for PNEP rule violations cited by interviewees included placement in administrative segregation, loss of privileges such as work assignments or visits, seizure of needle kits, and PNEP de-enrollment. Such consequences are confirmed by the Office of the Correctional Investigator (2022: 6). In cases where direct reprisal for PNEP participation does not occur, guards are still able to draw upon different tools in their exercise of punitive discretion:

"I don't know if the guards can charge them for having that equipment, but what will happen is the guards will take the knowledge that people are involved in the needle exchange, and they will come at them from another direction." (Interview 12; White man, ON)

Echoing McCahill's (2002) initial emphasis on how the surveillance web operates through new partnerships, alliances, and linkages, Norris and McCahill (2006) argue that the surveillance web departs from the centralized panoptic model by diffusing the responsibility for surveillance onto a range of agencies and actors. One example of this diffusion in the federal carceral context is the recruitment of diverse actors, including health care staff and other prisoners, to take on security-oriented risk management roles for ensuring compliance with PNEP requirements and institutional policies. Recognizing the central role of responsabilization techniques, the surveillance web comes into view, in part, through activating the broader incarcerated population in an intensification of lateral surveillance.

Interviewees recounted how risk management and responsabilization practices of this nature accentuated tensions between prisoners and increased hostility toward those who use drugs:

"That's another issue... you have total inconsistency. What about the poor guy, if he's double bunked? What about the poor rest of the guys in the house who are not on such a program, and then get labelled [a drug user]? Okay, now our house is getting searched every week because of this guy." (Interview 7; White man, ON)

While many of the risk management practices described here point to the work of guards, such techniques are also present at the administrative level and in CSC policy. The Threat Risk Assessment itself provides a case in point. It is used to determine PNEP eligibility, yet we argue that it should also be understood in relation to its surveillant functions, allowing the prison administration to amass highly sensitive and personal health information (e.g., that a prisoner uses illicit drugs, is able to procure illicit drugs while in prison, and intends to do so). As an interviewee told us of their experience applying to join the PNEP:

"They just wrote back on my request form saying, 'at this time, you do not qualify for the Prison Needle Exchange Program, please send in a request in a couple of months.'" (Interview 17; Indigenous trans person, NS)

This collection of information by way of the Threat Risk Assessment under the auspices of risk management points to another key theme in the interviewees' experiences of PNEP surveillance, one that is a central dimension of the surveillance web: the classification and sorting of prisoners stratified by the degree of supposed risk, which we turn to next.

Identification and social sorting: "They were singled out, you know" (Interview 5; Indigenous woman, ON)

The classification and profiling of groups and individuals into various categories—or social sorting (Lyon 2003)—is a defining dimension of contemporary surveillance, and plays out particularly clearly in the context of the PNEP. Constituted by separation and designation based on purported risk and/or threat, social sorting techniques are commonplace in healthcare settings that rely on risk stratification (e.g., emergency medicine triage methods or public health initiatives to identify priority populations). However, in the context of CSC institutions that operate a PNEP, risk is transmuted from an individual risk pertaining to prisoner health, such as the transmission of HIV or hepatitis C, to the presumed risks posed to guards. Here, Bigo's (2006, 2008) concept of the *banopticon* complements the social sorting techniques central to the PNEP and adds several important dimensions. The *banopticon*, reliant on profiling technologies and the creation of categories of exclusion, points to the construction, identification, and containment of risk, as opposed to its eradication (Bauman and Lyon 2013). While the *banopticon* is theorized primarily in relation to national security and border policy, it is useful in drawing our focus to the securitarian elements of the PNEP, in which health issues are transformed into security concerns.

In this respect, the social sorting techniques and *banoptic* securitarian mandate resonates with the security-oriented framework of the PNEP. For example, the use of the Threat Risk Assessment to determine PNEP eligibility, which classifies the risk posed by prisoners' enrollment in the PNEP as either "manageable" or "unmanageable," is a vivid illustration of the creation of groups designated for inclusion/exclusion through a security lens. This categorization stratifies access by effectively banning from health services those who are deemed irredeemably risky. Here once again we can see the punitive force of risk management practices, particularly among excluded groups who, despite stated and recognized need, must continue using non-sterile and potentially already used drug injection equipment, exposing them to significant health risks:

"Yes, I've seen people get their kits taken away. But that's more dangerous because they'll just use someone else's anyways." (Interview 4; Latina/White woman, ON)

"That's when you start to get people buying needles on the side or sharing." (Interview 1; Metis woman, ON)

We should emphasize that compliance with PNEP requirements does not shelter people in prison from drug-related surveillance and risk management practices, nor are non-drug using prisoners exempt. Many risk management techniques (such as lockdowns due to missing needles) impact everyone who is incarcerated. Those who require the use of needles for other health-related issues are also subject to a Threat Risk Assessment, though with notably different effects. People who are enrolled in the PNEP, even when adhering to its requirements, are subject to a higher degree of surveillance and discretionary punishment relative to others in the prison population.

As noted above, McCahill's (2002) surveillance web operates through the construction and detection of threat, through which specific targets come into view. As surveillance practices are refined, techniques deployed to identify these targets become more sophisticated, a process referred to as "target hardening" (Stenson 2005). It is through this iterative process that the subjects of surveillance become "known" to the

actors conducting surveillance, which then allows the classification and social sorting of individual targets. Interviewees identified such target hardening by guards:

"I would say, yes, for sure. If the guards are aware that people are participating in that program, they are coming for them." (Interview 12; White man, ON)

"I didn't do it because I didn't want my face being associated with the Needle Exchange Program because I didn't want the IPSO [Institutional Preventative Security Officer] all over me." (Interview 23; White man, BC)

"It was almost like they were picked on. They were singled out, you know?" (Interview 5; Indigenous woman, ON)

"If they know that they're on... the Needle Exchange Program, or they're taking a potent narcotic, then they really start watching them." (Interview 7; White man, ON)

Thus, the PNEP becomes visible as a technology that functions to identify risks, aggregate groups, and manage purported threats to security. Risk stratification is the mechanism whereby social sorting becomes possible, reflecting the banoptic (Bigo 2006, 2008) dimensions of the PNEP whereby manageable risks are begrudgingly contained, and unmanageable risks are subject to punitive exclusion. In so doing, the securitarian PNEP model as designed and implemented by CSC actively produces a number of health-related consequences that it purports to mitigate. Formal legal rights (e.g., prisoner access to essential health care) are directly undermined by the PNEP model itself, including its operational requirements such as the Threat Risk Assessment, and are further undermined by the discretionary practices of prison staff. This is illustrative of the *de facto* revocation of rights and identification of groups targeted for intensified forms of risk containment.

Conclusion

The myriad problems with the PNEP, identified by study participants, are not inherent to prison syringe distribution. Indeed, while prisons are sites of near total surveillance, there are established ways to preserve privacy and confidentiality, especially regarding prisoners' health, as other models and decades of international empirical evidence attests (Lazarus et al. 2018; Stöver and Hariga 2016). Rather, the limitations of the PNEP in Canada are produced by the specific program model designed and implemented by CSC. And while confidentiality provisions can be easily undermined by overriding security concerns or through breaches by prison staff, for which there is a lack of meaningful recourse for prisoners (Patrick 2006), such risks can be mitigated by clear jurisdictional separation between healthcare and security, as called for by health advocates (Chu et al. 2022; Scallan, Lancaster, and Kouyoumdjian 2021). With its single-minded security focus, which usurps its health objectives, and the extensive surveillant practices and networks deployed, we can see clearly how PNEP enrollment places incarcerated individuals into a carceral surveillance web comprised of multiple actors, manifold techniques, and a range of lines of sight and information flows. This manifestation of carceral surveillance is characterized by both routine and extraordinary methods and is both relationally and technologically mediated. It is also simultaneously high-tech and low-tech in nature, as forms of surveillance rooted in direct observation are complemented by bio-surveillance such as drug testing and urinalysis.

Given the extent to which institutional security supersedes and is conceived as at odds with prisoner health within CSC's PNEP model, risk management practices are a defining feature of the program, undercutting access and contributing to negative health outcomes among people who are in prison. Among the most visible manifestations of this are the discretionary extralegal punishments meted out by guards and other prison staff—including punitive reprisals, abuse of authority, breaches of confidentiality, and illegitimate targeting—rationalized on the basis of risk management. For those who enrol in the PNEP, these punishments are heightened by virtue of their increased visibility. People seeking to join the PNEP are

profiled and sorted into “manageable” and “unmanageable” categories based on their presumed risk levels, reflective of banoptic principles that distinguish between risks to be contained and risks to be met with punitive exclusion. The key document in this respect, the Threat Risk Assessment, is a prime illustration of social sorting as activated by the PNEP, facilitating target hardening and establishing the PNEP centrally as a matter of security.

Consistent with Norris and McCahill’s (2006) emphasis on how the surveillance web operates through the enlistment and responsabilization of diverse actors, CSC’s PNEP raises important ethical-legal concerns with respect to prison health care. It underscores that carceral surveillance operates through the construction, detection, and classification of threat, resulting in stratified access to an essential healthcare program. Perhaps unsurprisingly, due to design, implementation, and delivery impediments, there has been widespread non-uptake of the PNEP among prisoners who use drugs. As of March 2022, only forty-six individuals were participating in the program nationally, and half of the federal prisons with a PNEP had no active participants despite injection drug use frequently occurring in these settings (Office of the Correctional Investigator 2022: 7; Smith 2022). As the Office of the Correctional Investigator (2022: 7) underscores, the PNEP “remains a program largely in name only.” Low rates of engagement among incarcerated individuals, when considered against the findings presented here, exemplify the processes by which prisoners become disentitled to their legal rights. We further highlight the importance of considering the implications of these program limitations relative to the specific social location of people who use drugs while in prison, particularly given the over representation of racialized, Indigenous, and disabled peoples in federal prisons and the lower uptake of health and harm reduction services among these communities due to systemic barriers (see Lopez et al. 2022; Ware, Ruzsa, and Dias 2014).

Future research on the PNEP would benefit from a more focused examination of race, class, gender, and disability, especially vis-à-vis the basis upon which 23% of PNEP applications are denied by prison administrators and the corresponding health risks produced by such refusals. Other considerations for carceral surveillance researchers, as illuminated by the exploration of our findings, include the need to pay attention to both relational and embodied forms of surveillance, as well as to the transformations that unfold when embodied surveillance interacts with novel or technological forms. Relatedly, our study has highlighted that the constitutive role of discretionary practices and human linkages within contemporary surveillance arrangements are essential to consider when examining purportedly benevolent modes of surveillance motivated by health, as in the case of CSC’s PNEP. And finally, our findings suggest greater attention be paid to the ways in which carceral health and therapeutic objectives are mobilized as the rationale, or as an opening, for expanded surveillance practices. As we have seen, such an expansion stands to have myriad repercussions for people in prison.

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